

Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Reporting Instructions

Non-Quantitative Treatment Limitations (NQTL)

Seven Step Analysis

Data Reporting

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# Introduction:

The analysis report template and supplements are prepared to satisfy the requirements of §15-144, Insurance Article, Annotated Code of Maryland, to create a standard form for entities to submit the NQTL report in accordance with subsection §15-144(c)-(f). The templates have been updated to reflect only the five NQTLs selected by the Commissioner for the 2024 reporting period. Carriers are encouraged to review the prior versions of the template forms posted on the MIA website for direction on how to document comparative analyses for additional NQTL categories not included on the 2024 template forms. These instructions include general guidance for performing and documenting comparative analyses for all NQTLs, as well as specific guidance related to the five NQTLs selected by the Commissioner for 2024.

Complete analysis reports must include all data and information identified in COMAR 31.10.51 and in these instructions in the manner and format specified. Section 15-144(j) describes the actions the Commissioner may take if a carrier fails to submit a complete report, including imposing administrative penalties, charging the carrier for any additional expenses incurred by the Commissioner to review additional reports, and ordering the carrier to cease or modify the disputed conduct or practice. The failure to submit a complete analysis report is a violation of the Mental Health Parity and Addiction Equity Act (“Parity Act”).

Narratives and data shall be entered into the fields of the template or supplemental form.

In completing the analysis report, the analysis for MH may be combined with the analysis for SUD when the design and application of factors, processes, strategies, evidentiary standards, and sources are the same for both. If the design and/or application of factors, processes, strategies, evidentiary standards, or sources is different for mental health benefits vs. substance use disorder benefits as written or in operation, then mental health benefits and substance use disorder benefits shall be reported separately.

The steps outlined in these instructions are sequential and directly related to one another. The benefits, provider type, drugs etc. that are discussed in Step 1 should reflect the covered services listed under the benefit classifications section. Steps 2 and 3 are directly related and both must be addressed in the written policies analyzed in Step 4. Step 5 must consist of results of the reviews conducted to confirm the written policies from step 4 are functioning as intended, including any data and numerical results. Step 6 will summarize the plan’s efforts to coordinate with its delegated entities, if any, on MHPAEA analysis activities. In step 7 carriers will summarize the MHPAEA findings from each step of the analysis including the data supplement reports. **Because of this, an incomplete response to any step in the process may render the response for an entire NQTL incomplete.**

The following responses are likely to occur when differences between M/S and MH/SUD covered benefits are not accounted for and may result in a finding that a carrier failed to submit a complete analysis report:

1. Production of documents without a clear explanation of how and why each document pertains to the comparative analysis. This includes how each document has been analyzed in a comparative manner and how the comparability and stringency NQTL tests have been met, both in writing and in operation;

2. Generalized statements concerning factors, processes, standards, procedures, etc., as well as mere recitations of the legal standard and conclusions regarding compliance, without specific supporting evidence and detailed explanations of comparative analyses;

3. Identification of factors, evidentiary standards, and strategies without a clear description of how the factors, evidentiary standards, and strategies are defined and applied for M/S or MH/SUD benefits;

4. Identification of processes, strategies, sources, and factors without the required clear and detailed comparative analyses;

5. Statements that all factors, evidentiary standards and/or criteria, processes and/or strategies are the same for M/S and MH/SUD without detailed definitions and specific comparative analyses for each factor, evidentiary standard, criteria, process, strategy, etc. that substantiate such statements;

6. Reference to factors, evidentiary standards, and/or criteria that inherently rely on quantitative measures and/or are defined or applied in a quantitative manner, without the precise quantitative definitions; note that the MIA may now require a carrier to establish specific quantitative thresholds for evidentiary standards and perform a new comparative analysis if the report is insufficient in this regard;

7. Responses that do not to include comparative analyses, including results, and information necessary to examine the development and/or application of each NQTL, and do not clarify the methodologies utilized for such comparative analyses**;**

8. Analysis that is not for the applicable time period;

9. Analysis that is obsolete due to the passage of time, a change in plan structure, or for any other reason;

10. Failure to include specific data used in an analysis or audit to determine whether the NQTL is comparable to and no more stringently applied to MH/SUD benefits than to M/S benefits in operation.

11. Failure to provide an explanation for any disparities in comparative data analyses, as outlined in the instructions for Step 7.

# Definitions:

The terms in the instructions and the analysis report are defined in COMAR 31.10.51 or have the meaning indicated below. Use of these definitions in completing the report is mandatory.

 “Facility” means a person, other than an individual, that provides health care services. “Facility” includes entities that bill for a bundled set of services that include services provided by staff employed by the facility. Examples of facilities include hospitals, outpatient radiology centers, opioid treatment services providers, community mental health centers, and residential treatment centers.

 “Measures” means the steps, plan, methods, or course of action taken by a carrier to assess compliance in the development and implementation of an NQTL when the carrier has delegated management of covered benefits to another entity. Measures include written policies, procedures, and guidelines, as well as operational controls, checks, audits, and safeguards.

“Plan documents” means all documents under which the plan is established or operated in which a carrier describes a requirement related to an NQTL, or the processes, strategies, evidentiary standards, and other factors used to apply an NQTL, including a policy, certificate of coverage, medical policy, medical necessity criteria or guidelines, or provider manual. Plan documents also include any document reflecting analyses conducted or results from such analyses related to the comparability and stringency of an NQTL for MH/SUD benefits as compared to M/S benefits.

“Prescription Drug Formulary Design” means a continually updated list of prescription drugs approved for reimbursement, including generic, brand, and specialty drugs, and plan features that base reimbursement, cost-sharing, or authorization requirements on the formulary category into which a drug is placed. Prescription Drug Formulary Design may include processes to place drugs on specific tiers, or to exclude a drug from the formulary, as well as processes to impose step therapy requirements or quantity limits.

“Prior authorization” means the process that a carrier or any entity delegated by the carrier to manage mental health, substance use disorder, or medical/surgical benefits on behalf of the carrier requires a member or provider to follow prior to the rendering of services to determine if coverage will be provided based on considerations such as medical necessity, level of care, appropriateness of health care services, provider type, geographic location, or diagnosis exclusions. Prior authorization includes, but is not limited to, preauthorization, precertification, prospective review, preadmission review, pretreatment review, utilization review, and any requirement that a member or provider notify the carrier or organization prior to receiving or delivering a health care service. Prior authorization includes reauthorization of services or benefits that had received preauthorization, but for which the approval period has lapsed at the time the request is submitted. A request for prior authorization is one received during the reporting period, regardless of whether or when services are delivered or whether or when a claim is submitted.

 “Product” has the meaning stated in § 15-1309(a)(3) of the Insurance Article, and means a discrete package of health benefits that are offered using a particular product network type within a geographic service area. “Product” comprises all plans offered within the product.

“Provider Network Directory” means a list of the providers who participate with a carrier as an in-network provider under a particular product. For the purposes of this definition, “provider” includes physicians, non-physician practitioners, facilities, pharmacies, laboratories, and any other person or entity under contract with the carrier to provide covered services, items, or supplies to a member of the carrier. A Provider Network Directory may be online or in printed form, and it includes any provider-specific information disclosed by the carrier in the directory, such as provider name, telephone number, digital contact information, practicing specialty, services offered, quality ratings, physical address of practicing locations, whether the provider offers telehealth services, hours of operation, whether the provider is accepting new patients, languages spoken, race, ethnicity, gender; and other demographic and practice information.

“Provider Shortages” means deficiencies in the number or availability of in-network providers with appropriate training and expertise to sufficiently meet the needs of a carrier’s members to obtain covered services without unreasonable delay or travel. “Provider Shortages” includes determinations by a carrier that additional providers are required for the product’s network based on factors and evidentiary standards used by the carrier to measure network composition or to address network deficiencies in addition to meeting network adequacy standards set by a state or federal regulator.

“Reimbursement” means compensation or the amount allowed to a health care provider, member, or other person entitled to reimbursement by a carrier, or the combined amount of the carrier’s payment and member’s cost-sharing responsibility, for providing health care services, medications, or supplies to members of the health benefit plan. Reimbursement includes, but is not limited to, fee for service payments, capitation payments, bundled or global payments, and bonuses or other incentive payments.

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# NQTL Analysis Report Template Completion Instructions



## *Specific Guidance for the 5 NQTLs Selected for 2024:*

When providing the required comparative analysis information for the 5 NQTLs listed below, carriers must include information on any practice or process that meets the definition of the applicable NQTL, as defined in the preceding section of these instructions. In addition to addressing all of the items provided below for each step of the analysis in the “Important Guidance” section of these instructions, carriers must address the following NQTL-specific issues when completing the 2024 NQTL reports.

1. Prior Authorization Review Process

When completing Step 1(b), all services for which prior authorization is required must be listed under the applicable benefit classification or sub-classification. The services listed, and the categorization of a service as either M/S or MH/SUD, must be consistent with the Covered Service information provided in Step (a) of the Benefit Classifications section of the template form.

As required by COMAR 31.10.51.04G(4)(j), an NQTL analysis report must include a description of the consequences or penalties that apply when an NQTL requirement is not met. In the case of prior authorization, the carrier must explain whether failure to obtain prior authorization when required will result in a denial of benefits or an alternative penalty, such as a reduction in the amount of benefits otherwise payable. If the penalty varies based on the requested service or other circumstances, a comparative analysis must be provided to demonstrate comparability and relative stringency in the design and application of the penalty between M/S benefits and MH/SUD benefits.

There are three main components of the Prior Authorization Review Process that every analysis must address:

* First, a comparative analysis must be provided for the processes, strategies, evidentiary standards, and all factors the carrier uses to determine the list of services/benefits that are subject to a prior authorization requirement.
* Second, a comparative analysis must be provided for the administrative processes, including timelines, that the provider/member must use when submitting a prior authorization request, and that the carrier adheres to when processing the request.
* Third, a comparative analysis must be provided for the criteria the carrier uses to determine whether to approve or deny prior authorization requests when reviewing the underlying services for medical necessity, level of care, appropriateness, or other applicable considerations.

Data Supplement 1 must be submitted to support the in operation comparative analysis under Step 5 for the Prior Authorization Review Process NQTL.

1. Prescription Drug Formulary Design

The comparative analysis for the Prescription Drug Formulary Design NQTL should address how formulary decisions, including tier placement, specialty designation, and exclusions are made for the diagnosis and medically necessary treatment of M/S and MH/SUD conditions. Pertinent pharmacy management processes, including, but not limited to, cost-control measures, generic and/or therapeutic substitution, and step therapy must be described. If not addressed in PA NQTL, that information should be included in this NQTL Carriers must identify the disciplines, such as primary care physicians, internists, pediatricians, specialty physicians (e.g., psychiatrists), and pharmacologists, that are involved in the development of the formulary for medications to treat M/S and MH/SUD conditions. An analysis of the exception process for any applicable step therapy requirements or other formulary limitations must also be included.

When completing Step 1(a), a copy of the applicable formulary list must be provided. The version of the formulary provided shall be the most recent version on which the comparative analysis was based, including any in-operation data provided in response to Step 5. The formulary list shall identify the date it was effective.

Data Supplement 2 must be submitted to support the in operation comparative analysis under Step 5 for the Prescription Drug Formulary Design NQTL.

1. Provider (Including Facility) Reimbursement

The comparative analysis for the Provider (Included Facility) Reimbursement NQTL must address the process for determining reimbursement rates for in-network and out-of-network providers. A separate analysis must be provided for practitioner reimbursement vs facility reimbursement under each applicable benefits classification/sub-classification. To the extent there are differences in the process for determining reimbursement rates for physician practitioners vs non-physician practitioners (e.g. physician assistants, nurse practitioners, licensed social workers, and psychologists), separate analyses should be provided at this level as well. Any variance in rates applied by the carrier to account for factors such as the nature of the service, provider type, market dynamics, or market need, or availability (demand) must be comparable and applied no more stringently to MH/SUD benefits than M/S benefits.

Carrier responses must include consideration of any Maryland laws that establish specific rate methodologies for particular services or providers (i.e., §§ 14-205.2 and 15-604 of the Insurance Article and §§ 19-710(e) and 19-710.1 of the Health-General Article). The existence of a statutorily required reimbursement methodology for certain provider types within a benefit classification does not obviate the need for a comparative analysis for that benefit classification, since the Maryland laws do not apply to all providers and services. However, the focus of the comparative analyses in these cases should be on the providers and services not subject to the applicable law.

Data Supplement 3 must be submitted to support the in operation comparative analysis under Step 5 for the Provider (Including Facility) Reimbursement NQTL.

1. Strategies for Addressing Provider Shortages

The comparative analysis for the Strategies for Addressing Provider Shortages NQTL must address all considerations taken into account by the carrier when evaluating whether the provider network is sufficient to meet the needs of members, **beyond compliance with state or federal minimum standards for network adequacy**. The analysis must also address any and all adjustments made to provider admission standards when a network deficiency is identified, including increasing reimbursement rates, accelerating/streamlining the credentialing and contracting process, or offering other incentives to join the network. In describing the strategies employed in this area, the carrier must specifically address the following issues for both M/S and MH/SUD providers:

* Does the carrier set its own standards for network sufficiency for any provider types that are in excess of the minimum standards required under Maryland regulations, COMAR 31.10.44? If so, which provider types, and what is the rationale for establishing additional standards for these particular provider types?
* How does the carrier determine if the need for a specific provider type justifies negotiating fee schedules, or offering incentives to join the network?
* Does the carrier audit its reimbursement rates at the upper percentiles (e.g. 75th and 95th) to assess the rate that will incentivize providers to join networks?
* How does the carrier determine which providers are eligible for performance/quality bonuses?
* How does the carrier determine the amount of performance/quality bonuses that a provider may be eligible for?
* Does the carrier negotiate fees or differentiate fee schedules based on provider group size?
* How often does the carrier assess for provider shortages, and what is the process for making the assessment?

Data Supplement 4 must be submitted to support the in operation comparative analysis under Step 5 for the Strategies for Addressing Provider Shortages NQTL.

1. Provider Network Directories

Provider Network Directories function as an NQTL because the ability to locate and receive treatment from an in-network provider, which is contingent on the accuracy of the directory and the inclusion of only those providers who currently participate in the network and actively deliver services, is essential for ensuring members have meaningful access to benefits. The comparative analysis for the Provider Network Directories NQTL must address all considerations taken into account by the carrier in the design and maintenance of the directory, with a particular focus on the comparability between M/S and MH/SUD in the accuracy of the directory and the level of specificity with which provider information is displayed and searchable. The carrier must specifically address the following issues for both M/S and MH/SUD providers:

* What is the process for updating the directory and correcting inaccurate information? This includes the process for adding new participating providers to the directory, removing providers from the directory who are no longer participating, and updating provider-specific information displayed in the directory for existing participating providers.
* What methods are used for obtaining and verifying each type of provider-specific information displayed in the directory?
* What methods are used for verifying that a provider listed in the directory continues to participate as an in-network provider?
* How does the carrier determine which specialty, subspecialty, and facility types will be displayed in the directory and which specialty, subspecialty, and facility types will be separately searchable?
* How does the carrier determine which types of specific services offered by providers will be displayed in the directory and which services will be separately searchable? This question is focused on how the carrier selects the universe of possible services that may be listed in the directory, not how the carrier determines which services are offered by a particular provider. Identifying and verifying the services offered by a particular provider should be addressed in response to the first two bullet points above.
* Is there a limit on the number of specialty areas or types of services that can be attributed to a single provider listed in the directory?
* What, if any, additional assistance does the carrier provide to members who have difficulty using the directory to locate an available provider with the necessary training and expertise to treat the member without unreasonable delay or travel?

When completing Step 1(a), the carrier must include a complete list of the unique specialty practitioner types and facility types for M/S and MH/SUD that are separately listed and searchable in the provider network directory.

Data Supplement 5 must be submitted to support the in operation comparative analysis under Step 5 for the Provider Network Directories NQTL.

*Important Guidance for Completing Template Form:*

## Product/Plan Information

**Provide a brief description of the product, including an explanation of any features or characteristics that differentiate this product from other products offered by the carrier in the same market. Provide the form numbers, approval dates, and SERFF tracking numbers for all forms comprising the entire contract of insurance for the product. If there are separate schedule of benefits forms for each plan within the product, it is only necessary to provide the identifying information for one sample schedule of benefits form.**

A separate analysis report shall be submitted for each product. However, if, for any plan within a product, the processes, strategies, evidentiary standards, or other factors used in designing and applying the reported NQTLs to mental health benefits, substance use disorder benefits, or medical/surgical benefits are different, as written or in operation, from the other plans within the product, a separate analysis report shall be submitted for that plan. In this case, the information described above should be provided at the plan level instead of the product level.

## Benefit Classifications

1. List each covered service under the product/plan in the table provided on the template form. Indicate whether the covered service is treated as M/S or MH/SUD, and identify which of the following classifications or sub-classifications the covered service has been assigned to: In Network Inpatient; Out of Network Inpatient; In Network Outpatient (OR: In Network Outpatient-Office; In Network Outpatient-All Other); Out of Network Outpatient (OR: Out of Network Outpatient-Office; Out of Network Outpatient-All Other); Emergency; or Prescription.

Do not list non-medical dental or vision benefits in the list of covered services, and do not include these benefits in the NQTL analyses. Dental care that is customarily covered under medical policies, e.g. injury to sound natural teeth or treatment for cleft lip/cleft palate, should be included as a medical benefit.

For the purposes of the NQTL analyses for each product/plan, a carrier may elect to use the outpatient benefit classifications, or divide benefits furnished on an outpatient basis into the two sub-classifications described in 45 CFR § 146.136(c)(3)(iii)(C) for “office visits” and “all other outpatient items and services.” The election to use either the outpatient classifications or the outpatient sub-classifications shall be made at the product/plan level, and may not vary for different NQTLs under the same product/plan.

1. Explain the methodology used to assign M/S and MH/SUD benefits to each classification and/or sub-classification. Note: Classification of covered services must remain consistent across NQTL analyses within the same product/plan. In determining the classification in which a particular benefit belongs, the same standards must be applied to M/S benefits and to MH/SUD benefits. Intermediate MH/SUD benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment) must be assigned to the existing six classifications in the same way that intermediate medical/surgical benefits are assigned to these classifications. For example, if a product/plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits. If a product/plan treats home health care as an outpatient benefit, then any covered intensive outpatient MH/SUD services and partial hospitalization must be considered outpatient benefits as well

## Step 1 NQTL Description, Application and Methodology:

1. Provide a description of the plan’s applicable NQTLs as applied to M/S or MH/SUD benefits in the table provided on the template form.

Describe the specific NQTL plan language and procedures, as applied to M/S benefits and as applied to MH/SUD benefits, including identification of associated triggers, timelines, forms, and requirements.

Provide cross references to plan documents that contain language related to application of the NQTLs (i.e., all member documents, posted medical policies, internal documents and applicable provider manual references which are pertinent to providing notice of and information regarding the NQTL requirements). Note that for the purposes of Step 1(a), the term “plan documents” refers only to the documents describing the NQTL itself, and does not include documents reflecting analyses conducted or results from such analyses related to the comparability and stringency of an NQTL for MH/SUD benefits as compared to M/S benefits.

Copies of the applicable policy or certificate of coverage should be available, but are not required to be included with the submission. Copy the specific language from the policy or certificate into the report. Provide the page number, section number, and form number where the provision can be found in the policy or certificate. For plan documents other than the policy, certificate of coverage, or other form that has been previously filed with the MIA for approval, provide actual copies of the documents or internet links where the documents may be accessed online.

1. For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the area provided on the template form. Indicate whether the NQTL applies to all services within the classification and sub-classification by entering “Yes” or “No” in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

For the purposes of the NQTL analyses for each product/plan, if a carrier has elected not to divide benefits furnished on an outpatient basis into the two sub-classifications described in 45 CFR § 146.136(c)(3)(iii)(C) for “office visits” and “all other outpatient items and services,” then the “Outpatient-Office sub-classification” columns shall be used to identify the NQTLs applicable to the outpatient classification in general. In this case, the carrier shall include the following explanation in the “Outpatient-Office sub-classification” columns before identifying whether the listed NQTLs are applicable: “Outpatient sub-classifications were not utilized for the NQTL analysis for this [product/plan]. Responses apply to outpatient classification in general.”

**Steps 2 – 7 shall be performed for *each* benefit classification and/or sub-classification. Where applicable, responses should be conspicuously separated by benefit classification/sub-classification to clearly delineate differences in factors, sources, evidentiary standards, comparative analyses, etc. from one benefit classification/sub-classification to another. If all elements of the design and application of a particular step in the analysis of an NQTL are the same across one or more benefit classifications/sub-classifications, this must be expressly stated, and must be supported by the evidence and documentation provided.**

## Step 2 Factors and Sources by Benefit and Classification:

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification, or certain services within such classification or sub-classification for both MH/SUD and M/S benefits respectively. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Include responses in the applicable cells in the chart provided on the template form. Number each factor and corresponding source to clearly identify the sources and factors that go together. If the factors or sources are the same across any benefit classifications/sub-classifications, include a note to this effect instead of repeating all factors and sources. For example, the factor cell for a certain classification may state: “Same as factors for In Network Outpatient-Office” or “Factors 2 and 4 for In Network Outpatient-Office also apply to this classification.”

* Identify the factors that the plan uses to determine whether each benefit, service, or procedure/revenue code, as a matter of plan policy, is deemed subject to the NQTLs.

Illustrative examples of factors include, but are not limited to:

* Excessive utilization;
* High cost of treatment;
* Recent medical cost escalation;
* Provider discretion in determining diagnosis, or type or length of treatment;
* Lack of clinical efficiency of treatment or service;
* High variability in cost per episode of care;
* High levels of variation in length of stay;
* High variability in quality of care;
* Lack of adherence to quality standards;
* Claim types with high percentage of fraud;
* Clinical efficacy of the proposed treatment or service;
* Severity or chronicity of the MH/SUD or medical/surgical condition;
* Current and projected demand for services;
* Licensing and accreditation of providers;
* Geographic market (i.e., market rate and payment type for provider type and/or specialty);
* Provider type (i.e., hospital, clinic, and practitioner) and/or specialty;
* Supply of provider type and/or specialty;
* Network need and/or demand for provider type and/or specialty;
* Medicare reimbursement rates;
* Training, experience, and licensure of provider.
* Identify the source of the information the carrier used to assign the factors that the plan refers to when determining whether each service or code is deemed subject to the NQTLs, as a matter of plan policy.

Illustrative examples of sources of factors include, but are not limited to:

* Internal claims analysis;
* Medical expert reviews;
* State and federal requirements;
* National accreditation standards;
* Internal market and competitive analysis;
* Medicare physician fee schedules;
* Internal quality standard studies;
* External healthcare claims database;
* Current Medicare Physician Fee Schedule;
* Medicare RVUs for CPT codes.
* Identify factors that were considered, but rejected. If there were no factors that were considered and later rejected, the response should provide confirmation of this.
* If a factor was given more weight than another, what is the reason for the difference in weighting? Differences in weighting of factors include circumstances where multiple factors must generally be present to trigger the application of the NQTL, but the existence of a particular factor, by itself, will trigger the application of the NQTL, even if other factors are not present. An example of weighting would be if the factors and evidentiary standards are applied in a sequence or hierarchy. If all factors are weighted the same, the response should provide confirmation of this.
* If artificial intelligence (AI) is used or consulted in any capacity for the design or application of an NQTL, identify all types of AI decisions and outputs that are factors in the development, design, or implementation of the NQTL. Also identify the algorithms and training data (i.e. the data that is fed to the system to "train" the AI during the design/development phase) that are sources for the AI decisions.
* The fact that all services in a particular classification or sub-classification are subject to the NQTL does not eliminate the requirement to identify the factors and sources for each factor.

## Step 3 Evidence for Each Factor:

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

For each factor identified in Step 2, identify, define, and provide the source for the evidentiary standard and/or data source, and any other evidence relied upon, to determine that the NQTLs apply to MH/SUD and M/S services. Include responses in the applicable cells in the chart provided on the template form. Number each factor and corresponding evidentiary standard and source to clearly identify the factors, evidentiary standards, and sources that go together.

In some circumstances, the sources listed for an evidentiary standard in Step 3 may be identical to the sources identified for the underlying factor for the evidentiary standard in Step 2. However, it is generally expected that the sources listed for the evidentiary standards in Step 3 will be more specific than the sources listed for the factors in Step 2. The sources identified in Step 3 should be the sources used to establish the specific threshold or definition for the evidentiary standard. For example, if “excessive utilization” is a factor, the source identified in Step 2 may be “internal claims analysis.” If the corresponding evidentiary standard in Step 3 is “utilization that is two standard deviations above average utilization per episode of care,” the source listed in Step 3 would be the particular guideline/article/best practice that established that threshold.

If the factors or evidentiary standards/sources are the same across any benefit classifications/sub-classifications, include a note to this effect instead of repeating all factors and evidentiary standards/sources. For example, the evidentiary standards cell for a certain classification may state: “Same as evidentiary standards for In Network Outpatient-Office” or “evidentiary standard 3 for In Network Outpatient-Office also applies to this classification.”

* Using vague and subjective terms (such as “cost-effective” or “excessive”) within the definitions for factors is not sufficient, unless those terms are further defined with precise parameters identifying the applicable sources and evidentiary standards.
* Identify any threshold or quantitative evidentiary standard at which each factor will implicate the NQTL.
* For example, if high cost is identified as a factor used in designing a prior authorization requirement, the carrier would identify and explain:
	+ The threshold dollar amount at which prior authorization will be required for any benefit;
	+ The data analyses, and methodology and results used to determine the benefit is "high cost"; and how, if at all, the amount that is to be considered "high cost" is different for MH/SUD benefit as compared with M/S benefits, and how the carrier justifies this difference.
* Examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs include, but are not limited to:
	+ Excessive utilization may be considered as a factor to design the NQTL when utilization is two standard deviations above average utilization per episode of care;
	+ Recent medical cost escalation may be considered as a factor based on internal claims data showing that medical cost for certain services increased 10% or more per year for two years;
	+ Lack of adherence to quality standards may be considered as a factor when deviation from generally accepted national quality standards for a specific disease category occurs more than 30% of the time based on clinical chart reviews;
	+ High level of variation in length of stay may be considered as a factor when claims data shows that 25% of patients stayed longer than the median length of stay for acute hospital episodes of care;
	+ High variability in cost per episode may be considered as a factor when episodes of outpatient care are two standard deviations higher in total cost than the average cost per episode 20 percent of the time in a 12-month period;
	+ Lack of clinical efficacy may be considered as a factor when more than 50 percent of outpatient episodes of care for specific diseases are not based on evidence-based interventions (as defined by nationally accepted best practices) in a 12-month sample of claims data.
* Clear thresholds are critical to demonstrating comparability and relative stringency for comparative analyses required in Step 4 and Step 5. If specific thresholds are not used to determine when the factor will implicate the NQTL, a specific, detailed, and reasoned explanation of how the carrier ensures the factors are being applied comparably and no more stringently to MH/SUD services must be provided. In accordance with § 15-144(j)(3), the Commissioner may require the carrier to establish specific quantitative thresholds, if appropriate, if the carrier fails to provide a sufficiently reasoned explanation of comparability and relative stringency.
* Evidentiary standards and processes that a carrier relies on may include any evidence that a carrier considers in developing its medical management techniques, including internal carrier standards, recognized medical literature and professional standards and protocols (such as comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.
* If a source such as NCQA is used in determining comparability, the standards for that source and any analyses developed internally or provided to NCQA or other external agencies must be provided. NCQA standards for health plan accreditation are a roadmap for improvement, for use by organizations to perform a gap analysis and align improvement activities with areas that are most important to states and employers, such as network adequacy and consumer protection. However, using the standards for accreditation does not imply compliance with MHPAEA in terms of comparability

* Failure to include all of the information described in the instructions for Step 3 will result in a finding that a carrier failed to submit a complete analysis report and may result in the actions specified in § 15-144(j) of the Insurance Article.

## Step 4 Comparable Written Policies:

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

* Conclusory statements that the carrier determined that its processes were comparable and no more stringently applied, without additional explanation of the analysis leading to that conclusion, are not sufficient. Documentation must be provided that a comparative analysis was actually performed, and a clear explanation of the methodology must be included.
* Indicate how the factors, as defined and explained by the evidentiary standards identified in Step 2 and Step 3, are applied comparably to establish the written policy as to which services, MH/SUD and M/S, are subject to the NQTL.
* Explain comparability of how the factors are defined and applied between MH/SUD and M/S services (i.e., clearly delineate and explain any differences in factors, definitions of factors, or evidentiary standards used to determine application of the NQTL, and provide an explanation as to why and/or how the factors, definitions of factors, and evidentiary standards are deemed comparable).
* Include a brief description of each step, and comparative analysis, for the processes used in applying the NQTLs to MH/SUD and M/S services, and demonstrate comparable and no more stringent application to MH/SUD services at each step.
* Include information on the composition and deliberations of the decision-making staff responsible for the written policies, including the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.
* Demonstrate that there are not arbitrary or unfairly discriminatory differences in the written standards for applying underlying processes and strategies to NQTLs with respect to medical/surgical benefits versus MH/SUD benefits.
* Examples of methods/analyses demonstrating that factors, evidentiary standards, and processes are comparable include, but are not limited to:
* Review of published literature on rapidly increasing cost for services for MH/SUD and medical/surgical conditions and a determination that a key factor(s) was present with similar frequency and magnitude with respect to specific MH/SUD and medical/surgical benefits subject to the NQTL;
* A consistent methodology (e.g., internal claims analysis) for analyzing which MH/SUD and medical/surgical benefits had “high cost variability” (defined by identical factors and evidentiary standards for all services) and were therefore subject to the NQTL;
* Analysis that the methodology for setting usual and customary provider rates for both MH/SUD and medical/surgical benefits were the same, both as developed and applied; Internal Quality Control Reports showing that the factors, evidentiary standards and processes with respect to MH/SUD and medical surgical benefits are comparable and no more stringently applied to MH/SUD benefits;
* Summaries of research (e.g., clinical articles) considered in designing NQTLs for both MH/SUD and medical/surgical benefits, demonstrating that the research was similarly utilized for both MH/SUD and medical/surgical benefits;
* Internal review of published treatment guidelines by appropriate clinical teams (with comparable compositions and qualifications for both MH/SUD and medical/surgical benefits) to identify (using comparable standards and thresholds for both MH/SUD and medical/surgical benefits) covered treatments or services which lack clinical efficacy;
* Internal review to determine that the carrier’s panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
* Failure to include all of the information described in the instructions for Step 4 will result in a finding that a carrier failed to submit a complete analysis report and may result in the actions specified in § 15-144(j) of the Insurance Article.

## Step 5 Comparable In-Operation Audits/Reviews:

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

* Provide the Carrier’s analyses that demonstrate the comparability of the implementation of the written policies and procedures governing application of the NQTL.
* The analyses should include discussion of quality assurance and oversight policies, processes and metrics that the plan applies to monitor in operation compliance. Examples of information to include are results of comparative assessment of denial rates (both administrative and medical necessity) by service, reviews for correlation between basis for service denials and stated criteria, and internal and/or external appeals and overturn rates.
* **Note:** Disparate results or outcomes between MH/SUD and M/S services are not regarded as dispositive of parity noncompliance; however, disparities constitute a warning sign or red flag of potential noncompliance and warrant further investigation. Conversely, equal or more favorable outcomes for MH/SUD services as compared to M/S is a positive indicator; however, is not necessarily dispositive of parity compliance either.
* To ensure uniformity in reporting, the MIA may ask for data using the Medicare provider fee schedules as a metric to measure whether reimbursement rates are comparable. Carriers may also provide other comparative data in addition to Medicare benchmark data to support the comparability analysis.
* Examples of comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied in operation include, but are not limited to:
	+ Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable;
	+ Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits;
	+ Audit results that demonstrate the process of consulting with expert reviewers for MH/ SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved;
	+ Audit results that demonstrate utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews;
	+ Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits;
	+ Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits;
	+ Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category;
	+ Audit/review of utilization review documentation requirements;
	+ Audit results that indicate that coverage approvals and denials correspond to the plan’s criteria and guidelines;
	+ A comparison of inter-rater reliability results between MH/SUD reviewers and medical/ surgical reviewers ONLY WHEN it has been demonstrated in the comparative analyses for Step 4 that the development of M/S criteria vs. MH/SUD criteria is comparable and no more stringent. It is the comparability and no more stringency of the criteria themselves, not merely consistency in the interpretation or application of the criteria that is key. For example, an IRR validation would not identify if reviewers were consistently applying a more restrictive fail first standard to MH/SUD vs M/S, or consistently applying acute criteria to sub-acute care for MH/SUD.
	+ Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification;
	+ Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).
* When providing audit results, include specific details about the type and outcome of each audit that was performed. A summary statement alleging that an audit was performed revealing no statistically significant disparities is not sufficient, absent documentation of the review and a description of the methodology, including considerations such as sample size and operational proportionality.
* Failure to include all of the information described in the instructions for Step 5 will result in a finding that a carrier failed to submit a complete analysis report and may result in the actions specified in § 15-144(j) of the Insurance Article.

**See Instructions for Data Supplements 1 – 5 which contain requests for additional required data to supplement the responses provided in Step 5 of the NQTL Analysis Report.**

**Although each of the Data Supplements 1-5 was primarily designed to support the in-operation analysis for a specific NQTL, some of the data points are relevant to multiple NQTLs, and the MIA may request an explanation for disparate results for the same Data Supplement under more than one NQTL.**

**A separate data supplement must be submitted for each product, except that an additional separate data supplement shall be submitted for any plan within the product for which a separate NQTL report is required to be submitted under § 15-144(c)(4). A separate NQTL report is required for any plan within the product where the processes, strategies, evidentiary standards, or other factors used in designing and applying the reported NQTLs to mental health benefits, substance use disorder benefits, or medical/surgical benefits are different, as written or in operation, from the other plans within the product. The data reported on each data supplement must be specific to the product or plan for the corresponding NQTL report.**

     

## Step 6 Delegated Entities:

Identify the measures used to ensure comparable design, development, and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

This step is only required if administration of a benefit subject to the applicable NQTL has been delegated to another entity, e.g. formulary design of prescription benefits has been delegated to a pharmacy benefits manager.

* If the carrier delegates administration or management of certain benefits to a third party vendor or service provider (for example, a private review agent specializing in mental health and substance use disorder benefits or a pharmacy benefits manager), the carrier is responsible for coordinating with the subcontracted entity on the development and application of NQTLs for MH/SUD and medical/surgical benefits to ensure comparability.
* Include a description of the measures, processes, and standards implemented to ensure collaboration with all vendors and subcontracted entities that exert any influence on the design, development, or application of an NQTL.
* Include any written procedures or guidelines to ensure that that the NQTL is consistently applied to similarly situated individuals.

## Step 7 Specific Findings and Conclusions:

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with § 15-144 of the Insurance Article and the Parity Act. (§15-144(e)(6)).

* Explain the basis for the Carrier’s conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on medical/surgical benefits in each classification of benefits in which the NQTL is imposed.
* A general or conclusory statement of compliance is not sufficient.
* The analysis required for this section is not a restatement of prior sections of the report. Instead, carriers shall prepare a detailed summary of specific findings and conclusions demonstrating that the product is in compliance with the Parity Act both as written and in operation.
* To the extent there are differences noted between MH/SUD and M/S in the foregoing steps, delineate these in the summary and note how they were reconciled in the reporting. For example, if different factors were utilized to determine services to which the NQTLs would apply, explain how the processes, strategies, evidentiary standards, and other factors were determined to be comparable and applied no more stringently as written and in operation.
* To the extent there are disparities in any comparative data analyses, including quantitative disparities shown in the required data supplement forms or other in operation analyses, explain in detail how these disparities are not evidence of parity non-compliance, and whether steps will be taken to reduce these disparities. Include whether steps have been taken to ensure/improve access to in-network M/S providers and whether the same or comparable steps have been taken for MH/SUD.

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# Disclosure Requirements

# Identify the process used to comply with the Parity Act Disclosure Requirements for MH/SUD and M/S Benefits.

# Describe the process for disclosing the criteria used for a medical necessity determination for MH/SUD benefits to current or potential members, or to a contracting provider, upon request

* Carriers shall report any instructions, guidance or information available to the public concerning the carrier’s obligation to respond to disclosure requests, including where requests must be sent and what information is available in response to disclosure requests.
* Carriers shall report whether the designated division and/or individual(s) responsible for responding to disclosure requests.
* Carriers shall indicate whether they responded to any disclosure requests by denying access to the requested information and the basis for such denial.
* Carriers shall report any internal review process used to respond to disclosure requests for medical necessity criteria.
* Carriers shall report any template form response used to explain medical necessity criteria in response to a participant, beneficiary, provider, or authorized representative of the beneficiary or participant.

**Describe the process for disclosing the reasons for a denial of benefits for MH/SUD.**

* Carriers shall report any internal review process used to respond to disclosure requests for denials of benefits.
* Carriers shall report the criteria for responding to a disclosure request based on a denial of benefits for any applicable plan.
* Carriers shall report the number of disclosure requests received for denials of benefits and the number of instances when it failed to provide a response to a participant beneficiary, provider, or authorized representative of the beneficiary or participant within 30 days of the request.

**Describe the process for disclosing plan documents that contain information about the processes, strategies, evidentiary standards and any other factors used to apply a NQTL** **for MH/SUD and M/S benefits in connection with a member's request for individual or group plan information and for purposes of filing an internal coverage or grievance matter and appeals.**

* A carrier shall report how its procedures ensure that the following information is disclosed:
	+ any information regarding NQTLs that apply to MH/SUD and/or medical/surgical benefits offered under the applicable plan.
	+ any records documenting NQTL processes and how the NQTLs are being applied to both medical/surgical and MH/SUD benefits under any applicable plan.
	+ any available details as to how the standards were applied, and any internal testing, review, or analysis done by the applicable plan to support the rationale that the NQTL is being applied comparably and no more stringently to MH/SUD benefits than medical/surgical benefits.
* A carrier shall report how its procedures ensure that any plan materials related to the plan’s compliance with MHPAEA are disclosed in compliance with 45 C.F.R § 146.136, including the following:
	+ any references to provisions as stated on specified pages of the policy or certificate, or other underlying guidelines or criteria not included in the policy or certificate that the plan has consulted or relied upon;
	+ any information regarding specific related factors or guidelines, such as applicable utilization review criteria;
	+ any factors, such as cost or recommended standards of care, that are relied upon by an applicable plan for determining which M/S or MH/SUD benefits are subject to a specific requirement or limitation;
	+ a description of the applicable requirement or limitation that the applicable plan believes has been used in any given MH/SUD service adverse decision within the relevant classification; and
	+ the medical necessity guidelines relied upon for in- and out-of-network medical/surgical and MH/SUD benefits.
* A carrier shall provide a list of the responses provided in the prior calendar year to requests from a member or a member’s authorized representative for a copy of the NQTL comparative analysis. The actual responses are not required to be included with the initial submission, but shall be available to the Commissioner upon request.