

MHPAEA Compliance Reporting for NQTLs

Introduction: This 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)-(e).

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. Failure to submit a complete report may result in administrative penalties as specified in § 15-144 of the Insurance Article.

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

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

The following are examples of responses that 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.
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.

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.

“Case management” means a program to assist a member in accessing necessary medical, substance use disorder, or mental health services, and may include:

- (a) Coordinating access to care;
- (b) Exploring service and funding source alternatives;
- (c) Monitoring progress to established goals (set by a case manager and the patient);
- (d) Assisting with coordinating discharge planning and follow-up;
- (e) Helping ensure the patient's benefits are used effectively.

“Concurrent Review” means any process used by the carrier or its private review agent to conduct utilization review for ongoing health care or for an extension of treatment beyond previously approved health care.

“Emergency Services” means the treatment of a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the lack of immediate medical attention could reasonably be expected to result in placing the health of the patient, or, in case of pregnancy, the unborn child in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.

“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, and residential treatment centers.

“Failure to Complete a Course of Treatment” means a patient’s failure to follow a documented treatment plan prescribed or recommended by a healthcare professional, including, but not limited to, on the Uniform Treatment Plan form when the treatment is for mental health or a substance use disorder.

“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.

“Pharmacy services” means any of the following activities:

- (a) Providing pharmaceutical care;
- (b) Compounding, dispensing, or distributing prescription drugs or devices;
- (c) Compounding or dispensing nonprescription drugs or devices;
- (d) Monitoring prescriptions for prescription and nonprescription drugs or devices;
- (e) Providing information, explanation, or recommendations to patients and health care practitioners about the safe and effective use of prescription or nonprescription drugs or devices;
- (f) Identifying and appraising problems concerning the use or monitoring of therapy with drugs or devices;

(g) Acting within the parameters of a therapy management contract, as provided under Subtitle 6A of the Health-Occupations Article;

(h) Administering vaccinations in accordance with § 12–508 of the Health-Occupations Article or self-administered drugs in accordance with § 12–509 of the Health-Occupations Article;

(i) Delegating a pharmacy act to a registered pharmacy technician, pharmacy student, or an individual engaged in a Board approved pharmacy technician training program;

(j) Supervising a delegated pharmacy act performed by a registered pharmacy technician, pharmacy student, or an individual engaged in a Board approved pharmacy technician training program;

(k) Providing drug therapy management in accordance with § 19–713.6 of the Health – General Article; or

(l) Prescribing and dispensing contraceptive medications and self-administered contraceptive devices approved by the U.S. Food and Drug Administration.

“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 both generic and specialty drugs, and plan features that base reimbursement, cost-sharing, or authorization requirements on the formulary category into which a drug is placed.

“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.

“Process for Assessment of New Technology” means a systematic, scientific process to follow for evaluating medical and surgical treatments and mental health and substance use treatment in order to ensure that members under the carrier’s health benefit plan have access to appropriate treatments not previously covered by the carrier.

“Product” means a package of health insurance coverage benefits identified by a particular network type, limited to health maintenance organization, preferred provider organization, exclusive provider organization, point of service, or indemnity.

“Provider Credentialing and Contracting” means a carrier’s processes and procedures and standards for determining which health care providers to contract with, either directly or through a subcontracting entity, to provide health care services to the carrier’s enrollees under the carrier’s health benefit plan.

“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 enrollees 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.

“Reimbursement rates” means the formulae to calculate the dollar allowed amounts under a value-based or other alternative payment arrangement, dollar amounts, or fee schedules payable for a service or set of services.

“Restrictions for Provider Specialty” means, for services that are within the scope of practice for a health care provider, restrictions based on the licensure or certification of a health care provider that limit the scope or duration of benefits for services provided under the plan or coverage.

“Restrictions that Limit Duration or Scope of Benefits for Services” means non-numerical limits or restrictions based on geographic location, facility type, provider specialty, and other criteria, including exclusions of a specific or type of MH/SUD treatment, that limit the scope or duration of benefits for services provided under the plan or coverage.

“Retrospective Review” means utilization review of health care that has been provided to an enrollee.

NQTL Analysis Report Template Completion Instructions

Plan Information

Identify the five health benefit plans with the highest enrollment for each product offered by the carrier in the individual, small, and large group markets. Provide the form numbers, approval dates, and SERFF tracking numbers for all forms comprising the entire contract of insurance for the health benefit plan. A separate analysis report shall be submitted for each plan.

Benefit Classifications

- (a) List each covered service under the plan in the table below. 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 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 plan level, and may not vary for different NQTLs under the same plan.

- (b) 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 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 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 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:

- (a) Provide a description of the plan’s applicable NQTLs and identify whether the NQTL is applicable to M/S or MH/SUD benefits in the table below.

Please note that the questions listed under each category of NQTL's on the analysis report template are not exclusive or intended to limit the scope of applicable NQTL's that must be included in the report.

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.

- (b) 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 table below. Indicate whether the NQTL applies by 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 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 plan. Responses apply to outpatient classification in general.”

“Emergency” and “Prescription” are listed as one of the benefit classifications under each NQTL category on the analysis report template, while “Emergency Services” and “Pharmacy Services” are also included as separate NQTL categories on the template. Where “Emergency” and “Prescription” are listed as benefit classifications under a particular NQTL category, information on the applicable NQTLs should be reported in that section. The separate “Emergency Services” and “Pharmacy Services” NQTL categories are intended to encompass only those NQTLs that are not captured elsewhere in the analysis report. Additionally, for the separate “Emergency Services” and “Pharmacy Services” NQTL categories, no information for other benefit classifications and sub-classifications is required to be reported.

- (c) For each NQTL listed in the Step 1(b), explain the methodology used to determine whether to apply the NQTL to either the entire classification and/or sub-classification of benefits or to apply the NQTL to certain identified services within such classification and/or sub-classification

Steps 2 – 7 shall be performed for each benefit classification and/or sub-classification.

Step 2:

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. 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)).

- 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 sources for the factors that the plan uses to determine whether each service or code is deemed subject to the NQTLs.

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 a factor was given more weight than another, what is the reason for the difference in weighting?
 - **Notes:**
 - For utilization management NQTLs (e.g., prior authorization and concurrent review), it is understood that a determination of medical necessity is required for all services and it does not need to be noted as a factor.
 - 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:

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.

- 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.
- 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.
- 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.
- 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).

- 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.
- 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 administrative penalties as specified in § 15-144 of the Insurance Article.

Step 4:

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently 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)).

- 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.
- 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:
 - 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 administrative penalties as specified in § 15-144 of the Insurance Article.

Step 5:

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently 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 Company'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.
- 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).
- 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 administrative penalties as specified in § 15-144 of the Insurance Article.

[See Data Supplements 1 – 4 which contains requests for additional required data to supplement the responses provided in Step 5 of the NQTL Report.]

Step 6:

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 the NQTL is consistently applied to similarly situated individuals.

Step 7:

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with § 15-144 of the Insurance Article, the Parity Act, and other related federal regulations. (§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 plan 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.

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 it 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 in connection with a member's request for 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.

[Add Data Supplements 1 – 4 here - which contain requests for additional required data to supplement the responses provided in Step 5 of the NQTL Report.]

MHPAEA Compliance Reporting for Data Report

Introduction: This data collection tool is prepared to satisfy the requirements of §15-144, Insurance Article, Annotated Code of Maryland, to create a standard form for entities to submit the data report in accordance with subsection §15-144(f).

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. Failure to submit a complete report may result in administrative penalties as specified in § 15-144 of the Insurance Article.

The terms in the instructions and the analysis report are defined according to COMAR 31.10.51.

Data Report Completion Instructions

- Enter the health plan name in the yellow cell next to “Health Plan.”
- For the first table, enter the # of Authorization Requests Received, # of Authorization Requests Approved, and the # of Authorization Requests Denied for each of the classifications (INN-Inpatient, OON-Inpatient, Emergency Services, RX, INN-Outpatient-Office, OON-Outpatient-Office, INN-Outpatient-AllOther, and OON-Outpatient-AllOther) mental health benefits, substance use disorder benefits, and medical/surgical benefits.
- For the second table, enter the # of Claims Submitted, # of Claims Approved, and # of Claims Denied for each classification (INN-Inpatient, OON-Inpatient, Emergency Services, RX, INN-Outpatient-Office, OON-Outpatient-Office, INN-Outpatient-AllOther, and OON-Outpatient-AllOther) mental health benefits, substance use disorder benefits, and medical/surgical benefits.
- For the second table, also enter all of the applicable reasons for denial of claims in the far right column for each benefit and each sub-classification. Carriers shall also include a summary defining each applicable code listed in this column.
- When reporting the data for each plan, if, for purposes of the corresponding NQTL analyses performed on the plan, 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 “INN-Outpatient-Office” and “OON-Outpatient Office” categories shall be used to report data for the outpatient classification in general, and “N/A” shall be entered for the “INN-Outpatient-AllOther” and “OON-Outpatient-AllOther” categories.
- In counting the # of Authorization Requests Received and the # of Claims Submitted, use the number of requests received or claims lines (e.g. CPT code) submitted during the prior calendar year. The number of approvals and denials shall be those arising from the reported requests and claims.