Maryland
INSURANCE ADMINISTRATION

2026 NQTL Analysis Filings Pursuant to § 15-144

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Mary Kwei
Associate Commissioner of
Market Regulation and
Professional Licensing

Sharon Fountain
Director, Mental Health Parity and
Network Adequacy

Agenda

- Opening Statement
- Legislative and Regulatory Background
- Due Date, Reporting Period, Selected NQTLs, and Instructions
- Incomplete Reports, Red Flags, and Compliance Tips
- 5 NQTLs
- NQTL Analysis Report Template
- Overview of Claims Data Template
- Data Supplement Templates
- Questions
- Closing Statement

Legislative Background

Key legislation:

- Section 15-802 of the Insurance Article is Maryland's longstanding mandate for coverage of treatments for mental health and substance use disorders.
- Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") is a federal law that enacted many new requirements for coverage.
- Consolidated Appropriations Act of 2021 added NQTL reporting requirements to federal law.
- Section 15-144 of the Insurance Article added an NQTL reporting requirement to Maryland law. The first filings were received by the MIA on March 1, 2022.
- Section 15-144 was amended in 2024, and the next round of filings was made on July 1, 2024.

Regulations

To implement the filing requirements, the MIA promulgated regulations in COMAR 31.10.51.

Important information in the regulations:

- Definitions of key terms;
- Rules governing filing, including the information in a complete report;
- The rules for the Summary Form required by § 15-144; and
- The required contents of a compliance plan for a carrier that receives a notice of noncompliance.

Due Date and Reporting Period

Due Date for Reporting: September 1, 2026 (extended from July 1, 2026)

Reporting Period: Calendar Year 2025

Reporting by Product or Plan: Analysis reports are completed at the product level, except when plan level reporting is required.

> **Exception:** If the processes, strategies, evidentiary standards, or other factors used in designing and applying the selected NQTL to MH/SUD or medical/surgical benefits are different, as written or in operation, from the other plans within the product, the carrier must note the exception and identify the plan and submit a separate comparative analysis for the selected NQTL for the plan, as required under § 15-144(c)(4).

2026 NQTLs

The NQTLs for the 2026 reporting period are:

- NQTL 1, In-network provider (including facility) reimbursement and negotiations
- NQTL 2, Single case agreements/network gap exceptions and negotiations
- NQTL 3, Crisis and emergency services
- NQTL 4, Experimental/investigational/unproven treatments
- NQTL 5, Medical necessity guidelines/criteria

Incomplete Reports and Red Flags

See pages 4 - 5 of the instructions. Your report may be determined incomplete if you include any of the following:

- General statements or recitations of the legal standard and conclusions, without specific supporting evidence and detailed explanations;
- Information that is reliant on incomplete information provided in previous steps. Filings required by § 15-144 have 7 cumulative steps; a subsequent step will be incomplete if it relies on information from a previous step that was incomplete.
- Factors or evidentiary standards without clear definitions and descriptions of how they apply to benefits;
- Statements that the factors or evidentiary standards are the same, or the NQTL is applied the same to medical/surgical and MH/SUD benefits without detailed definitions and comparative analyses;
- Reference to factors or evidentiary standards that rely on quantitative measures without precise quantitative definitions.

Incomplete Reports and Red Flags (Continued)

Your response will be determined incomplete if you fail to include:

- Specific data used in an analysis or audit to determine whether the NQTL is comparable and no more stringently applied to MH/SUD benefits than to medical/surgical benefits;
- An explanation for any disparities in a comparative data analysis; or
- Comparative analysis, including results, and information necessary to examine the development and/or application of each NQTL.

Compliance Tips

Before Filing:

- Review plan design for parity in writing between medical/surgical and MH/SUD.
- Maintain thorough documentation of processes, strategies, evidentiary standards, and other factors used in designing and applying NQTLs to ensure parity in operation.
- Perform a self-audit and identify/re-adjudicate claims and denials where necessary.
- Review the instructions/definitions before preparing the comparative analysis.

Compliance Tips (Continued)

When Filing:

- Note some instructions apply to all NQTLs, while some instructions apply only to individual NQTLs.
- Be specific and complete in reporting so that the MIA can assess compliance.
- Provide accurate, detailed, and consistent data.
- Provide clear explanations for documents and data submitted.
- Correct insufficient responses, instances of noncompliance, and disparities in outcomes data.

NQTL Analysis Report Template Using the 7-Step Analysis

- **Provide a complete Comparative Analysis of the NQTLs:**
  - ❖ Product/Plan Information and Benefit Classifications in the General Information section.
  - ❖ A 7-step comparative analysis for each NQTL.
  - ❖ Data Supplements
  - ❖ Certificate of Compliance
- Use the definitions and instructions to the template and the 7-Step Instruction document.
- **Summary form** provided by the MIA available to plan members and the public on the carrier's website (with confidential and proprietary information removed).
- *More on this later*

NQTL 1: In-Network Provider (Including Facility) Reimbursement and Negotiations

The MIA has previously included reimbursement as an NQTL. For 2026, the focus is on the criteria and processes for the negotiation and determination of reimbursement rates.

A separate analysis must be provided for practitioner reimbursement and facility reimbursement under each applicable benefits classification and sub-classification.

If there are differences in the process for determining reimbursement rates for physician practitioners and non-physician practitioners (for example, physician assistants, nurse practitioners, licensed social workers, and psychologists), separate analyses should be provided.

NQTL 1: In-Network Provider (Including Facility) Reimbursement and Negotiations (Continued)

For this NQTL, the comparative analysis should include if applicable, the factors, evidentiary standards, and sources used to determine:

- Whether to initiate negotiations with a provider or facility for fees or reimbursement other than the standard fee schedule;
- Whether a practitioner type is reimbursed directly or under a supervising physician;
- The reimbursement negotiation strategy or approach, and final reimbursement determinations with a provider or facility for reimbursement other than the standard fee schedule;
- Alternative reimbursement arrangements, such as capitation payments, global payments, or value-based payments; and
- The percentage of providers/facilities in each classification of benefits for MH/SUD benefits and medical/surgical benefits for which: (a) negotiations resulted in a negotiated reimbursement contract out of all negotiations initiated; or (b) a negotiated fee or other reimbursement applies (as distinguished from a standard fee schedule).

NQTL 2: Single Case Agreements/ Network Gap Exceptions and Negotiations

Section 15-830(d) of the Insurance Article sets out the basic requirements with regard to permitting a member to see an out-of-network provider on an in-network basis. This is an important mechanism for people to receive care when a network provider is not available.

The MIA understands that carriers and providers usually enter into a single case agreement to determine the course of treatment and payment amounts.

The comparative analysis for the Single Case Agreements NQTL must address the criteria and processes for:

- The decision to implement single case agreements, the negotiations, and determination of reimbursement rates for practitioner reimbursement and facility reimbursement under each applicable benefits classification or sub-classification and the number of working days from the date of the request to the date of an executed agreement;

NQTL 2: Single Case Agreements/Network Gap Exceptions and Negotiations (Continued)

The comparative analysis for the Single Case Agreements NQTL must address the criteria and processes for:

- The member or provider to make a request to see an out-of-network provider pursuant to § 15-830(d);
- Determining who negotiates the agreement and who is consulted in the negotiations (including the member or patient);
- The carrier's internal criteria to determine if the member meets the requirements of § 15-830(d), including how the carrier determines whether there is a provider within the network capable of providing the treatment requested;
- Determining whether a requested provider is appropriate or assisting the member in finding a provider; and
- Determining the scope of services and the duration of the agreement.

NQTL 3: Coverage of Crisis and Emergency Services

The MIA previously included Emergency Services as an NQTL based on use of the NAIC template.

The instructions for the 2026 filings clarify what is required. Carriers should address how claims are evaluated to determine whether services were emergency services for which prior authorization is not required, or if prior authorization should have been obtained and how it would have been obtained.

A filing which indicates simply that emergency services are covered without requiring prior authorization will be considered insufficient.

Carriers are required to explain the development of definitions, criteria, policies, auto-pay lists, and procedures that are used to evaluate claims to determine if the services meet the definition of crisis and emergency services, and whether use of crisis or emergency services is medically necessary, appropriate, or efficient for particular diagnoses or patient conditions. Examples include how a carrier determines that a patient is a danger to self or others.

NQTL 4: Experimental/Investigational/Unproven (EIU) Treatments

A complete comparative analysis must address for both medical/surgical treatments and MH/SUD treatments:

- How medical treatments are selected for review and the criteria for the selection;
- How the definition of “experimental medical care” is developed;
- How the definition of “experimental medical care” is disclosed to providers and members;
- Whether the process described in § 15-123 (which requires carriers to establish systematic processes to evaluate emerging medical and surgical treatments) is applied to MH/SUD services, and whether there are any differences in the processes for medical/surgical or MH/SUD evaluation of new treatments.

NQTL 4: Experimental/Investigational/Unproven (EIU) Treatments (Continued)

A complete comparative analysis must address for both medical/surgical treatments and MH/SUD treatments:

- Assuming that medical literature is a source or factor, the evidentiary standards for inclusion of medical literature in the review process;
- Selection of the individuals or entity making the determination of whether a treatment will be covered or not covered based on EIU, and for which conditions or severity of those conditions; and
- How the carrier evaluates or determines whether:
  - ❖ To cover a new or emerging treatment;
  - ❖ That information about the treatment is sufficient to begin covering the treatment;
  - ❖ Whether to stop covering previously covered treatments; and
  - ❖ To start covering previously excluded treatments.

NQTL 5: Medical Necessity Guidelines/Criteria and ASAM Criteria

The comparative analysis for the Medical Necessity Guidelines/Criteria and ASAM Criteria NQTL must focus on the selection, development, and modification of medical necessity criteria. The comparative analysis must describe any and all external guidelines/criteria relied on by the carrier, and any and all internal guidelines/criteria developed by the carrier.

The MIA will determine a response to be incomplete or insufficient if the filing only states that medical necessity criteria are selected in compliance with Insurance Article § 15-10B-05, with no other explanation or detail. If the carrier selects criteria based on § 15–10B–05(a)(11), the comparative analysis must include the following:

- The process for determining whether a set of medical necessity criteria meets the statutory requirements;
- The process for selecting specific criteria sets where more than one set of guidelines/criteria exists that meets the statutory requirements; and
- The process for ensuring that the guidelines/criteria are objective and clinically valid and meet all requirements of § 15–10B–05 in operation.

NQTL 5: Medical Necessity Guidelines/Criteria and ASAM Criteria (Continued)

For each applicable benefit classification or sub-classification, the following information and details must be included in the narrative response:

- If the guidelines/criteria or best practices utilized are internally developed by the carrier, describe the processes, methodology, and sources for such guidelines/criteria;
- Define and describe any differences between the carrier's internally developed guidelines/criteria and the external sources relied on for such internally developed guidelines/criteria, and the rationale for such differences;
- If the carrier modifies any independent, externally developed level-of-care guidelines/criteria and/or professional best practices, describe in detail the modification(s) and rationale(s) for such modification(s).

NQTL 5: Medical Necessity Guidelines/Criteria and ASAM Criteria (Continued)

- In addition, the carrier must explain:
  - How the carrier selects the internal standards to be used in conducting utilization review, including the national criteria used by the carrier;
  - How the carrier modifies the standards for conducting utilization review, including internal guidance for national criteria;
  - How the carrier ensures the guidelines/criteria are sufficiently flexible to allow deviations when justified; and
  - How often the guidelines/criteria are reviewed, evaluated, and updated.

Filling Out the NQTL Analysis Report Template

General Information Section

Product/Plan Information:

- Brief description of the product or plan.

Benefit Classifications:

(a) In the table:

- List in the table each covered service for the product or plan.
- Indicate whether the covered service is medical/surgical or MH/SUD.
- Provide the benefit classification or sub-classification for the covered service.

(b) Explain the **methodology** used to assign the medical/surgical or MH/SUD benefits to each classification or sub-classification.

Filling Out the NQTL Analysis Report Template (Continued)

* Using NQTL 1, In-Network Provider (Including Facility) Reimbursement and Negotiations, as an example.

Step 1(a): NQTL Description, Application, and Methodology

- **Step(a):**
  - Describe and define the NQTL, including all of the carrier's INN reimbursement rate types.
  - Describe the processes, strategies, and methodologies utilized by the carrier in its reimbursement rate negotiations and final negotiated rates.
  - Describe the Specific NQTL plan language and procedures.
  - Identify associated triggers, timelines, forms, and requirements, and other information required in the Seven Step Analysis document.

Filling Out the NQTL Analysis Report Template (Continued)

Step 1(b):

- For each different type of INN reimbursement rate, identify whether each type is applicable to medical/surgical benefits or MH/SUD benefits for each applicable benefit classification and sub-classification.
- Indicate whether each INN reimbursement rate type applies to all services within the classification and sub-classification by entering “Yes” or “No.” If an INN reimbursement rate type applies only to certain services within a classification and/or sub-classification, list each covered service to which the INN reimbursement type applies.
- Responses should be explicit and indicate whether the “Yes” applies to both medical/surgical and MH/SUD.

Filling Out the NQTL Analysis Report Template (Continued)

Step 2, Factors and Sources by Benefit and Classification

- Identify the factors and the source(s) for each factor used to determine that it is appropriate to apply the NQTL to each classification, sub-classification, or certain services.
- Identify the factors and source(s) for each factor used to decide to initiate rate negotiations, to negotiate rates, and to make final rate determinations. Explain differences in weighting of factors.
- Provide a separate analysis for practitioner reimbursement and facility reimbursement by each applicable benefits classification and sub-classification.
- Provide a separate table for each type of INN reimbursement rate in Step 1(a).

Filling Out the NQTL Analysis Report Template (Continued)

Step 3, Evidence for Each Factor and Evidentiary Standard

- Define each factor and specific evidentiary standard(s) for each of the factors in Step 2 and any other evidence relied upon to design and apply the NQTL.
- Identify the source for each evidentiary standard.
- Identify and define the specific evidentiary standard(s) and source(s) for each factor utilized by the carrier to decide to initiate rate negotiations, to negotiate rates, and to make final rate determinations.
- A separate analysis must be provided for practitioner reimbursement and facility reimbursement under each applicable benefits classification and sub-classification.
- Provide a separate table for each type of INN reimbursement rate in Step 1(a).

Filling Out the NQTL Analysis Report Template (Continued)

Step 4: Comparable Written Policies

- Provide the comparative analyses performed and relied upon to determine whether the NQTL is comparable to and no more stringently designed and applied to MH/SUD benefits compared to medical/surgical benefits, as written.
- Include results of any audits, reviews, and analyses performed, and methodologies used.

Step 5: Comparable In-Operation Data Analysis/Audits/Reviews

- Provide the comparative analyses performed and relied on to determine whether the NQTL is comparable to and no more stringently designed and applied to MH/SUD benefits compared to medical/surgical benefits, in operation.
- Include results of any data collection and analysis, audits, reviews, and analyses performed and methodologies used.
- Address any and all disparities in the data provided in the Data Supplements.

Filling Out the NQTL Analysis Report Template (Continued)

Step 6: Delegated Entities

- Identify measures used to ensure comparable design, development, and application of the NQTL implemented by the carrier and any entity delegated to manage MH benefits, SUD benefits, or medical/surgical benefits on behalf of the carrier.

Step 7: Specific Findings and Conclusions

- Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the §15-144 and the Parity Act.

Overview of Claims Data Template

- Submission is optional.
- Request is for broad categories of information that are not specific to the NQTLs for the 2026 reporting period. Purpose is to assist the MIA in its review of overall parity compliance and provide context for other responses.
- For Prescription Drugs/Step Therapy, provide the total number of approved prescription drug claims that had Step Therapy applied. For Formulary Exception, enter the total number of Prescription Drug claims that had an approved formulary exception.

Data Supplement Templates

- DS 1, Office Visit Professional, In-Network Reimbursement Rates Indexed to Medicare.
- DS 2, Out-of-Network Utilization & Network Gap Exception Utilization.
- DS 3, Crisis and Emergency Services.
- DS 4, Experimental/Investigational/Unproven Treatments.
- DS 5(A), Medical Necessity Denial Rates.
- DS 5(B), American Society of Addiction Medicine Criteria.

Data Supplement Templates

- Templates are required and carriers must use definitions and instructions suppled by the MIA;
- Capture key quantitative measures related to Parity Act;
- Verify and add to the responses provided in the NQTL Analysis Report;
- Correspond to the 5 NQTLs;
- Are primarily used to support **in-operation analysis** for a specific NQTL; and
- Some are based on templates from Colorado and the Model Data Request Forms from the Bowman Family Foundation.

DS 1: Office Visit Professional In-Network Reimbursement Rates Indexed to Medicare

- **Corresponds to:** NQTL 1; covers In-Person and Telehealth.
- **Purpose is:** to index INN Reimbursements relative to Medicare benchmarks (i.e., Medicare Physician Fee Schedule) and calculate the weighted averages as a % of Medicare.
- Core metrics are the Allowed Amount per Professional Service (POS) Codes.
- Note: Medicare reimburses Physician Assistants, Nurse Practitioners, and Psychiatric Nurses 85% of the allowed amount in the MPFS and reimburses licensed MH/SUD Licensed Clinical Social Workers, Master's Level Counselors/Therapists, and Marriage and Family Therapists 75% of the allowed amount in the MPFS. Carriers should adjust MPFS when using the Medicare Allowed Amount in the formulas.
- Reimbursement rates are provided for the Rendering Provider.

DS 2: Out-of-Network Utilization & Network Gap Exception Utilization

- **Corresponds to:** NQTL 2.
- **Purpose is:** To analyze the utilization of OON services and network gap exceptions for adult and child/adolescent populations, combined, by comparing INN and OON utilization.
- First spreadsheet: provide Carrier's definitions of Acute Inpatient, Sub-Acute Inpatient, Outpatient, and Office Visit.
- Second spreadsheet: provide comparative OON Benefit Utilization and Network Gap Exception Utilization and required data metrics.
- Utilization - Tracks the volume of INN v. OON utilization for MH and SUD benefits.
- Gap Exception – Tracks the number of network gap claims from members.

DS 3: Crisis and Emergency Services

- **Corresponds to:** NQTL 3.
- **Purpose is:** to compare access to crisis and emergency facility types and denial rates for requests and claims for INN and OON services.
- **Facility type categories are:**
  - ❖ Crisis Stabilization Services Facilities/Behavioral Health Crisis Stabilization Centers;
  - ❖ Mobile Crisis Teams;
  - ❖ 24-Hour Crisis Residential Facilities; and
  - ❖ Hospital Emergency Departments or Freestanding Emergency Medical Facilities.
- See definitions of Key Terms in the Instructions to the DS.

DS 3: Crisis and Emergency Services (Continued)

First Spreadsheet:

- **Auto-Pay Code Table** - Provide the carrier's Auto-Pay Codes for Medical/Surgical, and combined MH/SUD in the four categories.
- **Diagnostic Code Denials Table** - Provide the diagnostic codes that were ever denied during Calendar Year 2025 for medical/surgical and MH/SUD benefits in the four categories for crisis and emergency services.
- **In the Mental Health/Substance Use Disorder columns,** include ALL codes applicable to MH and/or SUD benefits, not just those that apply to both.

DS 3: Crisis and Emergency Services (Continued)

Second Spreadsheet:

- Provide in the tables:
  - Number of facilities covered by the carrier in the 4 categories.
  - By INN and OON:
    - ❖ Number of requests for coverage or admission.
    - ❖ Number of denials of requests for coverage or admission (based on Utilization Review databases, no claims submitted).
    - ❖ Number of claims submitted for use of all services of the Facility Type (e.g., Mobile Crisis Teams) for Medical/Surgical and MH/SUD.
    - ❖ Of the number of claims submitted for all services of the Facility Type, provide the number of Claims Denials, in whole or in part.

DS 4: Experimental, Investigational & Unproven (EIU)

Corresponds to: NQTL 4.

Purpose: Identify adverse decisions or coverage decisions based on an EIU Exclusion and provide cross comparisons of Medical/Surgical and MH and SUD benefits for:

- Prescription medications (Table 1);
- Devices (as defined by the FDA) (Table 2); and
- Treatment services (all available treatment services, except for prescription medications and devices) (Table 3).

Key Definitions:

- “Adverse decision”
- "Appeal" and “Appeal decision”
- “Grievance” and "Grievance decision"

DS 4: Experimental, Investigational & Unproven (EIU) (Continued)

- **Tables 1 and 2:**
  - Total Initial Adverse Decisions or Coverage Decisions based on EIU Exclusions.
  - Of the total number of Initial Adverse Decisions or Coverage Decisions based on EIU Exclusions, provide the number of Adverse Decisions or Coverage Decisions:
    - ❖ Upheld by an Internal Appeal or Grievance Decision;
    - ❖ Overturned by in Internal Appeal or Grievance Decision;
    - ❖ Upheld on a complaint filed under Md. Code Ann., Insurance § 15–10A–03; and
    - ❖ Overturned on a complaint filed under Md. Code Ann., Insurance § 15–10A–03.
- **Table 3:**
  - Same as for Tables 1 and 2, but broken out by Inpatient Facility, Outpatient Facility, and Professional Services – Office.

DS 5(A): Medical Necessity Denial Rates Analysis

- **Corresponds to:** NQTL 5.
- **Purpose:** To gather data on Prior Authorization Review, Concurrent Review, and Retrospective Review, separated out by IN and OON.
- **Key Definitions:**
  - ❖ "Denial"
  - ❖ "Facility-Based Professional Services"
  - ❖ "Facility Services"
  - ❖ "Retrospective Review" – Categorize Denials separately for:
    - Post-Claim Payment Review (Retrospective Review that occurs *after* the claim has been paid); and
    - Pre-Claim Payment Review (Retrospective Review that occurs *before* the claim has been paid).

DS 5(A): Medical Necessity Denial Rates Analysis (Continued)

Key Definitions:

- "Professional Providers" - All of the following licensed **MH/SUD Providers**, combined:
  - Licensed MH/SUD Providers, such as Licensed Clinical Social Workers and others;
  - Psychiatric Nurse Practitioners;
  - Psychiatrists, including Child Psychiatrists; and
  - Psychologists, including Child Psychologists.
- "Professional Providers" - All of the following licensed **Medical/Surgical Providers**, combined:
  - Nurse practitioners;
  - Physician assistants;
  - Specialist physicians (category is all medical/surgical physicians other than psychiatrists and primary care physicians); and
  - Primary care physicians (category is general and family practice, internal medicine, OB/GYN, and pediatric physicians).

DS 5(A): Medical Necessity Denial Rates Analysis (Continued)

Additional instructions:

- **Data is provided separately** for Denials on Utilization Review for which a claim form WAS submitted and Denials on Utilization Review for which NO claim form was submitted.

- **For concurrent review**, denials should be counted separately for each review conducted during the course of an admission, stay, or episode of treatment. Do not include data for "notifications," as that term is defined by the carrier or plan.

DS 5(B): ASAM Criteria

- **Corresponds to:** NQTL 5.
- **Purpose:** Collect information using the American Society of Addiction Medicine criteria, **3rd Edition**. Maryland law requires the use of ASAM criteria for all Medical Necessity and Utilization Management determinations for Substance Use Disorder benefits. Insurance Article § 15-802(d)(5).
- **Table questions and requirements:**
  - ❖ Does the carrier or TPA modify ASAM or use other criteria in addition to ASAM?
  - ❖ Describe the application of ASAM at various levels of care and review, such as Inpatient Levels.
  - ❖ List and describe all review levels, including appeals levels, available when determining SUD Medical Necessity. The table includes typical review and appeals levels.
  - ❖ What circumstances trigger each level, the timeliness for each review level, and the required training, proficiency metrics, and required credentials of the reviewer?

Contact Information

Maryland Insurance Administration

800-492-6116 (toll-free)

410-468-2000 (local)

800-735-2258 (TTY)

insurance.maryland.gov

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Questions?


Thank you