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Compliance with the Mental Health Parity and Addiction Equity Act Comprehensive Report: New York Medicaid Managed Care, Alternative Benefit Plan, and Children's Health Insurance Program

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Compliance with the Mental Health Parity and Addiction Equity Act: New York Medicaid Managed Care, Alternative Benefit Plan, and Children’s Health Insurance Program

A. Executive Summary

The Centers for Medicare & Medicaid Services (CMS) final regulations (42 CFR Parts 438, 440 and 457) address the application of the Mental Health Parity and Equity Addiction Act (MHPAEA) requirements to:

- I. Medicaid Managed Care Programs (MMCPs);
- II. Medicaid benchmark and benchmark equivalent plans or Alternative Benefit Plan (in New York State, individuals covered by this benefit, childless adults between the ages of 19 and 64 that meet income-level criteria, are included under MMCP); and,
- III. the Children’s Health Insurance Program (CHIP).

The regulations delineate State and state Managed Care Organization (MCO) contractor responsibilities for assurance and demonstration of the basis for compliance with MHPAEA’s parity requirements. This report sets forth New York State’s assessment and conclusions regarding compliance with the parity requirements for its MMCP, Alternative Benefit Plan (ABP), and CHIP programs, and outlines its plans for further monitoring and review of essential parity matters.

New York State (“State”) has a myriad of managed care and fee for service payment systems for covered benefits which are operationalized in different ways under its MMCP, ABP, and CHIP programs (collectively, “Programs”). These are more fully described in this report.

The State undertook a comprehensive evaluation of the Medicaid fee for service delivery system and the Program benefits managed through its MCO contractors to evaluate and document compliance and/or identify potential parity issues that required corrective action. The State’s approach was driven by two overriding principles:

1. The federal parity rules and regulatory tests are well defined and interrelated. Each of the parity regulation requirements must be vetted for consistency with the rules and tests to assure compliance; and
2. The review and evaluation methodology and documentation must correlate with what the rules and tests demand to substantiate compliance, especially respecting nonquantitative treatment limitations (NQTL).

The compliance testing protocol and evaluation methodology was established based

on the guidance provided in the CMS *“Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children’s Health Insurance Programs”* and the *“Self -Compliance Tool for MHPAEA”* issued by the US Departments of Labor, Health and Human Services and Treasury.

The State proceeded in a phased approach to conduct NQTL evaluations to assess the application of any NQTL to any covered mental health or substance use disorder (MH/SUD) benefit. The NQTL evaluation methodology used for the assessment is rigorous and demands specific documentation from the MCOs to validate compliance with the NQTL regulatory test. This is to ensure standards and procedures for MH/SUD benefits and coverage, both as written and in operation, are comparable, and limitations are applied no more stringently than those applied to medical and surgical (M/S) benefits and coverage.

The State assessment of the Programs concluded the following:

1. There are no parity compliance issues with financial requirements as defined by the regulations for any of the Programs and no corrective actions are currently necessary;
2. There are no parity compliance issues with quantitative treatment limitations for CHIP;
3. Two quantitative treatment limitation issues were identified in the MMCP program review and the appropriate corrective action has been taken;
4. An informed conclusion and ongoing assurance of MCO compliance was dependent on additional actions regarding the assessment of MCO Phase I NQTLs.
5. When reexamining Phase I NQTLs and the addition of Phase II NQTLs in 2019 and 2020, the State identified:
 - a. MCO compliance with the provider type exclusion NQTL;
 - b. MCO reporting was not sufficient to confirm compliance with the remaining eight Phase I and Phase II NQTLs examined.
 - c. One MCO was determined to be in violation of MHPAEA for reimbursement.
6. The analysis of the final ten NQTLs for Phase III yielded similar results to Phase I and II, including:
 - a. Five MCOs were found in violation of MHPAEA for retrospective review and/or outlier review.
 - b. Most MCOs were found compliant for certification requirements, unlicensed provider/staff requirements, usual, customary, and reasonable (UCR) rate determinations, exclusions for court-ordered treatment, and failure to complete.
 - c. One MCO was deemed compliant for all ten Phase III NQTLs.

In addition, the State will augment parity monitoring through actions and initiatives

under a two-year plan (Appendix 1 New York State MHPAEA Two Year Workplan) to ensure full parity in the coverage of Program benefits and that MCO performance is consistent with all parity requirements. Activities outlined in the Workplan were delayed in 2020 and 2021 during the COVID-19 pandemic and public health emergency, as both State and MCO resources were directed to pandemic response. The primary components include: amendments to MCO contracts with the State for parity documentation and reporting aimed at assuring MCO attestations of parity compliance can be readily verified; modifications to the State's operational survey process for MCOs which specifically address fundamental parity oversight matters; and further identification and remediation of key parity issues which impact the availability of, and access to, covered behavioral health benefits under these Programs.

B. Introduction

- I. The final regulations (42 CFR Parts 438, 440 and 457) governing the application of the MHPAEA to coverage offered by MMCPs, ABPs (contained in MMCP), and the CHIPs, stipulate the requirements these programs must adhere to these requirements to ensure compliance with MHPAEA.
- II. The purpose of this report is to:
 1. Detail the State's review process and parity compliance analysis methodology;
 2. Provide to CMS the documentation necessary to substantiate compliance with the regulatory requirements codified at 42 CFR Parts 438, 440 and 457 respectively;
 3. Identify current state insurance program requirements that require modification to aid state MCOs to come into full compliance with the final rules; and
 4. Set forth the State's plan for ongoing and future parity compliance review, evaluation and monitoring, and publication of its basis for compliance as required by the final rules.
- III. **The New York State Medicaid Managed Care Programs** do not provide the full scope of covered MH/SUD services through its contracted MCOs; the full scope of covered MH/SUD benefits are provided through multiple services delivery systems. As required by 42 CFR § 438.920(b), the State is responsible for ensuring that the full scope of the benefits provided to MCO enrollees is in compliance with 42 CFR Part 438.
- IV. **The New York Medicaid Expansion Program Alternative Benefit Plan**

is contained within the MMCP. The full scope of the MH/SUD and M/S benefits are provided through multiple service delivery systems, including MCOs. As required by 42 CFR § 438.920(b), the State is responsible for analyzing and ensuring compliance with parity requirements by ABP contractors. Additionally, 42 CFR § 440.395(e)(3), obligates the State to provide sufficient information in its ABP State Plan Amendment to assure and document compliance.

- V. **The New York Children’s Health Insurance Program - Child Health Plus**, which is not a Medicaid program in the State, is governed by a different set of MCO contracts than those that govern MMCPs and the ABP. CHPlus does not meet statutory requirements for provision of Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits specified at Sections 1905(r) and 1902(a) (43) of the Social Security Act. Therefore, the State is not pursuing deeming of compliance and is required to conduct a parity analysis consistent with 42 CFR § 457.496 for CHIP and demonstrate parity compliance to CMS.

- VI. The New York State managed long term care plans include Partial Medicaid Managed Long Term Care Plan (PMLTC), Program for All-inclusive Care for the Elderly (PACE), Medicaid Advantage, Medicaid Advantage Plus (MAP), Fully Integrated Duals Advantage (FIDA), and Fully Integrated Duals Advantage for Individuals with Developmental Disabilities (FIDA- IDD). FIDA and FIDA-IDD enrollees receive services through managed care. The persons enrolled in these programs are not considered managed care enrollees because either they:
 - 1. are enrolled in a Prepaid Ambulatory Health Plan (PAHP) only-PMLTC;
 - 2. are enrolled in a program not deemed an MCO per the 42 CFR § 438.2 definition; i.e. the PACE program; or
 - 3. are dually eligible for Medicare and Medicaid and there are no provisions in the final rule specific to coverage provided to Medicare-Medicaid beneficiaries.

C. The New York State Medicaid Managed Care, Alternative Benefit Plan, and CHIP Programs

- I. The State has an array of managed care lines of business for persons who are Medicaid eligible only, and for those who are eligible for Medicare and Medicaid, also referred to as “dually eligible.” As reasons explained above, PMLTC and managed insurance products in which only dually eligible individuals are eligible for enrollment are not included in this analysis.

- II. The three state MMCPs (which includes the ABP), for Medicaid eligible persons are the Mainstream MMCP, the Health and Recovery Plan (HARP) and the HIV Special Needs Plan (HIV SNP). As of December 2021, there are 14 MCOs operating Mainstream MMCPs, 11 MCOs operating HARPs, and 3 MCOs operating HIV SNPs. Since 2015, the contracts between the State and these MCOs explicitly require compliance with MHPAEA.

- III. **The Mainstream Medicaid Managed Care Programs** provide comprehensive health care services to enrollees. HARPs manage care for adults with significant behavioral health needs. In addition to the State Plan Medicaid services offered by Mainstream MMCPs, qualified HARPs provide access to an enhanced benefit package comprised of home and community based services (HCBS), authorized in the State’s Medicaid Redesign 1115 waiver. HIV SNPs cover all the same services covered by other MMCPs, plus special services for people living with HIV/AIDS.

While the full scope of M/S benefits are provided through the contracted MCOs, the full scope of MH/SUD covered benefits are provided through the combination of MCOs and fee-for-service (FFS) arrangements. As of October 2018, there are only a few MH/SUD services carved out of the MMCP benefit package for adults and a greater number carved out for children. However, the State has or is in the process of transitioning additional MH/SUD benefit package services for children into managed care.

A complete list of the M/S and MH/SUD benefits by classification provided through the MMCP programs is contained in Appendix 2¹. Services reimbursed on an FFS basis are also described therein. The State’s MMCPs have no cost sharing requirements other than for prescription drugs.

- IV. **The State’s Alternative Benefit Plan** is the same as MMCP in terms of the governing contract and how covered MH/SUD benefits are provided by contracted MMCPs, with some covered benefits provided to enrollees on an FFS basis. The ABP is an extension of MMCP to childless adults aged 19 to 64 years old.

The New York Child Health Plus Program is the State’s Children’s Health Insurance Program. Children who are New York State residents

¹Please refer to Appendix K of the [Medicaid Managed Care Model Contract](#) for information related to the Medicaid Managed Care benefit package and service definitions.

under the age of 19 who are ineligible for Medicaid and have no other health insurance coverage or access to the New York State Health Benefits Program (NYSHIP) may be eligible for participation. CHPlus provides a comprehensive range of MH/SUD and M/S benefits to enrollees. There are no cost sharing requirements for covered benefits beyond the family portion of the CHPlus premium, which is calculated based on family size and income. A listing of the covered M/S and MH/SUD benefits is contained in Appendix 3.

D. The State Compliance Assessment Process

- I. The State recognizes and appreciates the importance of MHPAEA and the federal final rule and is striving to exceed these standards. The State has dedicated staff and resources to the goal of ensuring fair access to behavioral health services making sure they are restricted no more stringently than comparable physical health services. To assist the State in this MHPAEA compliance evaluation process, Milliman, Inc. was engaged to define and structure the State's review and evaluation process. The State's analyses were informed by, and are consistent with, the CMS "Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs" and the "Self-Compliance Tool for Compliance with MHPAEA" developed by the United States Departments of Labor (DOL), Health and Human Services (HHS) and Treasury.
- II. MHPAEA and the CMS final regulations stipulate a defined set of rules, regulatory standards, and tests to evaluate parity compliance, including:
 1. Defining MH/SUD disorders and MH/SUD benefits;
 2. Defining benefits classifications and mapping benefits to classifications;
 3. Testing for financial requirements, aggregate lifetime and annual dollars limits and cumulative financial requirements;
 4. Testing any identified quantitative treatment limitations and cumulative quantitative treatment limitations;
 5. Testing nonquantitative treatment limitation for comparability and application stringency, both as written and in-operation; and
 6. Ensuring the disclosure of specific information related to medical necessity criteria and benefit denials to enrollees.

The State's parity analysis reviewed financial requirements, quantitative treatment limitations, and nonquantitative treatment limitations. The State emphasized review of NQTLs, recognizing that for the Programs, the operational policies and protocols embedded therein are the principal

areas where MCOs have the most discretion to affect the scope of and enrollee access to covered MH/SUD benefits. The NQTL review focused on ensuring that the standards and processes for MH/SUD benefits and coverage were comparable and that any restrictions were applied no more stringently than for M/S benefits and coverage.

The State defined the approach for assessing parity compliance and required its contracted MCOs for Medicaid Managed Care, the ABP, and CHPlus, to report parity data. The State recognizes that appropriate reporting and submission of additional details and analysis from the MCOs is essential to adequately oversee compliance with MHPAEA. A workplan was established to conduct the review both within the responsible State agencies and with the MCO contractors. To ensure uniformity of response and evaluation, defined reporting formats and instructions were developed for the MCOs as primary input for the State's evaluation process for all financial requirements, quantitative treatment limitations, and nonquantitative treatment limitations. See Appendices 4, 5, 6 and 7. The same reporting format was utilized by the State to examine carve out benefits. This reporting format will be utilized by the State as the basis for any future State MHPAEA review.

- III. After the reporting format was developed and distributed, the State and Milliman conducted webinars for all involved MMCP (including ABP) and CHIP contractors to review the required reporting formats and establish a process for communications between the State, Milliman, and the MCOs to assure accurate and complete reporting. The State undertook a separate analysis of those MH/SUD benefits that are delivered through the Medicaid FFS system. The State also undertook a review and identification of state law, regulation, and policy manual requirements and/or State Plan features that apply to all Medicaid benefits that have parity implications, whether provided FFS or by an MCO contract for applicable financial requirements (FRs), quantitative treatment limitations (QTLs), and NQTLs. Milliman completed the final analysis of the MCO documentation submissions in consultation with State personnel. The State's conclusions and actions are presented below.
- IV. The NQTL reporting format was utilized for the second and third phase of NQTL review. The State provided MCOs the opportunity to resubmit Phase I NQTL workbooks along with workbooks from Phase II. See Appendix 7. After the reporting format was distributed for Phase II, the State created a comprehensive Parity Compliance Toolkit (<https://omh.ny.gov/omhweb/bho/parity-compliance-toolkit.pdf>; Appendix 6) designed to support MCOs in understanding and complying with federal

and state parity laws.

- V. The State distributed comprehensive report cards detailing each MCO's compliance status for each NQTL in Phase I, II, and III, along with explanatory guidance for every noncompliant result. The State offered each MCO individual consultations with representatives from the State and the State's contractor, Milliman, to discuss results, determinations, next steps, and future regulatory monitoring. The State's conclusions and corrective actions are presented below.

E. Defining Mental Health and Substance Use Disorders, Medical/ Surgical Conditions, and Benefits

- I. Applicable regulations require MH/SUD and M/S conditions be defined and that the basis for these definitions be consistent with a recognized independent standard and/or applicable state guidelines. MH/SUD benefits are items and services for MH/SUD conditions and M/S benefits are benefits for medical conditions or surgical procedures.
- II. Neither the Medicaid and CHPlus State Plans, nor state law adequately delineates a standard for defining MH/SUD disorders or M/S conditions for purposes of conducting the required parity analysis. The contract between the State and MCOs operating MMCPs, including ABP, does however define "substance use disorders" to mean "the misuse of, dependence on, or addiction to alcohol and/or legal or illegal drugs leading to effects that are detrimental to the individual's physical and mental health, or the welfare of others and shall include alcoholism, alcohol abuse, substance abuse, substance dependence, chemical abuse, and/or chemical dependence." The governing contract for CHPlus contractors does not define or set a standard for defining MH/SUD disorders or M/S conditions. There are no stated MH/SUD diagnostic exclusions for which covered services are not available.
- III. For evaluating and ongoing monitoring of MHPAEA compliance, the State will utilize the ICD-10 CM to define and differentiate between MH/SUD and M/S conditions and facilitate the identification of MH/SUD and M/S benefits. Hence, any item or service used to treat a primary ICD-10-CM diagnosis of F01-F99 is regarded as a MH/SUD benefit. Any item or service used to treat a primary ICD-10 diagnosis that is not within the F01-F99 range is considered a M/S benefit.

IV. Conclusions:

1. **Parity Compliance:**

The State's Medicaid program complies with the regulatory requirement to define MH/SUD and M/S conditions consistent with a generally recognized independent standard of medical practice for its MMCP and ABP. The State's CHIP program, while not a Medicaid product, still complies with these independent standards of medical practice.

2. **Actions Taken:**

None required.

F. Mental Health and Substance Use Disorder Benefits Under the New York Medicaid State Plan

- I. All Medicaid State Plan covered MH/SUD benefits (intended for enrollees with a primary F code diagnosis in the F01-F99 range) and covered M/S benefits (all other ICD-10-CM codes) were inventoried for all Medicaid products reviewed (including the ABP), namely the Mainstream MMCPs HARPs, and HIV SNPs.
- II. The State Plan inventory for the MH/SUD benefits for the MMCP (including the ABP) along with a brief description of the services, is incorporated in the benefits classification chart in Appendix 2. The covered benefits for M/S conditions are also incorporated into Appendix 2.
- III. The covered benefits for the CHPlus program are provided in Appendix 3.
- IV. The services covered by each type of Medicaid Managed Care plan and those available on an FFS basis to enrollees vary. The Appendices, where applicable, differentiate between services covered under the MCO contract and those services available through FFS. The Child Health Plus program coverage is all inclusive with no FFS benefits.

V. Conclusions:

1. **Parity Compliance:**

MH/SUD and M/S benefits were identified based on being provided in connection with the controlling ICD-10-CM F code diagnosis definition which defines the respective disorder/condition categories and are therefore in compliance with the regulatory requirement at 42 CFR § 438.900.

2. **Actions Taken:**

None required.

G. Defining Benefits Classifications and Mapping Benefits to the Classifications

- I. The parity regulations have the following stipulations regarding classifications and benefits mapping:
 1. There are four basic classifications- inpatient, outpatient, emergency and prescription drugs with certain permissible sub-classifications.
 2. The standard for assignment to a classification must be identical for MH/SUD and M/S benefits.
 3. If benefits are provided for M/S in a classification or sub-classification, benefits for MH/SUD conditions must also be available in that classification (42 CFR § 438.910(b)(2)).
 4. The classification scheme establishes the categories for proper identification and testing of all applicable FRs, QTLs and NQTLs applied to MH/SUD benefits, enables a determination that there are no separate limitations being applied to MH/SUD benefits, and ensures that MH/SUD benefits are being provided in every classification that M/S benefits are provided.
- II. State law and regulations have no provisions that impede proper classification.
- III. The State established the following classifications for all covered MMCP (including the ABP), and CHPlus plan benefits:
 1. Inpatient;
 2. Outpatient*;
 3. Emergency services; and
 4. Prescription drugs.

*The State determined that it would optionally permit MCOs to submit parity compliance appendices containing an outpatient sub-classification for “office visits,” where such sub-classification contains physician and other private practitioner services only and does not include any freestanding or facility-based outpatient services.

The preliminary standards for assignment of benefits to each of these classifications are as follows:

1. Inpatient – admission to any State defined inpatient facility.
2. Outpatient – services which do not require an overnight stay at their

- place of service.
3. Emergency services – covered items or services rendered in an emergency department or to stabilize an emergency/crisis in a non-inpatient setting.
 4. Prescription drugs – covered drugs, medications or other supplies requiring a prescription.

IV. Conclusions:

1. **Parity Compliance:**

All the State MMCP (including the ABP) and CHPlus covered benefits were classified as required. The same standards for MH/SUD benefits were utilized to assign benefits to a classification for MH/SUD benefits, and benefits are offered in every classification as for M/S benefits.

2. **Actions Taken:**

None required; however, the State acknowledges that further streamlining to the classification scheme and/or assignment of benefits may be required in the future to support development and implementation of ongoing and robust parity monitoring.

H. Financial Requirements

- I. Financial requirements (FRs) include coinsurance, deductibles, co-payments, out of pocket maximums, or similar requirements that are required in conjunction with use of a service. The parity rule, 42 CFR § 438.910, requires any financial requirements that apply to MH/SUD benefits be no more restrictive than the predominant financial requirements and quantitative treatment limits that apply to substantially all M/S benefits. There can be no separate FRs which apply only to MH/SUD benefits. The parity rules also prohibit cumulative FRs for MH/SUD benefits in a classification that accumulates separately from any established for M/S benefits in the same classification and define the conditions whereby aggregate lifetime or annual dollar limits are applied, when permissible. For the purposes of analysis and discussion here, the term FR includes aggregate lifetime and annual dollar limits and cumulative financial requirements.
- II. The NYS MMCP (including ABP) - Mainstream MMCP, HARP, and HIV SNP - do not have any Medicaid beneficiary cost sharing or other financial requirements or similar limitations for MH/SUD or M/S covered benefits, except for co-payments for prescription drugs, which are established

pursuant to State Social Services Law Section 367, subject to a number of exclusions, including psychotropic drugs, for which no cost sharing is permitted. Persons enrolled in the HARP program are exempted from the prescription drug co-payment requirement. The co-payment requirements and annual enrollee out of pocket maximum are identical for MH/SUD and M/S prescription and over the counter drugs. Therefore, the State determined that a complete analysis by State contracted MCOs of the “Predominant/Substantially All” test to confirm parity compliance was not necessary.

- III. The MMCPs were however asked to report on whether any type of cost sharing or financial requirement is being applied within any classification or applicable sub-classification to confirm compliance with established State requirements. Review of the documentation submitted confirmed that:
 1. No cost sharing requirements were in effect for the Mainstream MMCP plans, other than for the prescription drug co-payment.
 2. No cost sharing requirements were in effect for HARP enrollees.
 3. No cost sharing requirements were in effect for the HIV SNP plans other than for the prescription drug co-payment.
 4. No aggregate lifetime and annual dollar limits and cumulative financial requirements are being applied.

- IV. CHPlus program contractors are expressly prohibited from charging enrollees any amount (or otherwise applying any FR) for MH/SUD and M/S benefits other than the required family premium contribution. Therefore, testing per the regulations to assure that there are not any financial requirements was not necessary to determine parity compliance. Regardless of the express prohibition regarding enrollee cost sharing for CHPlus enrollees, the State required its MCO contractors to complete the Appendix 4 worksheets to confirm that no cost sharing or financial requirements are being applied to any MH/SUD services in any benefits classification. Review of the MCO submissions confirmed that there are no financial requirements of any type being applied to enrollees in the CHPlus program.

- V. Conclusions:
 1. **Parity Compliance:**
The State MMCP, ABP, and CHPlus comply with the parity regulation’s financial requirement provisions.

2. **Actions Taken:**

None required.

I. Quantitative Treatment Limitations

- I. Quantitative treatment limitations (QTLs) include inpatient day or visit caps, episodes of care limits, cumulative QTLs, etc. The parity rule requires that:
 1. Any quantitative treatment limitations that apply to MH/SUD benefits be no more restrictive than the predominant quantitative treatment limits that apply to substantially all M/S benefits; and
 2. There are no quantitative treatment limitations that apply to MH/SUD benefits, but not M/S benefits.
 3. There are no cumulative quantitative treatment limitations that do not comply with the general parity requirement.

- II. The State contract which is the controlling authority for MMCP contractor requirements (including ABP), only contains one MH/SUD provision that delineates a quantitative treatment limitation for MCO covered services.
 1. The one exception relates to smoking cessation counseling services. MCO contractors are only required to cover up to eight sessions, two of which can be furnished by a dental practitioner. This quantitative treatment limitation fails the Substantially All test in the outpatient benefit classification.

Outside of the controlling contract, the State's analysis revealed that there are two other types of Medicaid covered services, Partial Hospitalization Services and HARP HCBS, which are subject to quantitative treatment limitations. It should be noted, however, that the State's analysis also revealed that neither the MCOs nor the State are actively imposing either of these limitations. The specific limitations are as follows:

1. Partial Hospitalization Services are intensive mental health outpatient services provided by outpatient hospitals and freestanding mental health clinics licensed by the New York State Office of Mental Health (OMH). These services are appropriate for young adults beginning at age 15. As such, these services are in the Medicaid Managed Care benefit for adults but may be provided on a fee for service basis for individuals under age 21, for whom these services are still carved out. Both the State Medicaid Plan and state regulations currently limit services to 360 hours per year. While this limitation exists in these governing documents, the State's analysis revealed that MCOs are not currently applying this limitation. There are also currently no claims edit in the State's

Medicaid fee for service claims system to reject claims submitted in excess of 360 hours. Further analysis reveals that individuals almost never require partial hospitalization services at this threshold.

2. HARP Home and Community Based Services include an array of rehabilitative behavioral health services authorized in the New York State Medicaid Redesign 1115 waiver for adults only. Service utilization thresholds, including annual visit and expenditure limits are also specific in the 1115 waiver. However, formal policy permits the quantitative threshold to be exceeded provided there is evidence of medical necessity.
- III. The CHPlus coverage statements are explicit that there are no QTLs as defined in the parity regulation which are permitted.
 - IV. All MCO contractors for each of the program types discussed above were required to complete the provided worksheets for QTLs. As noted, a review of the submissions yielded several minor issues in the Medicaid Managed Care program category.
 - V. Conclusions:
 1. **Parity Compliance:**

The New York State Medicaid Managed Care, ABP, and CHPlus programs follow the parity requirements for QTLs but for two minor exceptions: smoking cessation counseling services and Partial Hospitalization Services. Examination revealed that the QTL issue for partial hospitalization only existed in writing and not in-operation. The governing language for this will be amended. The smoking cessation counseling limits requires further in-depth analysis, which the State is immediately undertaking. Further testing of this limit will determine if it is a parity violation and, if so, the State will take the appropriate action.
 2. **Actions Taken:**

The State submitted a State Plan Amendment to remove smoking cessation face-to-face counseling session limitations as well as limitations to Partial Hospitalization services. This Amendment has been approved and there are no longer limitations for smoking cessation or Partial Hospitalization services. The State is currently in the process of amending state regulations containing the hourly limitations for Partial Hospitalization Services as a part of an

omnibus regulatory update necessitated by the approval of NY SPA 10-18 in late 2017. This regulatory change should be finalized in 2021.

J. Nonquantitative Treatment Limitations

- I. Nonquantitative Treatment Limitations (NQTLs) are MCO provisions which are not expressed numerically but otherwise limit the scope or duration of benefits. NQTLs include medical necessity criteria, medical management protocols (e.g., prior authorization and concurrent review), reimbursement rates, among others. The final regulations provide that an NQTL may be not applied to any MH/SUD benefit in any classification unless under the terms of the plan, both as written and in-operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for M/S services in the classification. Moreover, there cannot be any NQTLs which separately apply to MH/SUD benefits.
- II. State law, regulations, formal guidance, and contract requirements have a number of provisions that are pertinent to the review and analysis of NQTLs for the MMCP (including ABP), and CHPlus.
- III. The State has undertaken several tasks evaluating compliance with the regulatory test for NQTLs, including identifying all possible NQTLs being applied to MH/SUD services within each respective benefit classification, whether they are embedded in State requirements or MCO policies and procedures. Additionally, the State has undertaken a review to assure the NQTLs it is responsible for, such as rate setting and approval of utilization review (UR) criteria for all behavioral health services, are parity compliant. The first step of the State methodology was to:
 1. Identify all covered MH/SUD services as discussed above.
 2. Delineate all applicable policy or administrative requirements thereto.
 3. Evaluate whether a requirement could otherwise limit the scope or duration of that benefit.
 4. Evaluate the identified NQTL per the NQTL test and prescribed methodology developed in conjunction with Milliman.
- IV. The initial phase of the parity evaluation process was to brief all MCO contractors on the form requirements and methodology prepared for the NQTL evaluation. The same reporting requirements and methodology were required for each program category. Given the scope of the reporting and

documentation requirements for the NQTLs, the State divided the review of the nineteen identified NQTLs into three phases, beginning with the review of the highest priority NQTLs, including medical necessity criteria, prior authorization, concurrent review, and formulary design. The analysis format created by the State followed a stepwise structure, very similar to the one in Section F of the *Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act*. The methodological steps were as follows:

1. Provide the specific MCO language regarding the NQTL and describe all services to which it applies in each respective classification of benefits.
2. Identify the factors that trigger the application of the NQTL.
3. Identify and describe the evidentiary standard for each of the factors identified and any other evidence relied upon to design and apply the NQTL.
4. Provide the comparative analyses used to determine as written comparability and equivalent stringency.
5. Provide the comparative analyses used to determine in-operation comparability and equivalent stringency.
6. Provide a summary statement justifying how performing the comparative analyses required by the subsequent steps has led the MCO to conclude that it is parity compliant.

To complete the reporting template, the State provided guidance to the MCOs that metrics such as inter-rater reliability statistics compared between MH/SUD and M/S, and the average length of time per review for MH/SUD reviews versus M/S reviews were valid initial metrics to perform retrospective analyses of in-operation performance. Information on service utilization and benefit coverage denials (whether from prior authorization, concurrent review, or retrospective review) was available for inclusion as this data is currently reported to the State.

- V. The State provided further technical assistance to all MCOs through webinars, written guidance, individual technical assistance sessions and a Parity Compliance Toolkit. Webinars were utilized to review and explain the nature of and how to complete the NQTL analysis steps, including a walkthrough of a completed example, to provide preliminary review findings, and to answer questions from the MCOs about aspects of the analyses. The State provided ongoing technical assistance to all MCOs through written guidance and individual conference sessions to address outstanding questions and provide clarification on particular NQTLs or requirements.

During these technical assistance sessions, the State consistently emphasized to the MCOs that there was no preferred or required method of

employing processes, strategies, evidentiary standards, or factors, but their use in MH/SUD design and operation must be comparable to and applied no more stringently to their design and operation for M/S services. The State reinforced that the factors must be clearly disclosed, and additional information may be required to complete analysis to enable appropriate evaluation.

Additionally, the State provided supplemental technical assistance through the release of the Parity Compliance Toolkit. The Parity Compliance Toolkit was developed to support insurers, providers, and consumers in understanding parity and the State's efforts toward achieving MH/SUD parity compliance, including the parity evaluation. The toolkit also includes a compilation of federal and state information and resources regarding MH/SUD parity.

- VI. The State reviewed NQTL analysis worksheets submitted by the MMCPs for Medicaid Managed Care (including the ABP), and CHPlus for the following three phases and NQTLs:
1. Phase I: Prior authorization; concurrent review; medical necessity criteria; and formulary design.
 2. Phase II: Coding edits; out-of-network coverage standards; geographic restrictions; reimbursement; and provider type exclusions.
 3. Phase III: Retrospective review; outlier review; experimental/investigational determinations; exclusions for court-ordered treatment or involuntary holds; fail first; failure to complete; provider credentialing; certification requirements; unlicensed provider/staff requirements; and UCR rate determinations.

VII. Conclusions:

1. **Parity Compliance:**

Overall, for Phases I and II the State found MCOs were able to complete the worksheets across all product lines, with many needing technical assistance and explanation. All MCOs submitted the requested materials; however, each submission exhibited inconsistencies with the methodology as articulated and/or provided insufficient information to varying degrees.

During the initial review of Phase I NQTL submissions, the State identified that the quality of MCO submitted worksheets did not enable an appropriate evaluation of parity compliance and that, in general MCOs were not actively analyzing all their NQTLs for parity compliance. Analysis of the worksheets demonstrated potential violations with MHPAEA, such with inter-rater reliability; however, it

was determined that further information was necessary to properly evaluate parity compliance. The initial review of Phase I also found that the CHPlus contractor category did not yield differential results. Due to the quality of the submissions, the State provided further technical assistance and requested the resubmission of Phase I NQTL worksheets from all MCOs in order to effectively evaluate parity compliance.

The analysis of resubmitted Phase I NQTL worksheets revealed that most MCO submissions lacked comprehensive responses and did not provide substantive comparative analyses for prior authorization, concurrent review, medical necessity criteria, and formulary design. Therefore, MCOs failed to demonstrate compliance with MHPAEA. Results of Phase I are demonstrated as follows:

Phase I NQTLs				
Plan	Prior Authorization	Concurrent Review	Medical Necessity Criteria	Formulary Design
Affinity	Noncompliant	Noncompliant	Compliant	Noncompliant
Amida Care	Noncompliant	Noncompliant	Noncompliant	Noncompliant
CDPHP	Noncompliant	Noncompliant	Noncompliant	Noncompliant
Emblem	Noncompliant	Noncompliant	Noncompliant	Compliant
Excellus	Compliant	Compliant	Compliant	Noncompliant
Fidelis	Noncompliant	Noncompliant	Noncompliant	Noncompliant
Healthfirst	Noncompliant	Noncompliant	Noncompliant	Noncompliant
HealthNow	Noncompliant	Noncompliant	Noncompliant	Noncompliant
HealthPlus	Noncompliant	Noncompliant	Noncompliant	Noncompliant
IHA	Noncompliant	Compliant	Compliant	Noncompliant
MetroPlus	Noncompliant	Noncompliant	Noncompliant	Noncompliant
Molina	Noncompliant	Noncompliant	Noncompliant	Noncompliant
MVP	Noncompliant	Noncompliant	Noncompliant	Noncompliant
UHC	Noncompliant	Noncompliant	Noncompliant	Noncompliant
VNSNY	Compliant	Noncompliant	Noncompliant	Compliant
WellCare	Noncompliant	Noncompliant	Noncompliant	Noncompliant
YourCare	Compliant	Compliant	Compliant	Noncompliant

The analysis of Phase II NQTL worksheets exhibited minimal improvement in submission quality, with most MCOs failing to demonstrate compliance with MHPAEA. Many submissions were unresponsive to the prompts, incomplete, and/or did not provide substantive comparative analyses with respect to coding edits, out of network coverage standards, and reimbursement NQTLs; however, all MCOs were found compliant for provider type exclusions and most were found compliant for geographic restrictions. Results of Phase II are demonstrated as follows:

Phase II NQTLs					
Plan	Coding Edits	OON Coverage Standards	Geographic Restrictions	Reimbursement	Provider Type Exclusion
Affinity	Compliant	Noncompliant	Compliant	Noncompliant	Compliant
Amida Care	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant
CDPHP	Noncompliant	Compliant	Compliant	Noncompliant	Compliant
Emblem	Noncompliant	Compliant	Compliant	Noncompliant	Compliant
Excellus	Compliant	Compliant	Compliant	Noncompliant	Compliant
Fidelis	Noncompliant	Noncompliant	Compliant	Noncompliant	Compliant
Healthfirst	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant
HealthNow	Noncompliant	Noncompliant	Compliant	Compliant	Compliant
HealthPlus	Noncompliant	Noncompliant	Compliant	Compliant	Compliant
IHA	Noncompliant	Noncompliant	Compliant	Noncompliant	Compliant
MetroPlus	Noncompliant	Noncompliant	Compliant	Noncompliant	Compliant
Molina	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant
MVP	Noncompliant	Compliant	Compliant	Noncompliant	Compliant
UHC	Noncompliant	Compliant	Compliant	Noncompliant	Compliant
VNSNY	Compliant	Noncompliant	Compliant	Noncompliant	Compliant
WellCare	Noncompliant	Noncompliant	Compliant	Noncompliant	Compliant
YourCare	Compliant	Compliant	Compliant	Noncompliant	Compliant

The examination of Phase II further revealed that one MCO, Independent Health Association, Inc., was in violation of MHPAEA after disclosing practices demonstrating that strategies used when determining reimbursement rates for MH/SUD services were not comparable to the strategies used in determining reimbursement rates for M/S services in the inpatient, outpatient, and emergency care benefit classifications. Regulatory action against Independent Health Association, Inc., is currently being considered by the State.

The analysis of Phase III NQTL worksheets demonstrated similar results to Phase I and II, as most MCO submissions lacked comprehensive responses and did not provide substantive comparative analyses for five of the ten NQTLs tested; retrospective review, outlier review, experimental/investigational determinations, fail first, and provider credentialing. In contrast however, MVP Health Plan Inc. was deemed compliant for all ten NQTLs, while most MCOs were found compliant for certification requirements, unlicensed provider/staff requirements, UCR rate determinations, exclusions for court-ordered treatment, and failure to complete. Results of Phase III are demonstrated as follows:

Plan	Phase III NQTLs									
	Retro Review	Outlier Review	Experimental/ Investigational Determinations	Fail First	Provider Credentialing	Cert Req.	Unlicensed Provider	UCR Rate Determinations	Exclusions for Court-Ordered Treatment	Failure to Complete
Affinity	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant	Compliant	Compliant	Compliant	Compliant	Noncompliant
Amida Care	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant	Compliant	Compliant	Compliant	Compliant
CDPHP	Compliant	Compliant	Noncompliant	Noncompliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
Emblem	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant	Compliant	Compliant	Compliant	Compliant
Excellus	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant	Compliant	Compliant	Compliant	Compliant
Fidelis	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant	Compliant	Compliant	Compliant	Compliant
Healthfirst	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant	Compliant	Compliant	Compliant	Compliant
Highmark*	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant	Compliant	Compliant	Compliant	Compliant
HealthPlus	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant	Noncompliant	Compliant	Noncompliant	Noncompliant
IHA	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant	Compliant	Compliant	Compliant	Compliant
MetroPlus	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant	Compliant	Compliant	Compliant	Compliant
Molina	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant	Compliant	Compliant	Compliant	Noncompliant
MVP	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
UHC	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant	Compliant	Compliant	Compliant	Compliant	Compliant
VNSNY	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Noncompliant	Compliant	Compliant	Compliant	Compliant	Compliant

*Highmark f/k/a. HealthNow

The Phase III analysis revealed that five MCOs, Affinity Health Plan, Inc., Amida Care, Inc., New York Quality HealthCare Corporation’s (Fidelis Care), Independent Health Association, Inc, and MetroPlus Health Plan Inc., violated MHPAEA for retrospective review and/or outlier review. Details are as follows:

Affinity Health Plan, Inc.’s submission for retrospective review in the inpatient and outpatient benefit classifications demonstrated that the factors in place for MH/SUD benefits were not comparable to the factors in place for M/S benefits. Affinity Health Plan, Inc.’s submission for outlier review in the inpatient and outpatient benefit classifications demonstrated that the MCO performs outlier review on MH/SUD benefits, but does not perform outlier review for M/S benefits.

Amida Care, Inc.’s submission for retrospective review in the inpatient and outpatient benefit classifications demonstrated that the processes, strategies, evidentiary standards, and other factors used to implement retrospective review for MH/SUD benefits were not comparable to those utilized for M/S benefits. The MCO indicated that it considers factors such as high cost for M/S benefits and other, non-comparable factors related to clinical care for MH/SUD benefits.

Fidelis Care’s submission for outlier review in the outpatient benefit classification demonstrated that the MCO performs outlier review on MH/SUD benefits but does not perform outlier review for M/S benefits; thereby making outlier review a separate and categorically noncomparable treatment limitation applied to MH/SUD benefits.

Independent Health Association, Inc.’s submission for retrospective review in the inpatient and outpatient benefit classifications demonstrated that the processes, strategies, evidentiary standards,

and other factors used in designing retrospective review for MH/SUD benefits were not comparable to those utilized for M/S benefits. The MCO's submission for outlier review in the inpatient and outpatient benefit classifications demonstrated that the evidentiary standards used to define the factor of "high cost" are not comparable to and are more stringently applied to MH/SUD benefits compared to M/S benefits. Independent Health Association, Inc. indicated that the monetary threshold for outlier review is 20 times greater for M/S services than for MH/SUD services.

MetroPlus Health Plan Inc.'s submission for retrospective review in the inpatient and outpatient benefit classifications demonstrated that the processes, strategies, evidentiary standards, and other factors used to implement retrospective review for MH/SUD benefits were not comparable to those utilized for M/S benefits. The MCO indicated that it considers whether the provider failed to obtain prior authorization for M/S benefits and other, non-comparable factors related to clinical care for MH/SUD benefits.

Regulatory action against these five MCOs is currently being considered by the State.

2. **Actions Taken:**

Some of the initially submitted Phase I worksheets had inadequate detail to confirm if factors triggering prior authorization and concurrent review were applied similarly and no more stringently to MH/SUD than M/S. The State provided additional technical assistance, including how to integrate the use of data, and allowed MCO's to resubmit Phase I worksheets.

Following the first-round review of the resubmitted Phase I worksheets, MCOs were provided with additional technical assistance via a webinar and individual sessions prior to the Phase II submission deadline. Once the review of Phase I and II worksheets were completed, the State provided each MCO with preliminary NQTL testing results, inclusive of report cards and details of areas of noncompliance. Each MCO then participated in an individual consultation with the State and Milliman to discuss the findings, next steps, and answer questions. The State then finalized the evaluation results for Phase I and II and issued applicable Statement of Deficiencies and Statement of Findings to all MCOs. MCOs were cited

https://www.health.ny.gov/health_care/managed_care/reports/focused_surveys/mental/index.htm) based on 10 NYCRR 98-1.16 (Disclosure and Filing) and section 35.1 of the Medicaid Managed Care Model Contract (Contractor and SDOH Compliance with Applicable Laws).

MCOs were required to take appropriate corrective action.

Phase III workbooks were reviewed and analyzed using the same approach as Phase I and II. Once the examination of all ten NQTLs was completed, MCOs were issued report cards and details of areas of noncompliance, along with citations. MCOs were cited based on 10 NYCRR 98-1.16 (Disclosure and Filing), PHL § 4406 (Health maintenance organization; regulation of contracts) and sections 10.2 (Compliance with State Medicaid Plan, Applicable Laws and Regulations), 18.5 (Reporting Requirements), and 35.1 (Contractor and SDOH Compliance with Applicable Laws) of the Medicaid Managed Care Model Contract, as applicable. MCOs were again required to take appropriate correction action. The State will continue to monitor compliance through future operational surveys and monitoring. Results will be publicly posted on the DOH website (https://www.health.ny.gov/health_care/managed_care/reports/focused_surveys/mental/index.htm) as accepted corrective action plans are received. Regulatory action against these five MCOs is currently being considered by the State.

K. Availability of Information

- I. Generally, the State or the various MCO program contractors must make available to any enrollee, potential enrollee, and Medicaid or contracting providers, the criteria for medical necessity determinations made by the State or MCO upon request. The State or MCOs must also make available to the enrollee the reason for any denial by the MCO of reimbursement or payment for services for MH/SUD benefits to the enrollee. The regulatory defined responsibility for disclosure varies amongst the MMCP (including the ABP), and CHPlus programs.
- II. State MCO contracts presently have requirements for disclosure of definitions of medical necessity and protocols for adverse benefit determinations and appeals notification which are consistent with the availability of information requirements in the parity regulations.
- III. Conclusions:
 1. **Parity Compliance:**
The current MMCP (including the ABP) and CHPlus contracts include these disclosure requirements or obligations on the part of the MCO contractors.

2. **Actions Taken:**

While the Programs are in compliance with the parity requirements with respect to the information collected in the submissions, the State will continue to review and assess MCO performance in this area through ongoing surveys.

L. State MCO Contract Requirements

I. CMS has set forth essential parity compliance MCO contract provisions in its “State Guide to CMS Criteria for Medicaid Managed Care Contract Review and Approval” (January 20, 2017). The CMS State Guide outlines all applicable contract requirements for MCOs that must be met and includes requirements pertaining to MHPAEA. These include contract requirements specific to MCO compliance with the parity rules governing financial requirements, quantitative treatment limitations, and nonquantitative treatment limitations. MCO contracts must specify the necessary MCO documentation and state reporting regarding parity in MH/SUD benefits required to demonstrate compliance with 42 CFR Part 438, subpart K.

II. The State currently has standardized MCO contracts that require compliance with MHPAEA. Article 49 of the New York Public Health law also requires MCO contractors to attest to compliance with MHPAEA.

III. Conclusions:

1. **Parity Compliance:**

The current New York MCO standard contracts do not include all of the required clauses which may be applicable to the Programs stipulated under the CMS criteria for Managed Care contracts.

2. **Actions Taken:**

The State has amended its MCO contracts to include the CMS required contract clauses. As discussed below, consideration is being given to additional language that will stipulate the exact types of documentation expected of MCO plans to enable the State’s parity evaluation effort going forward.

M. Monitoring Parity Compliance

I. As required by State law, 42 CFR Part 438, and the applicable 1115 MRT Waiver Standard Terms and Conditions, the State is required to conduct compliance surveys and monitor performance of its contracted MCOs, PIHPs and PAHPs.

- II. The State has a standing operational survey process to conduct retrospective reviews or audits of MCOs for overall compliance and enforcement with New York State Public Health Law Article 44, Health Maintenance Organizations, and Article 49, Utilization Review and External Appeals. Findings of noncompliance are processed via Statements of Deficiency to MCO contractors that stipulate a required corrective action plan and timetable to remediate deficiencies.
- III. While the current operational surveys do not have protocols specifically dedicated to parity compliance, the survey process provides a structure to review and monitor for parity compliance. The process requires State monitors from the Department of Health (the single State Medicaid agency) and the State's behavioral health agencies (OMH and OASAS) to review utilization management practices, and interview MCO staff to determine and analyze the "in-operation" component of the NQTL regulatory tests and actual MCO contractor implementation activities regarding MH/SUD benefits.
- IV. In addition to the operational survey process, State regulators are constantly engaged in the review and assessment of data MCOs are required to routinely report regarding service authorization requests and denials, grievances and appeals regarding the administration and reimbursement of benefits, and network design and adequacy, among others.
- V. Conclusions:
 - 1. **Parity Compliance:**
While compliant, the State intends to move beyond MCO contractor attestations of MHPAEA compliance and develop specific protocols and analysis for MCO contractors to report and document the basis for their compliance in a manner which can be more efficiently evaluated by the State. MCO documentation as the basis for compliance must correlate with the methodological elements stipulated in federal guidance for each of the essential parity requirements.
 - 2. **Actions Taken:**
The State, as part of the overall parity compliance evaluation, is examining protocols for operational surveys specific to parity compliance. These may include MCO contract parity reporting and documentation requirements regarding compliance with parity rules that go beyond the parity contract criteria stipulated by CMS. The State

will utilize the findings from the review process to inform how best to optimize oversight with MCO contractors. The formal parity compliance monitoring plan will be finalized once the State completes its review of the full scope of NQTLs identified by CMS in the final rule.

Additionally, the State established the Mental Health and Substance Use Disorder Parity Compliance Program (10 NYCRR Subpart 98-4 and 11 NYCRR Part 230). The Parity Compliance Program requires insurers to establish corporate governance for parity compliance, identify discrepancies in coverage of services for the treatment of MH/SUD, and ensure appropriate identification and remediation of improper practices. Annually, MCOs must certify that they satisfactorily meet the requirements set forth in the Parity Compliance Program.

N. Posting of State Parity Compliance Documentation

- I. Where the full scope of M/S and MH/SUD benefits are not provided through the MCO, the State has the responsibility to ensure compliance with the parity requirements. The State must provide documentation of compliance with the parity requirements to the public and post this information on the State's Medicaid Website.
- II. The State will submit this document to CMS and post publicly via the DOH website.
- III. Conclusions:
 1. **Actions Taken:**
The analysis and monitoring plan referenced in N. II. above will be posted on the Department of Health's website.

O. Appendix 1: New York State MHPAEA Two Year Workplan

New York State MHPAEA Two Year Workplan

January 2022

Timeframe	Objective
Q1 2019	Children's MMC benefit begins adding new services
Q2 2019	Include NQTL evaluation methodology documentation requirements in the State's contracts with MCOs
Q2 2019	Amend MCO contracts for parity clauses, documentation, and reporting for ongoing parity monitoring
Q2 2019	Parity report submitted to CMS
Q2 2019	Publicly post report
Q2 2019	Develop and engage in process to improve/evaluate MCO Phase I reports
Q2 2019	Begin Phase II of NQTL testing - distribute instructions and workbooks to MCOs
Q2 2019	Conduct webinar/ informational session for Phase II NQTL testing
Q2 2019	Provide plan specific technical assistance as needed
Q3 2019	Address exceptions of QTL compliance by removing prohibited limitations
Q4 2019	Deadline for Phase II workbook submissions
Q1 2020	Begin Phase III of NQTL testing - distribute instructions and workbooks to MCOs
Q2 2020	Complete analysis of Phase II workbooks
Q2 2020	Publish NYS Parity Compliance Toolkit
Q2 2020	Provide plan specific technical assistance as needed
Q2 2020	Summarize and report findings from Phase I and Phase II parity analysis
Q3 2020	Deadline for Phase III workbook submissions
Q3 2020	Issue Phase I and Phase II preliminary findings reports to plans
Q3 2020	Provide plan specific Phase I and II preliminary findings consultations as requested
Q3 2020	Continue to review and assess MCO compliance with parity via workbooks submissions
Q4 2020	Issue Phase I and Phase II parity citations
Q4 2020	Complete analysis of Phase III workbooks
Q4 2020	Summarize and report findings from Phase III parity analysis
Q1 2021	Summarize and report all findings from Phase I and Phase II in comprehensive report
Q4 2021	Issue Phase III parity report cards and citations
Q1 2022	Summarize and report all findings from Phase III and finalize comprehensive report
Q1 2022	Implement all corrective actions from testing
Q2 2022	Develop formal parity compliance protocols for use during State operational surveillance of MCOs and ongoing monitoring
Q2 2022	Initiate parity field audits to test for in-operation components of NQTLs
Q2 2022	Expand MHPAEA Two Year Workplan to include ongoing in-operation surveys

**shaded items have been completed*

P. Appendix 2: MMCP (including ABP) and FFS M/S and MH/SUD Benefits Mapping

MMCP Package Benefits Mapping*			
Category	Medical/Surgical Benefits	Mental Health Benefits	Substance Use Disorder Benefits
Inpatient	Inpatient Hospital Services	Inpatient Mental Health Services	Medically Managed Inpatient Detoxification
	Inpatient Stay Pending Alternate Level of Medical Care	Inpatient Services applicable to HARP and HIV SNP: Intensive Crisis Respite	Inpatient Services – SUD Detoxification, Rehabilitation and Treatment Services
	Residential Health Care Facility (Nursing Home) Services (RHCF) - Short Term Placement		SUD Residential Addiction Treatment Services
	Nurse Home Services - Long Term Placement		Medically Supervised Inpatient Withdrawal Services
Outpatient	Physician Services	Outpatient Mental Health Services (Clinic Services and Independent Practitioners)	Medically Supervised Ambulatory Outpatient Clinic Programs
	Nurse Practitioner Services	Personalized Recovery Oriented Services (PROS)	Medically Supervised Outpatient Rehabilitation Programs
	Midwifery Services	Continuing Day Treatment Services	Medically Supervised Outpatient Withdrawal
	Preventive Health Services	Partial Hospitalization Services	Outpatient Chemical Dependence for Youth
	Second Medical/Surgical Opinion	Assertive Community Treatment Services	Opioid Treatment Services – Office Based Services
	EPSDT Services/Child Teen Health Program (C/THP)	Health Home Care Management	Buprenorphine Prescribers
	Foot Care Services	Community Mental Health/LBHP Waiver Services	Opioid Treatment Programs
	Eye Care and Low Vision Services	Intensive Outpatient Services	Buprenorphine and Buprenorphine Management
	Audiology Services		Opioid Treatment Services – Non-Office Visit

MMCP Package Benefits Mapping*

Category	Medical/Surgical Benefits	Mental Health Benefits	Substance Use Disorder Benefits
Outpatient (continued)	Family Planning and Reproductive Health Services		
	Dental available to all MMC enrollees. Orthodontic Services - limited to enrollees up to 21 years of age. Available to 21 years and older in connection with necessary surgical treatment.	Outpatient Services applicable to HARP and HIV SNP:	Outpatient Services applicable to HARP and HIV SNP:
	Laboratory Services	Psychosocial Rehabilitation (PSR)	Psychosocial Rehabilitation (PSR)
	Radiology Services	Community Psychiatric Support and Treatment (CPST)	Community Psychiatric Support and Treatment (CPST)
	Rehabilitation Services (not including Psychosocial Rehabilitation (PSR))	Habilitation Services	Habilitation Services
	Home Health Services	Family Support and Training	Family Support and Training
	Private Duty Nursing Services	Short Term Crisis Respite	Short Term Crisis Respite
	Durable Medical Equipment (DME)	Education Support Services	Education Support Services
	Prosthetic/Orthotic Services/Orthopedic Footwear	Peer Supports	Peer Supports
	Hearing Aid Services & Products	Pre-Vocational Services	Pre-Vocational Services
	Hospice	Transitional Employment	Transitional Employment
	Personal Care Services	On-Going Supported Employment	On-Going Supported Employment
	Personal Emergency Response System (PERS)	Intensive Supported Employment	Intensive Supported Employment
	Renal Dialysis		
	Home Delivered Meals - Covered for enrollees transitioning from the LTHHCP. Not available to all MMC enrollees.		
	Adult Day Health Care		
	AIDS Adult Day Health Care		

MMCP Package Benefits Mapping*

Category	Medical/Surgical Benefits	Mental Health Benefits	Substance Use Disorder Benefits
Outpatient (continued)	Tuberculosis Directly Observed Therapy		
	Non-Emergency Transportation (only where included as optional benefit in the MMC plan benefit package)		
	Durable Medical Equipment (DME)		
Emergency Services	Emergency Services	Emergency Services, including Comprehensive Psychiatric Emergency Program Services	Emergency Services
	Post-Stabilization Care Services	Post-Stabilization Care Services	Post-Stabilization Care Services
	Observation Services	Observation Services	Observation Services
	Emergency Transportation (only where included as optional benefit in the MMC plan benefit package)		
Prescription Drugs	Smoking Cessation Products	Smoking Cessation Products	Smoking Cessation Products
	Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula	Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula	Prescription and Non-Prescription (OTC) Drugs, Medical Supplies, and Enteral Formula
	Hemophilia blood factors		

*As of 12/31/18

FFS Benefits Mapping

Category	Medical/Surgical Benefits	Mental Health Benefits	Substance Use Disorder Benefits
Inpatient	Inpatient Hospital Services when admit date precedes effective date of enrollment	Inpatient Hospital Services when admit date precedes effective date of enrollment.	Inpatient Rehabilitation and Treatment Services Provided by OASAS certified programs to SSI enrollees
		For SSI-related enrollees under age 21, MH inpatient services	
Outpatient	Family Planning and Reproductive Health Services (if excluded pursuant to MMC or EP contractor's contract)	For SSI-related enrollees under age 21: OMH-licensed clinic services	Opioid Treatment Program
	Nursing Home Services for Enrollees under age 21 in long term placement status, and HARP enrollees.	For both MAGI and SSI-related enrollees under age 21: OMH-licensed Partial Hospitalization Services, Continuing Day Treatment Services, PROS, and ACT Services	Outpatient Rehabilitation and Treatment Services Provided by OASAS Licensed Clinics
	School-Based Health Center Services	Day Treatment Services for Children	Medically Supervised Ambulatory Chemical Dependence Outpatient Clinic Programs
	Non-Emergency Transportation (except where included as optional benefit in the MMC plan benefit package)	Home and Community Based Services Waiver for Seriously Emotionally Disturbed Children	Outpatient Rehabilitation and Treatment Services Provided by OASAS Licensed Clinics:
		School-Based Health Center Services	Medically Supervised Chemical Dependence Outpatient Rehabilitation Programs
		Home Health Services	Outpatient Rehabilitation and Treatment Services Provided by OASAS Licensed Clinics:

FFS Benefits Mapping

Category	Medical/Surgical Benefits	Mental Health Benefits	Substance Use Disorder Benefits
Outpatient (continued)		Clinic Services Provided by OMH-licensed and designated Clinics for Children With A Diagnosis of Serious Emotional Disturbance (SED) (both MAGI and SSI-R kids)	Outpatient Chemical Dependence for Youth Programs
		OMH-licensed Rehabilitation Services in Community Residences for Adults and Children and Youth.	
		Long Term Therapy Services provided by OPWDD-licensed clinics	
		OPWDD-licensed Day Treatment Services	
		Medical Service Coordination for individuals with intellectual and development disabilities	
		Non-Emergency Transportation OPWDD Waiver Services	
Emergency Services	Emergency Transportation (except where included as optional benefit in the MMC plan benefit package)	Emergency Transportation	
Prescription Drugs			

Q. Appendix 3: Child Health Plus Benefits Mapping

Child Health Plus Benefits Mapping			
Category	Medical/Surgical Benefits	Mental Health Benefits	Substance Use Disorder Benefits
Inpatient	Inpatient Hospital or Medical or Surgical Care	Inpatient Mental Health Services	Inpatient Alcohol and Substance Abuse Services
	Inpatient Rehabilitation		
	Maternity Care		
Outpatient	Professional Services for Diagnosis and Treatment of Illness and Injury	Diagnosis and Treatment of an Autism Spectrum Disorder	Outpatient Visits for the Diagnosis and Treatment of Alcoholism and Substance Abuse Conditions
	Second Surgical Opinion	Outpatient Visits for the Diagnosis and Treatment of Mental Health	
	Second Medical Opinion		
	Dental Care		
	Hospice Services and Expenses		
	Outpatient Surgery		
	Diagnostic and Laboratory Test		
	Therapeutic Services		
Pre-Surgical Testing			
Emergency Services	Emergency Medical Services	Emergency Medical Services	Emergency Medical Services
	Ambulance Services	Ambulance Services	Ambulance Services
Prescription Drugs	Durable Medical Equipment (DME), Prosthetic Appliances and Orthotic Devices	Speech and Hearing Services Including Hearing Aids	
	Prescription and Non Prescription Drugs		
	Diabetic Supplies and Equipment		
	Speech and Hearing Services Including Hearing Aids		

R. Appendix 4: MHPAEA Testing Workbook for Financial Requirements

New York State - Office of Mental Health Mental Health Parity Analysis Workbook

Last updated: MM/DD/2018

Instructions

The purpose of this workbook is for insurers to demonstrate the compliance of their plans with the mental health parity requirements under the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its implementing regulations and guidance. 42 U.S.C. 1396u-2(b)(8); 42 U.S.C. 1396u-7(b)(6); 42 U.S.C. 1397cc(c)(6); 42 U.S.C. 300gg-26.; 42 CFR Parts 438, 440, and 457; and N.Y. Ins. Law §§ 3103, 3201, 3221, 4303, and 4308 and Article 49.

Please include only **one plan per workbook**; submit a separate workbook for each plan in the filing.

Please include the 2019 plan name in the file name of each complete plan workbook. Submit the completed plan workbooks as Excel files under the Supporting Documents tab of the applicable 2019 form filing.

The worksheets in this workbook contain additional instructions that appear by clicking on either the field or the column heading.

The worksheets in this workbook are password protected to prevent formula changes. If you find an error or need to alter underlying formatting or formulas to tailor the workbook to your plan design and data, please contact the Department contact listed below.

If you have any questions regarding this workbook, please contact (insert contact name) at the email provided below:

Quantitative Analysis Worksheets

This Mental Health Parity Analysis Workbook consists of separate Quantitative Analysis (QA) worksheets for each classification and sub-classification specified in 42 CFR § 438.910, 42 CFR §440.395, and 42 CFR 457.496. Please note the in-network and out-of-network classifications for the inpatient classification and outpatient classification and sub-classifications have been combined onto one worksheet.

Complete a separate workbook for each plan. There should be only one plan reflected in each QA workbook.

Inpatient Worksheet: Please enter the insurer name, product name, state tracking number (if a state tracking number has not been assigned, provide the SERFF tracking number), and 2019 plan name at the top of the worksheet in the designated fields. This information will be automatically copied onto other worksheets.

Benefits and Services Column: Every medical/surgical benefit or service that is listed in this QA worksheet for a

given classification or sub-classification should also be listed in the Benefit Classification Tables (in Part III.B of the Mental Health Parity Supporting Documentation Template) for that classification or sub-classification. Likewise, every medical/surgical benefit or service that appears in the Benefit Classification Tables should also appear in the QA worksheet for the applicable classification or sub-classification. Please note the exception provided for benefits in the Prescription Drugs classification, as noted below.

Enter all medical/surgical benefits in all classifications and sub-classifications for which an analysis is required. Use the same benefit labels as in the Benefit Classification Tables in Part III.B of the Mental Health Parity Supporting Documentation Template. Ensure that the assigned classification or sub-classification for each benefit aligns with the assignment of benefits in your Benefit Classification Tables.

Only list covered medical/surgical benefits in the QA tabs. Do not include any mental health or substance use disorder benefits, or any benefits that are not covered under the plan, in this worksheet.

Cost Sharing Column: Under the Cost Sharing column, please describe the complete cost sharing of the listed benefit under the plan. The description should state all applicable cost sharing types and levels for that benefit—including the copay, coinsurance, and whether the deductible applies—in the same cell. Please ensure this information matches the cost sharing provided for that benefit in the policy forms for this plan. This column serves to facilitate verification by the filer and the Department reviewer that correct cost sharing inputs (types and levels/amounts) were used in the QA.

Total Allowed Costs Column: Enter the total allowed costs (total plan payments and member out-of-pocket costs) by providing the absolute value of total spend allowed costs in in dollar amounts. Do not provide converted or relative values. If the plan provides out-of-network coverage, please enter the applicable total payment data for out-of-network benefits under the out-of-network total payment data column.

Copay, Coinsurance, Deductible, No Cost Share: Under the column for each applicable cost sharing type, provide the applicable cost sharing level (i.e., amount) for that benefit. If no cost sharing applies to a covered benefit, mark the "No Cost Share" column with an X. Please note these columns have been preformatted for dollar amounts and percentages or text as appropriate.

Substantially All Analysis: Each worksheet is designed to automatically evaluate cost sharing types and identify which ones meet the substantially all threshold of 42 CFR § 438.910(c)(1)(i), 42 CFR 440.395(b)(3)(i)(A), and 42 CFR 457.496(d)(3)(A). Results will be displayed once data has been entered in each worksheet. Cost sharing types meeting the federal parity thresholds in each classification or sub-classification will be automatically highlighted in green.

Predominance Analysis: The Predominance Analysis tables **require additional user inputs**. After you have entered all relevant data in the main table in a worksheet, the template will automatically identify the cost sharing types that meet the substantially all test. For each cost sharing type that meets the substantially all test in a given classification or sub-classification, please enter all levels of that cost sharing type **from lowest to highest** in the Predominance Analysis table for that cost sharing type. The worksheet will then evaluate each cost sharing level for predominance. If a single cost sharing type meets the predominance threshold of 42 CFR § 438.910(c)(1)(ii), 42 CFR 440.395(b)(3)(i)(B), and 42 CFR 457.496(d)(3)(B) in a classification or sub-classification, it will be automatically highlighted in green.

If no single cost sharing level within a type meets the predominance threshold (>50%), filers may combine levels until the combination of different cost sharing levels applies to more than half of the benefits in that classification which are subject to that cost sharing type. The least restrictive level within the combination will be considered the predominant level of that type in the classification. **This function is not automated** in the worksheets and must be manually done by the filer.

Summary of Analysis: At the top of each worksheet, please enter the final results of the analysis for each classification and sub-classification. Enter the cost sharing type and level that meets the substantially all and predominance tests under the MHP QA column. Under the Schedule column, enter the applicable cost sharing for MH/SUD in that classification or sub-classification as provided in the plan's schedule and policy forms. Under the SBC column, provide the cost sharing requirements reflected in the SBC for MH/SUD benefits in that classification or sub-classification.

If no cost sharing type applies to MH/SUD benefits in a classification or sub-classification under the plan, enter "0" or "N/A" in all three cost sharing rows under the Schedule and SBC columns.

If the schedule or SBC reflects any cost sharing type or level for MH/SUD that is not compliant with the results of the mental health parity QA for that classification or sub-classification, **the cost sharing in the forms must be revised** to be compliant with mental health parity law.

Outpatient, OP-Office, and OP-Other Worksheets: At the top of the Outpatient worksheet, please indicate whether the in-network outpatient analysis for each plan is performed at the level of the outpatient classification or outpatient sub-classifications (office visits, and all other outpatient items and services) by selecting "Yes" or "No" from the drop-down list. This input will be carried over into the OP-Office and OP-Other worksheets. If the plan does not sub-classify outpatient MH/SUD benefits, please only complete the Outpatient worksheet and leave the OP-Office and OP-Other worksheets blank. If the plan sub-classifies outpatient MH/SUD benefits, please complete all three of the Outpatient, OP-Office, and OP-Other worksheets.

Emergency Care Worksheet: Please complete this worksheet if the plan imposes different financial requirements for benefits in this classification depending on whether they are medical/surgical or MH/SUD in nature.

Prescription Drugs Worksheet: Please complete this worksheet if a mental health parity analysis is required for the Prescription Drugs classification.

Summary of Analysis	In-Network			Out-of-Network		
	MHP QA	Schedule	SBC	MHP QA	Schedule	SBC
Inpatient MH/SUD Cost Sharing						
Copay	Fail			Fail		
Coinsurance	Fail			Fail		
Deductible	Fail			Fail		

	In-Network				Out-of-Network		
	Total	%	Result		Total	%	Result
Substantially All Analysis (≥2/3)				Substantially All Analysis (≥2/3)			
Copay	0	NA	Fail	Copay	0	NA	Fail
Coins	0	NA	Fail	Coins	0	NA	Fail
Ded	0	NA	Fail	Ded	0	NA	Fail
Total Payments	0			Total Payments	0		

Predominance Analysis (>50%)							
INN Copay	In-Network			OON Copay	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
<i>Not Applicable</i>				<i>Not Applicable</i>			
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		
INN Coins	In-Network			OON Coins	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
<i>Not Applicable</i>				<i>Not Applicable</i>			
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		
INN Ded	In-Network			OON Ded	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
<i>Not Applicable</i>				<i>Not Applicable</i>			
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		

Summary of Analysis	In-Network			Out-of-Network		
	MHP QA	Schedule	SBC	MHP QA	Schedule	SBC
Outpatient MH/SUD Cost Sharing	Fail			Fail		
Copay	Fail			Fail		
Coinsurance	Fail			Fail		
Deductible	Fail			Fail		

	In-Network				Out-of-Network		
	Total	%	Result		Total	%	Result
Substantially All Analysis (≥2/3)				Substantially All Analysis (≥2/3)			
Copay	0	NA	Fail	Copay	0	NA	Fail
Coins	0	NA	Fail	Coins	0	NA	Fail
Ded	0	NA	Fail	Ded	0	NA	Fail
Total Payments	0			Total Payments	0		

Predominance Analysis (>50%)							
INN Copay	In-Network			OON Copay	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
<i>Not Applicable</i>				<i>Not Applicable</i>			
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		
INN Coins	In-Network			OON Coins	Out-of-Network		
<i>Not Applicable</i>	Total Allowed Costs	Predominance	Result	<i>Not Applicable</i>	Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		
INN Ded	In-Network			OON Ded	Out-of-Network		
<i>Not Applicable</i>	Total Allowed Costs	Predominance	Result	<i>Not Applicable</i>	Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		

Summary of Analysis OP-Office MH/SUD Cost Sharing	In-Network			Out-of-Network		
	MHP QA	Schedule	SBC	MHP QA	Schedule	SBC
Copay	Fail			Fail		
Coinsurance	Fail			Fail		
Deductible	Fail			Fail		

Substantially All Analysis (≥2/3)	In-Network			Substantially All Analysis (≥2/3)	Out-of-Network		
	Total	%	Result		Total	%	Result
Copay	0	NA	Fail	Copay	0	NA	Fail
Coins	0	NA	Fail	Coins	0	NA	Fail
Ded	0	NA	Fail	Ded	0	NA	Fail
Total Payments	0			Total Payments	0		

Predominance Analysis (>50%)							
INN Copay <i>Not Applicable</i>	In-Network			OON Copay <i>Not Applicable</i>	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		
INN Coins <i>Not Applicable</i>	In-Network			OON Coins <i>Not Applicable</i>	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		
INN Ded <i>Not Applicable</i>	In-Network			OON Ded <i>Not Applicable</i>	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		

Summary of Analysis OP-Other MH/SUD Cost Sharing	In-Network			Out-of-Network		
	MHP QA	Schedule	SBC	MHP QA	Schedule	SBC
Copay	Fail			Fail		
Coinsurance	Fail			Fail		
Deductible	Fail			Fail		

	In-Network				Out-of-Network		
	Total	%	Result		Total	%	Result
Substantially All Analysis (≥2/3)				Substantially All Analysis (≥2/3)			
Copay	0	NA	Fail	Copay	0	NA	Fail
Coins	0	NA	Fail	Coins	0	NA	Fail
Ded	0	NA	Fail	Ded	0	NA	Fail
Total Payments	0			Total Payments	0		

Predominance Analysis (>50%)

INN Copay <i>Not Applicable</i>	In-Network			OON Copay <i>Not Applicable</i>	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		
INN Coins <i>Not Applicable</i>	In-Network			OON Coins <i>Not Applicable</i>	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		
INN Ded <i>Not Applicable</i>	In-Network			OON Ded <i>Not Applicable</i>	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		

Emergency Care Benefit	Emergency Cost Share per Schedule
Med/surg MH/SUD	

Summary of Analysis	In-Network & Out-Of-Network		
Emergency Care MH/SUD Cost Sharing	MHP QA	Schedule	SBC
Copay	Fail		
Coinsurance	Fail		
Deductible	Fail		

Substantially All Analysis (≥2/3)	In-Network & Out-Of-Network		
	Total	%	Result
Copay	0	NA	Fail
Coins	0	NA	Fail
Ded	0	NA	Fail
Total Allowed Costs	0		

Predominance Analysis (>50%)			
Copay	In-Network & Out-Of-Network		
<i>Not Applicable</i>	Total Payments	Predominance	Result
			NA
Total	0		
Coins	In-Network & Out-Of-Network		
<i>Not Applicable</i>	Total Payments	Predominance	Result
			NA
Total	0		
Ded	In-Network & Out-Of-Network		
<i>Not Applicable</i>	Total Payments	Predominance	Result
			NA
Total	0		

Summary of Analysis	In-Network & Out-Of-Network		
Prescription Drugs MH/SUD Cost Sharing	MHP QA	Schedule	SBC
Copay	Fail		
Coinsurance	Fail		
Deductible	Fail		

Substantially All Analysis (≥2/3)	In-Network & Out-Of-Network		
	Total	%	Result
Copay	0	NA	Fail
Coins	0	NA	Fail
Ded	0	NA	Fail
Total Allowed Costs	0		

Predominance Analysis (>50%)			
Copay	In-Network & Out-Of-Network		
<i>Not Applicable</i>	Total Payments	Predominance	Result
		NA	
Total	0		
Coins	In-Network & Out-Of-Network		
<i>Not Applicable</i>	Total Payments	Predominance	Result
		NA	
Total	0		
Ded	In-Network & Out-Of-Network		
<i>Not Applicable</i>	Total Payments	Predominance	Result
		NA	
Total	0		

S. Appendix 5: MHPAEA Testing Workbook for Quantitative Treatment Limitations

New York State - Office of Mental Health Mental Health Parity Analysis Workbook

Last updated: MM/DD/2018

Instructions

The purpose of this workbook is for insurers to demonstrate the compliance of their plans with the mental health parity requirements under the federal Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and its implementing regulations and guidance. 42 U.S.C. 1396u-2(b)(8); 42 U.S.C. 1396u-7(b)(6); 42 U.S.C. 1397cc(c)(6); 42 U.S.C. 300gg-26.; 42 CFR Parts 438, 440, and 457; and N.Y. Ins. Law §§ 3103, 3201, 3221, 4303, and 4308 and Article 49.

Please include only **one plan per workbook**; submit a separate workbook for each plan in the filing.

Please include the 2019 plan name in the file name of each complete plan workbook. Submit the completed plan workbooks as Excel files under the Supporting Documents tab of the applicable 2019 form filing.

The worksheets in this workbook contain additional instructions that appear by clicking on either the field or the column heading.

The worksheets in this workbook are password protected to prevent formula changes. If you find an error or need to alter underlying formatting or formulas to tailor the workbook to your plan design and data, please contact the Department contact listed below.

If you have any questions regarding this workbook, please contact (insert contact name) at the email provided below:

Quantitative Analysis Worksheets

This Mental Health Parity Analysis Workbook consists of separate Quantitative Analysis (QA) worksheets for each classification and sub-classification specified in 42 CFR § 438.910, 42 CFR §440.395, and 42 CFR 457.496. Please note the in-network and out-of-network classifications for the inpatient classification and outpatient classification and sub-classifications have been combined onto one worksheet.

Complete a separate workbook for each plan. There should be only one plan reflected in each QA workbook.

Inpatient Worksheet: Please enter the insurer name, product name, state tracking number (if a state tracking number has not been assigned, provide the SERFF tracking number), and 2019 plan name at the top of the worksheet in the designated fields. This information will be automatically copied onto other worksheets.

Benefits and Services Column: Every medical/surgical benefit or service that is listed in this QA worksheet for a given classification or sub-classification should also be listed in the Benefit Classification Tables (in Part III.B of the Mental Health Parity Supporting Documentation Template) for that classification or sub-classification.

Likewise, every medical/surgical benefit or service that appears in the Benefit Classification Tables should also appear in the QA worksheet for the applicable classification or sub-classification. Please note the exception provided for benefits in the Prescription Drugs classification, as noted below.

Enter all medical/surgical benefits in all classifications and sub-classifications for which an analysis is required. Use the same benefit labels as in the Benefit Classification Tables in Part III.B of the Mental Health Parity Supporting Documentation Template. Ensure that the assigned classification or sub-classification for each benefit aligns with the assignment of benefits in your Benefit Classification Tables.

Only list covered medical/surgical benefits in the QA tabs. Do not include any mental health or substance use disorder benefits, or any benefits that are not covered under the plan, in this worksheet.

Cost Sharing Column: Under the Cost Sharing column, please describe the complete cost sharing of the listed benefit under the plan. The description should state all applicable cost sharing types and levels for that benefit—including the copay, coinsurance, and whether the deductible applies—in the same cell. Please ensure this information matches the cost sharing provided for that benefit in the policy forms for this plan. This column serves to facilitate verification by the filer and the Department reviewer that correct cost sharing inputs (types and levels/amounts) were used in the QA.

Total Allowed Costs Column: Enter the total allowed costs (total plan payments and member out-of-pocket costs) by providing the absolute value of total spend allowed costs in in dollar amounts. Do not provide converted or relative values. If the plan provides out-of-network coverage, please enter the applicable total payment data for out-of-network benefits under the out-of-network total payment data column.

Copay, Coinsurance, Deductible, No Cost Share: Under the column for each applicable cost sharing type, provide the applicable cost sharing level (i.e., amount) for that benefit. If no cost sharing applies to a covered benefit, mark the "No Cost Share" column with an X. Please note these columns have been preformatted for dollar amounts and percentages or text as appropriate.

Substantially All Analysis: Each worksheet is designed to automatically evaluate cost sharing types and identify which ones meet the substantially all threshold of 42 CFR § 438.910(c)(1)(i), 42 CFR 440.395(b)(3)(i)(A), and 42 CFR 457.496(d)(3)(A). Results will be displayed once data has been entered in each worksheet. Cost sharing types meeting the federal parity thresholds in each classification or sub-classification will be automatically highlighted in green.

Predominance Analysis: The Predominance Analysis tables **require additional user inputs**. After you have entered all relevant data in the main table in a worksheet, the template will automatically identify the cost sharing types that meet the substantially all test. For each cost sharing type that meets the substantially all test in a given classification or sub-classification, please enter all levels of that cost sharing type **from lowest to highest** in the Predominance Analysis table for that cost sharing type. The worksheet will then evaluate each cost sharing level for predominance. If a single cost sharing type meets the predominance threshold of 42 CFR

§ 438.910(c)(1)(ii), 42 CFR 440.395(b)(3)(i)(B), and 42 CFR 457.496(d)(3)(B) in a classification or sub-classification, it will be automatically highlighted in green.

If no single cost sharing level within a type meets the predominance threshold (>50%), filers may combine levels until the combination of different cost sharing levels applies to more than half of the benefits in that classification which are subject to that cost sharing type. The least restrictive level within the combination will be considered the predominant level of that type in the classification. **This function is not automated** in the worksheets and must be manually done by the filer.

Summary of Analysis: At the top of each worksheet, please enter the final results of the analysis for each classification and sub-classification. Enter the cost sharing type and level that meets the substantially all and predominance tests under the MHP QA column. Under the Schedule column, enter the applicable cost sharing for MH/SUD in that classification or sub-classification as provided in the plan's schedule and policy forms. Under the SBC column, provide the cost sharing requirements reflected in the SBC for MH/SUD benefits in that classification or sub-classification.

If no cost sharing type applies to MH/SUD benefits in a classification or sub-classification under the plan, enter "0" or "N/A" in all three cost sharing rows under the Schedule and SBC columns.

If the schedule or SBC reflects any cost sharing type or level for MH/SUD that is not compliant with the results of the mental health parity QA for that classification or sub-classification, **the cost sharing in the forms must be revised** to be compliant with mental health parity law.

Outpatient, OP-Office, and OP-Other Worksheets: At the top of the Outpatient worksheet, please indicate whether the in-network outpatient analysis for each plan is performed at the level of the outpatient classification or outpatient sub-classifications (office visits, and all other outpatient items and services) by selecting "Yes" or "No" from the drop-down list. This input will be carried over into the OP-Office and OP-Other worksheets. If the plan does not sub-classify outpatient MH/SUD benefits, please only complete the Outpatient worksheet and leave the OP-Office and OP-Other worksheets blank. If the plan sub-classifies outpatient MH/SUD benefits, please complete all three of the Outpatient, OP-Office, and OP-Other worksheets.

Emergency Care Worksheet: Please complete this worksheet if the plan imposes different financial requirements for benefits in this classification depending on whether they are medical/surgical or MH/SUD in nature.

Prescription Drugs Worksheet: Please complete this worksheet if a mental health parity analysis is required for the Prescription Drugs classification.

Summary of Analysis	In-Network			Out-of-Network		
	MHP QA	Schedule	SBC	MHP QA	Schedule	SBC
Inpatient MH/SUD limitations						
Copay	Fail			Fail		
Coinsurance	Fail			Fail		
Deductible	Fail			Fail		

	In-Network					Out-of-Network			
	Total	%	Result			Total	%	Result	
Substantially All Analysis (≥2/3)					Substantially All Analysis (≥2/3)				
Day limits	0		NA Fail		Day limits	0		NA Fail	
Episode limits	0		NA Fail		Episode limits	0		NA Fail	
Other limits	#REF!		NA Fail		Other limits	#REF!		NA Fail	
Total Payments	0				Total Payments	0			

Predominance Analysis (>50%)							
INN Day limit	In-Network			OON Day limit	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
<i>Not Applicable</i>				<i>Not Applicable</i>			
	NA NA NA NA		NA		NA NA NA NA		NA
Total	0			Total	0		
INN Episode limit	In-Network			OON Episode limit	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
<i>Not Applicable</i>				<i>Not Applicable</i>			
	NA NA NA		NA		NA NA NA		NA
Total	0			Total	0		
INN Other limit	In-Network			OON Other limit	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
<i>Not Applicable</i>				<i>Not Applicable</i>			
		#REF!	#REF!			#REF!	#REF!
		#REF!	#REF!			#REF!	#REF!
		#REF!	#REF!			#REF!	#REF!
		#REF!	#REF!			#REF!	#REF!
Total	#REF!			Total	#REF!		

Summary of Analysis	In-Network			Out-of-Network		
	MHP QA	Schedule	SBC	MHP QA	Schedule	SBC
Outpatient MH/SUD limitations						
Visit limits	Fail			Fail		
Episode limits	Fail			Fail		
Other limits	Fail			Fail		

	In-Network				Out-of-Network		
	Total	%	Result		Total	%	Result
Substantially All Analysis (≥2/3)				Substantially All Analysis (≥2/3)			
Visit limits	0	NA	Fail	Visit limits	0	NA	Fail
Episode limits	0	NA	Fail	Episode limits	0	NA	Fail
Other limits	0	NA	Fail	Other limits	0	NA	Fail
Total Payments	0			Total Payments	0		

Predominance Analysis (>50%)							
INN visit limits	In-Network			OON visit limits	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
<i>Not Applicable</i>				<i>Not Applicable</i>			
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		
INN episode limits	In-Network			OOO episode limits	Out-of-Network		
<i>Not Applicable</i>	Total Allowed Costs	Predominance	Result	<i>Not Applicable</i>	Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		
INN other limits	In-Network			OOO other limits	Out-of-Network		
<i>Not Applicable</i>	Total Allowed Costs	Predominance	Result	<i>Not Applicable</i>	Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		

Summary of Analysis OP-Office MH/SUD Limits	In-Network			Out-of-Network		
	MHP QA	Schedule	SBC	MHP QA	Schedule	SBC
Visit limits	Fail			Fail		
Episode limits	Fail			Fail		
Other limits	Fail			Fail		

Substantially All Analysis (≥2/3)	In-Network			Substantially All Analysis (≥2/3)	Out-of-Network		
	Total	%	Result		Total	%	Result
Visit limits	0	NA	Fail	Visit limits	0	NA	Fail
Episode limits	0	NA	Fail	Episode limits	0	NA	Fail
Other limits	0	NA	Fail	Other limits	0	NA	Fail
Total Payments	0			Total Payments	0		

Predominance Analysis (>50%)							
INN visit limits <i>Not Applicable</i>	In-Network			OON visit limits <i>Not Applicable</i>	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		
INN episode limits <i>Not Applicable</i>	In-Network			OON episode limits <i>Not Applicable</i>	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		
INN other limits <i>Not Applicable</i>	In-Network			OON other limits <i>Not Applicable</i>	Out-of-Network		
	Total Allowed Costs	Predominance	Result		Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		

Summary of Analysis OP-Other MH/SUD Limits	In-Network			Out-of-Network		
	MHP QA	Schedule	SBC	MHP QA	Schedule	SBC
Visit limits	Fail			Fail		
Episode limits	Fail			Fail		
Other limits	Fail			Fail		

Substantially All Analysis (≥2/3)	In-Network			Out-of-Network		
	Total	%	Result	Total	%	Result
Visit limits	0	NA	Fail	0	NA	Fail
Episode limits	0	NA	Fail	0	NA	Fail
Other limits	0	NA	Fail	0	NA	Fail
Total Payments	0			0		

Predominance Analysis (>50%)

INN visit limits	In-Network			OON Visit limits	Out-of-Network		
<i>Not Applicable</i>	Total Allowed Costs	Predominance	Result	<i>Not Applicable</i>	Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		
INN episode limits	In-Network			OON episode limits	Out-of-Network		
<i>Not Applicable</i>	Total Allowed Costs	Predominance	Result	<i>Not Applicable</i>	Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		
INN Other limits	In-Network			OON other limits	Out-of-Network		
<i>Not Applicable</i>	Total Allowed Costs	Predominance	Result	<i>Not Applicable</i>	Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	0			Total	0		

Emergency Care Benefit	Emergency limits per Schedule
Med/surg MH/SUD	

Summary of Analysis	In-Network & Out-Of-Network		
Emergency Care MH/SUD Cost Sharing	MHP QA	Schedule	SBC
Day limits	Fail		
Episode limits	Fail		
Other limits	Fail		

Substantially All Analysis (≥2/3)	In-Network & Out-Of-Network			
	Total	%		Result
Day limits	0		NA	Fail
Episode limits	0		NA	Fail
Other limits	0		NA	Fail
Total Allowed Costs	0			

Predominance Analysis (>50%)				
Day limits	In-Network & Out-Of-Network			
<i>Not Applicable</i>	Total Payments	Predominance	Result	
			NA	
Total	0			
Episode limits	In-Network & Out-Of-Network			
<i>Not Applicable</i>	Total Payments	Predominance	Result	
			NA	
Total	0			
Other limits	In-Network & Out-Of-Network			
<i>Not Applicable</i>	Total Payments	Predominance	Result	
			NA	
Total	0			

Summary of Analysis	In-Network & Out-Of-Network		
Prescription Drugs MH/SUD Limits	MHP QA	Schedule	SBC
Refill limits	Fail		
Other limits	Fail		

Substantially All Analysis (≥2/3)	In-Network & Out-Of-Network		
	Total	%	Result
Refill limits	0	NA	Fail
Other limits	0	NA	Fail
Total Allowed Costs	0		

Predominance Analysis (>50%)			
Refill limits	In-Network & Out-Of-Network		
<i>Not Applicable</i>	Total Payments	Predominance	Result
		NA	
Total	0		
Other limits	In-Network & Out-Of-Network		
<i>Not Applicable</i>	Total Payments	Predominance	Result
		#REF!	#REF!

T. Appendix 6: MHPAEA Nonquantitative Treatment Limitations Instructions and Guidance

I. NQTL Spreadsheet Guidance

NQTL Spreadsheet Guidance

Below is an in-depth description of each step that is delineated in the NQTL spreadsheet. Each managed care organization and their vendors (if applicable) should refer to this document for full context regarding each step in the NQTL spreadsheet. Please direct all questions and requests for technical assistance to Milliman contractor.

Step 1: Provide the specific plan language regarding the NQTL and describe all services to which it applies in each respective classification of benefits.

Identify and provide the specific language of the NQTL as provided in the plan documents. This shall include each step, associated triggers, timelines, forms and requirements.

Step 2: Identify the factors that trigger the application of the NQTL.

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

Examples of factors for medical management and utilization review include (these examples are merely illustrative and not exhaustive):

- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

Examples of sources for medical management and utilization review factors include:

- Internal claims analyses
- Internal quality standard studies
- Expert medical review

Examples of factors for provider network adequacy include:

- Service type
- Geographic market
- Current demand for services
- Projected demand for services
- Practitioner supply and provider-to-enrollee ratios
- Wait times
- Geographic access standards
- Out-of-network utilization rates

Examples of sources for provider network adequacy factors include:

- State and federal regulatory requirements
- National accreditation standards
- Internal plan market analyses
- CAHPS data

Examples of factors for provider reimbursement include:

- 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

Examples of sources for provider reimbursement factors include:

- External healthcare claims database (e.g., Fair Health)
- Medicare Physician Fee Schedule
- Internal market and competitive analysis

- Medicare RVUs for CPT codes

As noted above, these are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.

Step 3: Identify and describe the evidentiary standard for each of the factors identified in step 2 and any other evidence relied upon to design and apply the NQTL.

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified in Step 2 and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term “evidentiary standards” is not limited to a means for defining “factors.” Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including 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.

Examples of evidentiary standards to define the factors identified in Step 2, their sources, and other evidence considered include:

- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
- Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).
- Two published RCTs required to establish a treatment or service is not experimental or investigational.

- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

As noted above, these are illustrations of evidentiary standards and are not an exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.

Step 4: Provide the comparative analyses used to determine as written comparability and equivalent stringency.

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/ surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. 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.

Additional as written processes may include, but are not limited to, utilization management manuals, utilization review criteria, specific criteria hierarchy for performing utilization review, factors considered when applying utilization review criteria, initial screening scripts and algorithms, case management referral criteria, stipulations about submitting written treatment plans, utilization management committee and/or quality management committee notes, description of processes for identifying and evaluating clinical issues and utilizing performance goals, delegation agreements, network contracting information, factors that determine reimbursement rates, among others.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:

- Results from analyses of the health plan’s paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan’s MH/SUD and medical/surgical services.

- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had “high cost variability” (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan’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.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

As noted above, these are illustrations of comparative analyses and are not an exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.

Step 5: Provide the comparative analyses used to determine in operation comparability and equivalent stringency.

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits.

Please identify each process employed for a particular NQTL. In operation processes include, but are not limited to, peer clinical review, telephonic consultations with attending providers, consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, adherence to utilization review criteria and criteria hierarchy, professional judgment used in lieu of utilization review criteria, actions taken when incomplete information is received from attending providers, utilization review decision timeliness, requests of patient medical records, process for sharing all clinical and demographic information on individual patients among various clinical and administrative departments, among others.

Illustrative analyses includes:

Medical Management

- 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.

Network Adequacy

- 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).

As noted above, these are illustrations of comparative analyses and are not an exhaustive list of comparative analyses. While not illustrated, additional analyses would apply to different types of NQTLs.

Step 6: Summary statement justifying how performing the comparative analyses required by the subsequent steps has led the plan to conclude that it is in compliance.

Based on the responses provided in the steps above, clearly summarize the basis for the plan or issuer'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.

II. Reporting Instructions

New York Department of Health /Office of Mental Health/Office of Alcoholism and Substance Abuse Services Medicaid Managed Care NQTL Reporting

The basis for the content of the NY DOH/OMH/OASAS required NQTL reporting, as we discussed, is the protocol for NQTL parity analysis stipulated in the [Federal Self Compliance Tool](#) (Tool) set forth on pages 12-20. (link to the Tool). The only modification is that the NY reporting format divides Step 4 into a Step 4 and a step 5 to separate the compliance reporting into a section for the “as written” analysis (Step 4) and one for the “in-operation” analysis (Step 5) and requests a summary explanation (Step 6).

Please note that as stipulated in the Tool, MCOs should be prepared to provide any and all, if requested, documentation relied upon to demonstrate the basis for its compliance with requirements of the NQTL test. This would include details on how standards were applied, internal testing, and any other review or analysis done by the MCO to sustain its basis for compliance. This documentation is not to be provided with this reporting but should be noted where applicable.

The Tool was designed to provide a uniform reporting protocol for Mental Health and Substance Use Disorder (MH/SUD) NQTL compliance justification, based on the terms of the nondiscrimination regulatory test for NQTLs. The essential terms of the NQTL are comparability and equity as to application between those NQTLs applied to MH/SUD benefits and those applied to medical/surgical benefits. The following discussion is intended to provide clarification, based on our discussions with the Medicaid MCOs, as to the information required for each Step to ensure a complete response. Some of the comments below may not apply to your MCO. Note that a response deemed complete is not a final determination per se by NY DOH/OMH/OASAS that an NQTL is parity compliant.

The first row for each column requires that the MCO identify the MH/SUD and medical services (M/S) to which the NQTL applies in each respective column. There is a need for some clarification in the reporting for the term “prior authorization”. Where prior authorization means pre-certification of medical necessity for the requested service at the point of admission, this should be noted. If the term is intended to mean notification to the MCO with a subsequent determination of medical necessity, this should be noted. The reporting should also note whether the NQTL applies to out-of-network services, especially regarding substance use services, given the NY requirements for OASAS certified facilities. Also please note that there is some reporting variation in how plans treat inpatient psychiatric admissions. Some are treated as post-stabilization admission subsequent to an emergency or urgent care situation, and others regard them as independent of urgent/emergency care situation or both. This should be clarified in the text along with at what point the medical necessity determination is made and with what criteria. In addition, please note, especially in the outpatient column, all services for which the state requires prior authorization or concurrent review. In addition, if there are outpatient services for which prior authorization of concurrent review is not required but the plan does utilize the protocol, please delineate which services those are. There has been inconsistent reporting in this row for inpatient and outpatient services subject to prior authorization and concurrent review.

Step 1 requires a description of the NQTL procedure as generally applied. The reporting prompt asks for identification of associated triggers, timelines, forms and requirements. Hence, any differences in the procedures, protocols or processes between MH/SUD and M/S should be noted. If prior authorization means notification of the admission to the MCO, are all services reviewed back to the date of admission to determine medical necessity? Are there differences in the procedures and the amount of information required for medical necessity determinations as between the two service categories where prior authorization notification is required?

Step 2 requires an identification of the factors the plan uses to determine whether a service is deemed subject to the NQTL and whether they are comparable. The source of the factor should be noted, and factors considered but not relied upon should be noted as well. The reporting prompt provides illustrations of factors an MCO may use to which services are subject to the NQTL. The factors listed are illustrations and there may be other factors the plan has utilized, which is acceptable. There is not a list of acceptable and nonacceptable factors. The requirement here is that they be identified and discussed as to how they are comparable. As noted in our discussions, the term “comparable” has two meanings: similar or identical. If the factors are identical, there is no need for further discussion as they are identical. Where they are not identical, the plan should provide some rationale as to its determination that they are similar. For example, if a plan uses the factor of high cost to trigger prior authorization for MH/SUD but uses excessive utilization to trigger prior authorization for medical/surgical, there certainly could be a valid explanation as to why and/or how those factors are comparable and it should be explained. The differences should be accounted for. In some cases, it is reported that all MH/SUD and M/S services are subject to the NQTL and, therefore, there would be no need to report factors as there is no differentiation between the two categories as to what triggers the service for the NQTL.

Step 3 has two components and a dual meaning for the term evidentiary standard. In the first instance, it requires the evidentiary standard used to define the factors identified in Step 2; e.g., if variation in length of stay is a factor, how is it defined? If it is defined by a coefficient of variation, then indicate that and the value utilized for the coefficient; e.g., 70%. The basis for requiring this information is to enable a review as to the comparability of the factors and how they were defined and applied in application to determine which services will be subject to the NQTL. For example, if variation in length of stay is a factor and the trigger for application of the NQTL is 60% for all services, then it is identical. However, if the trigger for application is 60% for medical and 30% for MH/SUD, this difference requires some explanation. Also, please note that it is fine if you use a much less-sophisticated definition for the factor of variation in length of stay or any other factor. But you still must provide what that definition is. Another example of a factor utilized to target services is ‘high variability in defining diagnosis.’ While it may be a valid factor Step 3 requires that this be defined. Step 3 also asks for “evidentiary standards” which may be relied upon but are not a means for defining “factors” identified in Step 2. These types of evidentiary standards include other evidence considered in designing and applying its prior authorization protocols such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional guild associations or other third-party entities, publicly available or proprietary clinical definitions internally developed to supplement national guidelines, and outcome metrics from consulting or other organizations. The source of the evidentiary standard, regardless of type, should always be noted. To report that “nationally recognized standards” are utilized is not an exact identification. Differences in factors, definitions of factors or evidentiary standards between MH/SUD and M/S services utilized to determine application of the NQTL should be clearly delineated.

Step 4 concerns the comparability and application of the NQTL as written. This has several components. Comparability of reviewer qualifications is one element. The written policies and procedures for operationalization of the NQTL are another; i.e., the actual processes utilized to conduct the review. Are provider to MCO teleconferences required as part of the written medical necessity review protocol? Are they identical? If there are differences what is the basis for the difference? If utilization management is conducted by different entities for MH/SUD and M/S services, how are policies and procedures; e.g., manuals, vetted and coordinated to ensure comparability? Also note that measures of in-operation impact and comparability such as inter-rater reliability studies are frequently noted in Step 4 but should be part of the response to Step 5 because they are measures of performance which demonstrate equitable application in operation. Additionally, note that we are not asking that you submit any materials such as medical necessity criteria or criteria hierarchies or the actual written protocols governing provider to MCO

teleconferences or utilization manuals themselves. We are only asking for a description of how the plan has gone about determining that these written materials are comparable and applied no more stringently, along with a note indicating that any all analysis and material documentation is available upon request.

Step 5 concerns the comparability of implementation and impact- or application- of the written policies and procedures. The pertinent information which the reporting prompt is requesting concerns evaluation measures which demonstrate comparability of outcomes. A re-articulation of the response in Step 4 is not what is required here. This can include a variety of quality and control measures utilized by a plan: e.g., interrater reliability studies, review of denial rates by service type for assurance of appropriate application of criteria, reviews for correlation between basis for service denials and stated criteria, appeal overturn rates, is clinical judgment ever utilized in lieu of plan criteria and if so how is it comparable respecting both sets of services, frequency of concurrent reviews as between MH/SUD and M/S, frequency of initial reviews that are sent to peer clinical review by the first-line UM reviewer, and so on. Note that disparate results or outcomes are not dispositive of parity noncompliance. What types of corrective action plans are deployed where there are disparities in impact? If utilization review is conducted by different entities, what measures are in place to ensure comparable application of utilization management policies. Where measures of in-operation performance are reported to substantiate comparability, detailed examples should be noted; e.g., interrater reliability studies were conducted and were found to be 90% for M/S services and 91% for MH/SUD. The availability of documentation to substantiate the measures utilized should be noted.

Step 6 requests a summary statement which explains the rationale for compliance. To the extent there are differences noted as between MH/SUD and M/S in the foregoing steps, delineate these in the summary and note that they were explained in the text. For example, if the review standards for all services are based on MCG criteria and those for MH/SUD include criteria which supplement MCG this should be noted with a notation that the corresponding reason for the difference is provided in the text. Or, for example, different factors were utilized to determine services to which the NQTL would apply.

III. Phase I and II Technical Assistance Webinar



NEW YORK
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Mental Health

New York State Parity Analysis Reporting

Part I results and next steps

June 19, 2019

This slide is the title page for the webinar. It features the New York State logo and the Office of Mental Health name in the top left. The main title is 'New York State Parity Analysis Reporting' in a large, bold, purple font. Below it, the subtitle 'Part I results and next steps' is in a smaller purple font. At the bottom, the date 'June 19, 2019' is displayed in white on a purple background.

1



2

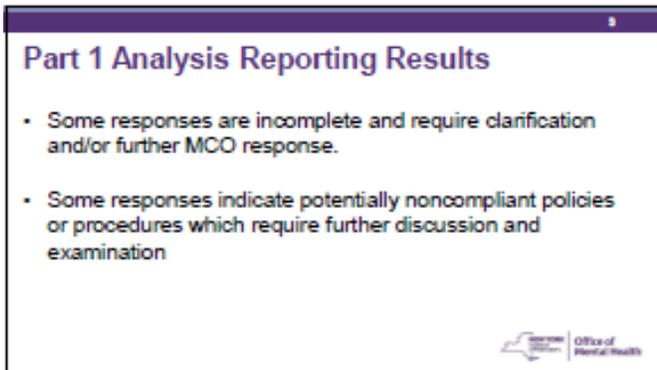
Agenda for Today's Discussion

- Part 1- Results
- NYS Parity Compliance Report to CMS
- Next Steps regarding Part 1
- Part 2- new NQTL analysis reporting
- NQTL Analysis requirements revisited



This slide is the agenda for the webinar. It has a purple header with the number '2'. The title 'Agenda for Today's Discussion' is in a large, bold, purple font. Below the title is a bulleted list of five items: 'Part 1- Results', 'NYS Parity Compliance Report to CMS', 'Next Steps regarding Part 1', 'Part 2- new NQTL analysis reporting', and 'NQTL Analysis requirements revisited'. The New York State Office of Mental Health logo is in the bottom right corner.

2



3

Part 1 Analysis Reporting Results

- Some responses are incomplete and require clarification and/or further MCO response.
- Some responses indicate potentially noncompliant policies or procedures which require further discussion and examination



This slide reports on the results of the Part 1 analysis. It has a purple header with the number '3'. The title 'Part 1 Analysis Reporting Results' is in a large, bold, purple font. Below the title is a bulleted list of two items: 'Some responses are incomplete and require clarification and/or further MCO response.' and 'Some responses indicate potentially noncompliant policies or procedures which require further discussion and examination'. The New York State Office of Mental Health logo is in the bottom right corner.

3



4

NYS Parity Compliance Report to CMS

- NYS noted in its report that a more comprehensive review of the NQTL analyses received was necessary
- CMS' review specifically requested that the results of NYS review be provided including the completed reporting spreadsheets for each plan and NQTL



This slide discusses the NYS Parity Compliance Report to CMS. It has a purple header with the number '4'. The title 'NYS Parity Compliance Report to CMS' is in a large, bold, purple font. Below the title is a bulleted list of two items: 'NYS noted in its report that a more comprehensive review of the NQTL analyses received was necessary' and 'CMS' review specifically requested that the results of NYS review be provided including the completed reporting spreadsheets for each plan and NQTL'. The New York State Office of Mental Health logo is in the bottom right corner.

4

Next Steps Per Part 1

- Milliman will be contacting each plan regarding the responses provided and defining needed modifications
- The discussion should assist in enabling responses to the NQTLs identified as part of Part 2



5

Part 2 NQTL Analysis Reporting

- Coding Edits
- Out-of-Network Coverage Standards
- Geographic Restrictions
- Reimbursements
- Provider Type Exclusions



6

NQTL Analysis Requirements Revisited

- Federal Guidance defines the methodology required to demonstrate NQTL parity Compliance
- Identify the factors that trigger application of the NQTL for MH/SUD and Medical
- Identify and describe evidentiary standards that define the factors and any other evidence relied upon in designing the NQTL
- Provide comparative analyses to determine as written comparability and equivalent stringency
- Provide comparative analyses to determine in operation comparability and equivalent stringency
- Summary statement explaining how analyses performed have led to an overall determination of compliance for the NQTL



7

UNBUNDLING THE NQTL TEST

- As written and in operation
- Processes, strategies, evidentiary standards and factors
- Comparable to and applied no more stringently
- Compared to medical surgical



8

The Purpose for the “in operation” Component of the NQTL Test

- The phrase, “applied no more stringently” was included to ensure that any processes, strategies, evidentiary standards, or other factors that are comparable on their face are applied in the same manner to medical/surgical benefits and to mental health or substance use disorder benefits. Thus, for example, assume a claims administrator has discretion to approve benefits for treatment based on medical necessity. If that discretion is routinely used to approve medical/surgical benefits while denying mental health or substance use disorder benefits and recognized clinically appropriate standards of care do not permit such a difference, the processes used in applying the medical necessity standard are considered to be applied more stringently to mental health or substance use disorder benefits. The use of discretion in this manner violates the parity requirements for nonquantitative treatment limitations.



9

The Disparate Results “Doctrine”

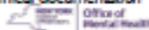
- Different types of illnesses or injuries may require different review, as well as different care. The acute versus chronic nature of a condition, the complexity of it or the treatment involved, and other factors may affect the review. Although the processes, strategies, evidentiary standards, and other factors used in applying these limitations must generally be applied in a comparable manner to all benefits, the mere fact of disparate results ;e.g., denial rates, does not mean that the treatment limitations do not comply with parity.



10

The Proportionality Issue

- A plan applies concurrent review to inpatient care where there are high levels of variation in length of stay. The application of this standard affected 60% of MH/SUD, but only 30% of medical/surgical conditions. This is parity compliant. The evidentiary standard used by the plan is applied no more stringently for MH/SUD benefits, even though it results in an overall difference in the application of concurrent review for MH/SUD conditions than for medical/surgical conditions.
- A plan requires prior authorization for all outpatient MH/SUD benefits but only for three outpatient medical/surgical benefits. It is unlikely that the processes, strategies, evidentiary standards, and other factors considered by the plan in determining that those three (and only those three) outpatient medical/surgical benefits require prior authorization would also result in ALL outpatient MH/SUD benefits needing prior authorization.
- The in- operation analysis, however, must also look at the administrative requirements for the NQTL, whether there are differences in review processes, clinical documentation requirements, etc.



11

NQTL Required Analysis

- Considerations regarding the identified factors : identical or comparable and if comparable explain.
- Considerations regarding evidentiary standards : quantitative and qualitative considerations.
- Considerations regarding comparative analysis “as written” and explanation of discretionary factors utilized, if any.
- Considerations regarding comparative analysis “in operation” with explanation of discretionary factors in the application of the NQTL.



12

The Part 2 NQTLs- Discussion

- Analysis considerations and expectations for each:
- Coding Edits
- Out-of- Network Coverage Standards
- Geographic Restrictions
- Reimbursements
- Provider Type Exclusions



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Clarifying Questions?

Please email:

Steve Melek at Milliman: steve.melek@milliman.com, or

OMH at bho@omh.ny.gov with additional questions



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IV. Phase III Reporting Guidance

Phase III Nonquantitative Treatment Limitation (NQTL) Reporting Guidance

The required reporting for the Phase III NQTL has brought forth questions and request for clarification about what is encompassed by the following topics: 1) outlier review; 2) usual, customary and reasonable (UCR) rate determinations; and 3) unlicensed provider/staff requirements.

Outlier review contemplates plan reporting on algorithms which a plan may use, pre- or post- payment, to identify claims which require secondary review. Outlier in this case means claims that are materially different from other similar claims by any number of plan chosen metrics. This is not simply about the detection of fraud even though a secondary review may result in a review for this. Algorithms used by a plan may be quantitative or qualitative and may or may not involve clinical review. An example of a quantitative trigger for review would be high cost claims and how "high cost" is defined. High readmission rates as compared to other similar providers could be the basis for outlier review. *Outlier review* may also involve statistical profiling of providers across any number of dimensions. There may be qualitative triggers which indicate a quality of care pattern retrospective review is indicated. The plan can categorize them as they deem appropriate. However, the reporting should be inclusive of all triggers which identify outliers on any basis that can result in a claim being subject to secondary review and disposition. The reporting of this must follow the required format provided and enable an assessment as to comparability between factors or triggers used for mental health and substance use disorder (MH/SUD) and medical/surgical (M/S) services.

UCR rate determinations is an inquiry into whether a plan considers UCR rates as a basis or point of comparison for negotiating and establishing reimbursement which deviates from state established fee schedules. Most plans have indicated that they do negotiate reimbursement which varies from state established schedules albeit with varying frequency. The use of UCR as a reference point would be relevant whether the plan is establishing a reimbursement schedule for a participating provider schedule or single case agreements. Again, where this may be a factor the plan reporting should follow the format provided.

Unlicensed provider/staff requirements involve whether a plan uses personnel who are not licensed or certified to conduct clinical review activities on a training, internship or other basis. This inquiry covers all services whether behavioral or medical. The identification of a plan's policies and procedures in this regard are required at a minimum as is the basis and rationale for this.

V. NYS OMH Parity Toolkit

New York State Office of Mental Health Parity Compliance Toolkit

A. Introduction

The federal government has recognized disparities between health plan coverage for mental health and substance use disorder (MH/SUD) benefits compared to their medical/surgical (M/S) counterparts. New York State (NYS) and the NYS Office of Mental Health (NYS OMH) are committed to addressing and ensuring MH/SUD parity compliance for every New Yorker needing or receiving MH/SUD care. The NYS OMH, in coordination with the NYS Department of Health (DOH), the NYS Department of Financial Services (DFS) and the NYS Office of Addiction Services and Supports (OASAS), is currently working on several initiatives to enforce MH/SUD parity compliance for NYS regulated health insurers.

The New York State Office of Mental Health Parity Compliance Toolkit is a compilation of Federal and State information and resources regarding MH/SUD parity in the state of New York. The following toolkit was developed to support insurers, providers, and consumers in understanding parity and NYS' efforts toward achieving MH/SUD parity compliance.

B. MHPAEA Parity Compliance for Medicaid Programs

The oversight, monitoring, and enforcement of the Mental Health Parity and Addiction Equity Act (MHPAEA) is currently taking place within NYS. MHPAEA requires many health insurance plans offering MH/SUD benefits to provide coverage for those services that is comparable to and no more restrictive than the predominant coverage for comparative medical or surgical (M/S) services.

The Centers for Medicare & Medicaid Services (CMS) final regulations (42 CFR Parts 438, 440 and 457), addressing the application of the MHPAEA, set forth Federal reporting requirements for State regulated Medicaid managed care organizations (MCOs), Medicaid Alternative Benefit Plans, and Children's Health Insurance Programs (hereafter Medicaid programs). The NYS OMH, in partnership with the NYS OASAS, the NYS DOH and the NYS DFS, is collecting and analyzing data to ensure MH/SUD parity compliance in NYS Medicaid programs.

MHPAEA and the CMS final regulations stipulate a defined set of rules, regulatory standards, and tests to evaluate parity compliance for all financial requirements (FRs), quantitative treatment limitations (QTLs), and non-quantitative treatment limitations (NQTLs) which apply to MH/SUD benefits. The parity compliance evaluation is being conducted in three phases, with emphasis on the review of 19 distinct NQTLs. NQTL reporting and NYS reviews concentrate on ensuring the standards and processes used to determine MH/SUD benefits and coverage are applied no more stringently than to M/S benefits and coverage.

I. Phases of NYS MHPAEA Compliance for Medicaid Programs

1. Instructions and Technical Assistance:

- a. [Medicaid Managed Care NQTL Reporting Instructions](#)

- b. [NQTL Spreadsheet Guidance](#)
2. **Phase I:** NYS provided NQTL excel workbook templates and technical assistance requesting MCOs to conduct and provide parity analysis data on the first set of four NQTLs: prior authorization, concurrent review, medical necessity criteria, and formulary design.
 - a. [Blank Phase I NQTL Workbook Template](#)
 - b. [NYS Mental Health Parity and Addiction Equity Report](#) (April 2019)
 - c. [NYS Parity Analysis Reporting - Phase 1 Results and Next Steps Webinar](#) (June 19, 2019)
 3. **Phase II:** NYS provided NQTL excel workbook templates and technical assistance to complete their analysis on the following NQTLs: coding edits, out-of-network coverage standards, geographic restrictions, reimbursement, and provider type exclusion.
 - a. [Blank Phase II NQTL Workbook Template](#)
 4. **Phase III:** NYS provided MCOs with workbook document templates on the remaining NQTLs in spring 2020. The following NQTLs included in this phase are: retrospective review, outlier review, experimental/investigational determinations, exclusions for court-ordered treatment or involuntary holds, fail first, failure to complete, provider credentialing, certification requirements, unlicensed provider/staff requirements, and usual, customary and reasonable (UCR) rate determinations.
 - a. [Blank Phase III NQTL Workbook Document Templates](#)

C. Mental Health Clinical Review Criteria

A second initiative related to MH/SUD parity is the examination and approval of mental health clinical review criteria. Chapter 57 of the Laws of 2019 (Part BB) added a new provision to the utilization review (UR) program standards in Insurance Law § 4902 and Public Health Law § 4902. The new provision requires that, when conducting UR for purposes of determining health care coverage for a mental health condition, health maintenance organizations and insurers, and their contracted UR agents (collectively, “UR Agents”), must utilize evidence-based and peer reviewed clinical review criteria. The clinical review criteria must be appropriate to the age of the patient and have been deemed appropriate and approved for use in determining health care coverage for the treatment of mental health conditions by the Commissioner of the NYS OMH, in consultation with the Commissioner of Health and the Superintendent of Financial Services. These provisions became effective January 1, 2020 and apply to health insurance policies issued or renewed on and after that date. The NYS OMH, in collaboration with the NYS DOH and the NYS DFS, is reviewing all current mental health clinical review criteria in use by NYS regulated commercial insurers and Medicaid programs.

The NYS OMH, in partnership with the NYS DOH and NYS DFS, initiated the review and approval of mental health clinical review criteria to ensure coverage determinations for mental health services are made in a manner consistent with accepted medical practices and Federal and State behavioral health parity laws. UR Agents were required to submit all clinical review criteria and policies and procedures used to determine coverage for treatment for mental health conditions, including medical necessity criteria and/or level of care tools, to NYS OMH for review and approval.

The NYS OMH developed the *Guiding Principles for the Review and Approval of Clinical Review Criteria for Mental Health Services* (Guiding Principles); having incorporated stakeholder feedback. The Guiding Principles are to assist UR Agents in understanding what constitutes an acceptable submission, specifically clinical review criteria. The Mental Health Clinical Review Criteria component of NYS' parity compliance initiative is currently underway; however, the NYS OMH, in coordination with the NYS DOH and NYS DFS, will continue to review, approve, and monitor clinical review criteria on an ongoing basis. Ongoing reviews and monitoring will include newly established insurers and implementations of new or revised clinical review criteria.

- I. [Guiding Principles for the Review and Approval of Clinical Review Criteria for Mental Health Services](#)
- II. [Submission Instructions for Clinical Review Criteria, Policies, and Procedures](#)
- III. [Clinical Review Criteria, Policies, and Procedures Submission Coversheet](#)
- IV. [Clinical Review Criteria for the Treatment of Gender Dysphoria](#)

D. Prohibition of Preauthorization and Concurrent Review During First 14 Days of an Inpatient Admission for a Mental Health Condition for Individuals under 18

Part BB of Chapter 57 of the Laws of 2019 added other provisions to the Insurance Law and Public Health Law to prohibit NYS regulated health insurance policies and contracts from requiring preauthorization for inpatient psychiatric hospital services for children up to age 18 when provided by in-state and in-network hospitals, as defined in the Mental Hygiene Law. Additionally, such health insurance policies or contracts may not subject inpatient psychiatric hospital services for children to concurrent review during the first 14 days of treatment, provided the facility notifies the health insurer of the admission and initial treatment plan within two business days of the admission and participates in periodic consultation with the health insurer. All care may be reviewed retrospectively and may be denied if not medically necessary. If coverage is denied retrospectively, the patient is held financially harmless, except for allowable co-pay and deductibles amounts.

I. Department of Financial Services

1. [Insurance Circular Letter No. 13](#) (December 20, 2019)

II. Department of Health

1. [Plan Circular Letter](#) (December 20, 2019)

III. Office of Mental Health

1. [Prohibition Against Preauthorization and Concurrent Review During First 14 Days of an Inpatient Admission for a Mental Health Condition for Individuals Under 18](#) (December 30, 2019)
2. [Addendum A: Two-Day Notification and Initial Treatment Plan – fillable PDF](#)

E. Parity Laws & Legislation

I. Federal Laws & Legislation

1. [The Mental Health Parity Addiction and Equity Act \(MHPAEA\)](#)
2. [Federal Register Vol. 81, No. 61 / Wednesday, March 30, 2016 / Rules and Regulations \(MHPAEA\)](#)
3. [Patient Protection and Affordable Care Act of 2010](#)

II. State Laws & Legislation

1. [NYS Mental Health and Substance Use Disorder Parity Reporting Act of 2018](#)
2. [Chapter 57 of the Laws of 2019 \(Part BB\)](#)

F. Federal Toolkits and Materials

I. Department of Labor

1. [Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act \(MHPAEA\)](#)

II. Centers for Medicare & Medicaid Services

1. [Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs](#)
2. [Compliance Assistance Materials Index](#)

G. New York State Reports

- I. [NYS Department of Financial Services Mental Health and Substance Use Disorder Parity Reports of 2017 and 2018](#)
- II. [NYS Attorney General Mental Health Parity Report](#) (May 2018)
- III. [NYS Mental Health Parity and Addiction Equity Report](#) (April 2019)

H. Informational Resources

- I. [NYS Attorney General Mental Health Parity Brochure](#)
- II. [NYS Department of Financial Services Chapter 57 of the Laws of 2019 FAQ](#)
- III. [Parity Terminology](#)

I. Consumer Resources and Supports

- I. [American Psychological Association Health Center - Mental Health Insurance Coverage: Get the Whole Picture](#)
- II. [Community Health Access to Addiction and Mental Health Care Project \(CHAMP\): The NYS Behavioral Health Ombudsman Program \(Brochure\)](#)
- III. [Legal Action Center Parity Resource](#)
- IV. [NYS MH/SUD Parity Red Flag Resource](#)
- V. [Parity Enforcement Project Initiative](#)
- VI. [NYS DFS Insurance Company Search](#)

J. Parity Related Grievances

- I. New York Attorney General Health Care Bureau [Online Complaint Form](#)
Helpline: 1-800-428-9071
- II. New York Department of Financial Services [Online Complaint Form](#)
Consumer Assistance Unit: 1-800-342-3736
- III. New York Department of Health
Email: managedcarecomplaint@health.ny.gov
Phone: 1-800-206-8125

K. Questions

For questions related to Mental Health Parity in NYS, e-mail OMH-Parity@omh.ny.gov.

U. Appendix 7: MHPAEA Testing Workbooks for Nonquantitative Treatment Limitations

I. Phase I NQTL Workbook

INSTRUCTIONS: Complete a chart for the application of the NQTL to each classification of benefits. If the NQTL is applied differently for a different benefit package, complete charts for each NQTL for each benefit package. If the NQTL is not applied to MH/SUD benefits within a classification, stop and do not complete the sheet for that benefit classification. Conversely, if the NQTL does not apply to medical/surgical benefits within a classification but is applied to MH/SUD benefits within that classification, the NQTL will violate MHPAEA and must either be eliminated or applied to medical/surgical benefits. See the accompanying guide for more information.				
NQTL Name <i>(as noted in NQTL List)</i>	Plan's Description of NQTL			
Prior Authorization	Provide the documentation of and results of the comparative analyses that substantiate that the processes, strategies, evidentiary standards, and factors are comparable and no more stringently applied, as specified in each step			
Prompt	Inpatient Benefits	Outpatient Benefits	Emergency Benefits	Prescription Drugs
Benefit/Service(s) to which prior authorization applies.	[List the services to which prior authorization applies]	[List the services to which prior authorization applies]	[List the services to which prior authorization applies]	[List the services to which prior authorization applies]
Step 1: Describe the NQTL's requirements and associated procedures				
<ul style="list-style-type: none"> Describe the prior authorization procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms and requirements. Are the required qualifications/training for persons performing prior authorization review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.) 	[Provide the Step 1 documentation and answer the question]	[Provide the Step 1 documentation and answer the question]	[Provide the Step 1 documentation and answer the question]	[Provide the Step 1 documentation and answer the question]
Step 2: Describe the reason for applying the NQTL				
<p>Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of prior authorization for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.</p> <p>Examples of factors for determining that prior authorization is appropriate include (these examples are merely illustrative and not exhaustive):</p> <ul style="list-style-type: none"> Ø Excessive utilization Ø Recent medical cost escalation Ø Lack of adherence to quality standards Ø High levels of variation in length of stay Ø High variability in cost per episode of care Ø Clinical efficacy of the proposed treatment or service Ø Provider discretion in determining diagnoses Ø Claims associated with a high percentage of fraud Ø Severity or chronicity of the MH/SUD condition <ul style="list-style-type: none"> Examples of sources for data to identify factors: <ul style="list-style-type: none"> Ø Internal claims analyses Ø Internal quality standard studies 	[Provide the Step 2 documentation]	[Provide the Step 2 documentation]	[Provide the Step 2 documentation]	[Provide the Step 2 documentation]

Ø Expert medical review				
Step 3: Identify and describe evidentiary standards and other evidence relied upon				
<p>Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified in Step 2 and any other evidence relied upon to establish the prior authorization protocols for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the prior authorization protocols for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected.</p> <p>Please note, the term “evidentiary standards” is not limited to a means for defining “factors”. Evidentiary standards also include all evidence considered in designing and applying its prior authorization protocols such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional guild associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.</p> <p>Examples of evidentiary standards and their sources are provided in the toolkit.</p>	[Provide the Step 3 documentation]			
Step 4: Processes and strategies used to design NQTL as written				
<p>Provide the comparative analysis demonstrating that the processes and strategies used to design the prior authorization protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the prior authorization protocols, as written, for medical/surgical benefits.</p> <p>These processes may include, but are not limited to, the composition and deliberations of decision-making staff, e.g. 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.</p>	[Provide the Step 4 documentation]			
Step 5: Processes in implementation of NQTL in operation				
<p>Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing prior authorization for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing prior authorization for medical surgical benefits.</p> <p>Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.</p>	[Provide the Step 5 documentation]			
Step 6: Summary conclusion of how plan or issuer has determined overall compliance				
<p>Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose prior authorization on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose prior authorization on medical/surgical benefits in each classification of benefits in which prior authorization is imposed.</p>	[Provide the Step 6 documentation]			

INSTRUCTIONS: Complete a chart for the application of the NQTL to each classification of benefits. If the NQTL is applied differently for a different benefit package, complete charts for each NQTL for each benefit package. If the NQTL is not applied to MH/SUD benefits within a classification, stop and do not complete the sheet for that benefit classification. Conversely, if the NQTL does not apply to medical/surgical benefits within a classification but is applied to MH/SUD benefits within that classification, the NQTL will violate MHPAEA and must either be eliminated or applied to medical/surgical benefits. See the accompanying guide for more information.

NQTL Name (as noted in NQTL List)	Plan's Description of NQTL			
Concurrent Review	Provide the documentation of and results of the comparative analyses that substantiate that the processes, strategies, evidentiary standards, and factors are comparable and no more stringently applied, as specified in each step			
		Inpatient Benefits	Outpatient Benefits	Emergency Benefits
Benefit/Service(s) to which concurrent review applies.	[List the services to which concurrent review applies]	[List the services to which	[List the services to which	[List the services to which concurrent review

		concurrent review applies]	concurrent review applies]	applies]
Step 1: Describe the NQTL's requirements and associated procedures				
<ul style="list-style-type: none"> Describe the concurrent review procedures for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms and requirements. Are the required qualifications/training for persons performing concurrent review for MH/SUD benefits and medical/surgical benefits comparable? If not, provide a rationale (i.e., state law requirements, etc.) 	[Provide the Step 1 documentation and answer the question]	[Provide the Step 1 documentation and answer the question]	[Provide the Step 1 documentation and answer the question]	[Provide the Step 1 documentation and answer the question]
Step 2: Describe the reason for applying the NQTL				
<p>Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of concurrent review for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.</p> <p>Examples of factors for determining that concurrent review is appropriate include (these examples are merely illustrative and not exhaustive):</p> <ul style="list-style-type: none"> Ø Excessive utilization Ø Recent medical cost escalation Ø Lack of adherence to quality standards Ø High levels of variation in length of stay Ø High variability in cost per episode of care Ø Clinical efficacy of the proposed treatment or service Ø Provider discretion in determining diagnoses Ø Claims associated with a high percentage of fraud Ø Severity or chronicity of the MH/SUD condition <p>• Examples of sources for data to identify factors:</p> <ul style="list-style-type: none"> Ø Internal claims analyses Ø Internal quality standard studies Ø Expert medical review 	[Provide the Step 2 documentation]			
Step 3: Identify and describe evidentiary standards and other evidence relied upon				
<p>Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified in Step 2 and any other evidence relied upon to establish the concurrent review protocols for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the concurrent review protocols for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected.</p> <p>Please note, the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence considered in designing and applying its concurrent review protocols such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional guild associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.</p> <p>Examples of evidentiary standards and their sources are provided in the toolkit.</p>	[Provide the Step 3 documentation]			
Step 4: Processes and strategies used to design NQTL as written				
<p>Provide the comparative analysis demonstrating that the processes and strategies used to design the concurrent review protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the concurrent review protocols, as written, for medical/surgical benefits.</p> <p>These processes may include, but are not limited to, the composition and deliberations of decision-making staff, e.g. 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.</p>	[Provide the Step 4 documentation]			
Step 5: Processes in implementation of NQTL in operation				

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing concurrent review for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing concurrent review for medical surgical benefits.	[Provide the Step 5 documentation]			
Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.				
Step 6: Summary conclusion of how plan or issuer has determined overall compliance				
Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose concurrent review on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose concurrent review on medical/surgical benefits in each classification of benefits in which prior authorization is imposed.	[Provide the Step 6 documentation]			

INSTRUCTIONS: Complete a chart for the application of the medical necessity criteria within each classification of benefits. If the medical necessity criteria is applied differently for a different benefit package, complete charts for the medical necessity criteria for each benefit package. If the medical necessity criteria does not differ among classifications of benefits, simply complete Column 2 and write N/A in the other columns.

NQTL Name (as noted in NQTL List)	Plan's Description of NQTL				
Development/Modification/Addition of Medical Necessity/ Medical Appropriateness/Level of Care Guidelines	Provide the documentation of and results of the comparative analyses that substantiate that the processes, strategies, evidentiary standards, and factors are comparable and no more stringently applied, as specified in each step				
Prompt	Inpatient Benefits	Outpatient Benefits	Emergency Benefits	Prescription Drugs	
Benefit/Service(s) to which the medical necessity applies. Medical necessity will also apply as a component of the application of prior authorization, concurrent review, retrospective review, outlier review, and appeals. However, it must be analyzed as a separate NQTL.	[List the services which the medical necessity criteria is relied upon during utilization review]	[List the services which the medical necessity criteria is relied upon during utilization review]	[List the services which the medical necessity criteria is relied upon during utilization review]	[List the medications which the medical necessity criteria is relied upon during utilization review]	
Step 1: Describe the NQTL's requirements and associated procedures					
NA (proceed to steps 3-6)	N/A	N/A	N/A	N/A	
Step 2: Describe the reason for applying the NQTL					
NA (proceed to steps 3-6)	N/A	N/A	N/A	N/A	
Step 3: Identify and describe evidentiary standards and other evidence relied upon					
Provide the comparative analysis demonstrating that the evidentiary standard(s) and other evidence relied upon in the creation the medical necessity criteria for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) and other evidence relied upon in the creation the medical necessity criteria for medical/surgical benefits. Describe evidentiary standards and evidence considered, but rejected.	[Provide the Step 3 documentation]	[Provide the Step 3 documentation]	[Provide the Step 3 documentation]	[Provide the Step 3 documentation]	
Evidentiary standards include all evidence or guidelines the plan or issuer considers in designing and applying its medical necessity criteria, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional guild associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.					
Step 4: Processes and strategies used to design the medical necessity criteria as written					

<p>Provide the comparative analysis demonstrating that the processes and strategies used to design the medical necessity criteria, as written for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the medical necessity criteria, as written, for medical/surgical benefits.</p> <p>These processes may include, but are not limited to, the composition and deliberations of decision-making staff, e.g. 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.</p>	[Provide the Step 4 documentation]			
<p>Step 5: Processes in implementation of the medical necessity criteria in operation</p> <p>Provide the comparative analysis demonstrating that the processes and strategies used in applying the medical necessity criteria, in operation, to MH/SUD benefits are comparable and no more stringently applied than the processes and strategies used in applying the medical necessity criteria, in operation, to medical surgical benefits.</p> <p>Processes and strategies used in applying the medical necessity criteria may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in applying the criteria, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.</p> <p>A key indicator for determining if the medical necessity criteria has been applied comparably and no more stringently may be an examination and comparison of interrater reliability audits for MH/SUD and medical/surgical utilization reviewers.</p>	[Provide the Step 5 documentation]			
<p>Step 6: Summary conclusion of how plan or issuer has determined overall compliance</p> <p>Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to design and apply the medical necessity criteria for MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to design and apply the medical necessity criteria for medical/surgical benefits in each classification of benefits in which utilization review is performed involving the use of the medical necessity criteria.</p>	[Provide the Step 6 documentation]			

<p>INSTRUCTIONS: Complete a chart for the application of the NQTL to each classification of benefits. If the NQTL is applied differently for a different benefit package, complete charts for each NQTL for each benefit package.</p>	
<p>NQTL Name (as noted in NQTL List)</p>	
<p>Formulary Design</p>	
<p>Prompt</p>	<p>Prescription Drugs</p>
<p>N/A proceed to step 1</p>	<p>N/A</p>
<p>Step 1: Describe the NQTL's requirements and associated procedures</p>	
<ul style="list-style-type: none"> Describe the Formulary Design procedures and requirement. Include each step, associated triggers, timelines, forms and requirements. What are the required qualifications/training for persons developing and applying the formulary? 	<p>[Provide the Step 1 documentation and answer the question]</p>
<p>Step 2: Describe the reason for applying the NQTL</p>	

<p>Provide the comparative analysis demonstrating that comparable factors were used to determine how and whether to include drugs on the formulary for MH/SUD medications as were used for medical/surgical medications, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.</p> <p>Examples of factors for determining how and whether medications will be included on the formulary include (these examples are merely illustrative and not exhaustive):</p> <ul style="list-style-type: none"> Ø contract requirement Ø Recent prescription drug cost escalation Ø Lack of adherence to quality standards in prescribing Ø High levels of variation in prescribing practices Ø High variability in cost per patient with similar diagnoses Ø Prescriptions associated with a high percentage of fraud • What standards or evidence support(s) the rationale for applying a formulary/PDL to the(se) benefit(s) (e.g., practice guidelines, published research, data analysis, statistics)? <p>Examples of sources include:</p> <ul style="list-style-type: none"> Ø Internal claims analyses Ø Internal quality standard studies Ø Expert medical review 	<p>[Provide the Step 2 documentation]</p>
<p>Step 3: Identify and describe evidentiary standards and other evidence relied upon</p>	
<p>Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified in Step 2 and any other evidence relied upon to develop the formulary for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to develop the formulary for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected.</p>	<p>[Provide the Step 3 documentation]</p>
<p>Step 4: Processes and strategies used to design NQTL as written</p>	
<p>Provide the comparative analysis demonstrating that the processes and strategies used to formulary, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to develop the formulary, as written, for medical/surgical benefits.</p> <p>These processes may include, but are not limited to, the composition and deliberations of decision-making staff, e.g. 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.</p>	<p>[Provide the Step 4 documentation]</p>
<p>Step 5: Processes in implementation of NQTL in operation</p>	
<p>Provide the comparative analysis demonstrating that the processes and strategies used in providing coverage for MH/SUD medications that are not on the formulary in certain instances are comparable to and no more stringently applied than the processes and strategies used in providing coverage for medical surgical medications in certain instances.</p> <p>Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.</p>	<p>[Provide the Step 5 documentation]</p>
<p>Step 6: Summary conclusion of how plan or issuer has determined overall compliance</p>	
<p>Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose prior authorization on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose prior authorization on medical/surgical benefits in each classification of benefits in which prior authorization is imposed.</p>	<p>[Provide the Step 6 documentation]</p>

II. Phase II NQTL Workbook

INSTRUCTIONS: Complete a chart for the application of the NQTL to each classification of benefits. If the NQTL is applied differently for a different benefit package, complete charts for each NQTL for each benefit package. If the NQTL is not applied to MH/SUD benefits within a classification, stop and do not complete the sheet for that benefit classification. Conversely, if the NQTL does not apply to medical/surgical benefits within a classification but is applied to MH/SUD benefits within that classification, the NQTL will violate MHPAEA and must either be eliminated or applied to medical/surgical benefits. See the accompanying guide for more information.

NQTL Name <i>(as noted in NQTL List)</i>	Plan's Description of NQTL			
Coding edits (e.g. requiring providers to limit bill codes that could otherwise be applicable)	Provide the documentation of and results of the comparative analyses that substantiate that the processes, strategies, evidentiary standards, and factors are comparable and no more stringently applied, as specified in each step			
Prompts	Inpatient	Outpatient	Emergency Benefits	Prescription Drugs
Benefit/Service(s) to which the coding edits apply. For example, if same-day claims for certain services are prohibited pursuant to a claim edit.	[List the services to which coding edits apply]	[List the services to which coding edits apply]	[List the services to which coding edits apply]	[List the services to which coding edits apply]
Step 1: Describe the NQTL's requirements and associated procedures				
<ul style="list-style-type: none"> Describe the coding edit protocols for both MH/SUD benefits and medical/surgical benefits. Include each step, associated triggers, timelines, forms and requirements. 	[Provide the Step 1 documentation and answer the question]	[Provide the Step 1 documentation and answer the question]	[Provide the Step 1 documentation and answer the question]	[Provide the Step 1 documentation and answer the question]
Step 2: Identify factors				
Demonstrate that comparable factors were used to determine the applicability of coding edits for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors. Examples of factors for determining that coding edits are appropriate include (these examples are merely illustrative and not exhaustive): <ul style="list-style-type: none"> Excessive utilization Recent medical cost escalation Lack of adherence to quality standards High levels of variation in length of stay High variability in cost per episode of care Clinical efficacy of the proposed treatment or service Provider discretion in determining diagnoses Claims associated with a high percentage of fraud Severity or chronicity of the MH/SUD condition Examples of sources for data to identify factors: <ul style="list-style-type: none"> Internal claims analyses Internal quality standard studies Expert medical review 	[Provide the Step 2 documentation]	[Provide the Step 2 documentation]	[Provide the Step 2 documentation]	[Provide the Step 2 documentation]
Step 3: Identify and describe evidentiary standards and other evidence relied upon				
Demonstrate that the evidentiary standard(s) used to define factors identified in Step 2 and any other evidence relied upon to establish the coding edit protocols for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the coding edit protocols for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected. <p>Please note, the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence considered in designing and applying its coding edit protocols such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional guild associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.</p>	[Provide the Step 3 documentation]	[Provide the Step 3 documentation]	[Provide the Step 3 documentation]	[Provide the Step 3 documentation]
Step 4: Processes and strategies used to design NQTL as written				

Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the coding edit protocols, as written, for medical/surgical benefits. These processes may include, but are not limited to, the composition and deliberations of decision-making staff, e.g. 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.	[Provide the Step 4 documentation]			
Step 5: Processes in implementation of NQTL in operation				
Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used in operationalizing coding edits for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used in operationalizing coding edits for medical surgical benefits. Processes and strategies may include, but are not limited to, peer clinical review, consultations with expert reviewers, clinical rationale used in approving or denying benefits, reviewer discretion, adherence to criteria hierarchy, and the selection of information deemed reasonably necessary to make a medical necessity determination.	[Provide the Step 5 documentation]			
Step 6: Summary conclusion of how plan or issuer has determined overall compliance				
Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose coding edits on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose coding edits on medical/surgical benefits in each classification of benefits in which prior authorization is imposed.	[Provide the Step 6 documentation]			

INSTRUCTIONS: Complete a chart for the application of the NQTL to each classification of benefits. If the NQTL is applied differently for a different benefit package, complete charts for each NQTL for each benefit package. If the NQTL is not applied to MH/SUD benefits within a classification, stop and do not complete the sheet for that benefit classification. Conversely, if the NQTL does not apply to medical/surgical benefits within a classification but is applied to MH/SUD benefits within that classification, the NQTL will violate MHPAEA and must either be eliminated or applied to medical/surgical benefits. See the accompanying guide for more information.

NQTL Name (as noted in NQTL List)			
Standards for out-of-network coverage (OON)			
		Inpatient	Outpatient
Benefit/Service(s) to which the OON coverage applies.		[List the services that are covered out-of-network]	[List the services that are covered out-of-network]
Step 1: Describe the NQTL's requirements and associated procedures			
• Describe the procedures that must be followed for the coverage of OON services. Include each step, associated triggers, timelines, forms and requirements.		[Provide the Step 1 documentation]	[Provide the Step 1 documentation]
Step 2: Describe the factors considered to determine the OON services will be covered			
List any factors that determine whether a benefit/service will be eligible for OON coverage.		Provide the Step 2 documentation	Provide the Step 2 documentation
Step 3: Define the factors listed in step 2 and describe evidentiary standards relied upon			
Define each of the factors listed in step 2 and demonstrate that the evidentiary standard(s) used to develop the OON approval protocols for MH/SUD benefits are comparable to the evidentiary standards used to develop the OON approval protocols for medical/surgical benefits.		[Provide the Step 3 documentation]	[Provide the Step 3 documentation]
Step 4: As written processes and strategies			

<p>Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the OON approval protocols, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design the OON approval protocols, as written, for medical/surgical benefits.</p> <p>Also demonstrate that any as written processes and strategies that govern the approval of OON coverage for MH/SUD benefits are comparable to and applied no more stringently than any as written processes and strategies that govern the approval of OON coverage for med/surg benefits</p> <p>Processes and strategies used to design the OON approval protocols may include, but are not limited to, the composition and deliberations of decision-making staff, e.g. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from medical literature and/or professional guidelines, consultations with panels of experts.</p> <p>As written processes and strategies that govern the approval of OON coverage may include utilization management manuals, criteria hierarchy, summary plan description, written protocols relied upon by utilization review staff, etc.</p>	[Provide the Step 4 documentation]	[Provide the Step 4 documentation]
Step 5: Processes in implementation of NQTL in operation		
<p>Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used in operationalizing OON approval protocols for MH/SUD benefits are comparable and no more stringent than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used in operationalizing the OON approval protocols for medical surgical benefits.</p>	[Provide the Step 5 documentation]	[Provide the Step 5 documentation]
Step 6: Summary conclusion of how plan or issuer has determined overall compliance		
<p>Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to design and apply the OON approval protocols for MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to design and apply the OON approval protocols for medical/surgical benefits in each applicable classification of benefits.</p>	[Provide the Step 6 documentation]	[Provide the Step 6 documentation]

<p>INSTRUCTIONS: Complete a chart for the application of the NQTL to each classification of benefits. If the NQTL is applied differently for a different benefit package, complete charts for each NQTL for each benefit package. If the NQTL is not applied to MH/SUD benefits within a classification, stop and do not complete the sheet for that benefit classification. Conversely, if the NQTL does not apply to medical/surgical benefits within a classification but is applied to MH/SUD benefits within that classification, the NQTL will violate MHPAEA and must either be eliminated or applied to medical/surgical benefits. See the accompanying guide for more information.</p>		
<p align="center">NQTL Name (as noted in NQTL List)</p>		
Standards for out-of-area coverage		
Prompts	Inpatient	Outpatient
Benefit/Service(s) for which there are geographic restrictions	[List the benefits for which geographic restrictions apply]	[List the benefits for which geographic restrictions apply]
Step 1: Describe the NQTL's requirements and associated procedures		
• Describe the procedures and any plan language that apply to geographic restrictions	[Provide the Step 1 documentation and answer the question]	[Provide the Step 1 documentation and answer the question]
Step 2: List the factors that determine whether a benefit may be subject to a geographic restriction		
List any factors that determine whether a benefit may be subject to a geographic restriction	(Provide the Step 2 documentation)	(Provide the Step 2 documentation)
Step 3: Define each of the factors listed in step 2 and describe any evidentiary standards used to develop the geographic restriction		
Define the factors listed in step 2 and demonstrate that comparable evidentiary standard(s) are used to develop geographic restrictions for MH/SUD benefits as are used to develop geographic restrictions for medical/surgical benefits.	[Provide the Step 3 documentation]	[Provide the Step 3 documentation]
Step 4: Processes and strategies used to design NQTL as written		

<p>Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design geographic restrictions, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design geographic restrictions, as written, for medical/surgical benefits.</p> <p>Also demonstrate that any as written processes and strategies applicable to geographic restrictions for MH/SUD benefits are comparable to and applied no more stringently than any as written processes and strategies applicable to geographic restrictions for med/surg benefits</p> <p>Processes and strategies used to design the OON approval protocols may include, but are not limited to, the composition and deliberations of decision-making staff, e.g. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from medical literature and/or professional guidelines, consultations with panels of experts.</p> <p>As written processes and strategies that govern the approval of OON coverage may include utilization management manuals, criteria hierarchy, summary plan description, written protocols relied upon by utilization review staff, etc.</p>	[Provide the Step 4 documentation]	[Provide the Step 4 documentation]
Step 5: Processes in implementation of NQTL in operation		
<p>Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used in operationalizing geographic restrictions for MH/SUD benefits are comparable to and no more stringently than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used in operationalizing geographic restrictions for medical/surgical benefits.</p>	[Provide the Step 5 documentation]	[Provide the Step 5 documentation]
Step 6: Summary conclusion of how plan or issuer has determined overall compliance		
<p>Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to design and apply the out-of-area approval protocols for MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to design and apply the out-of-area approval protocols for medical/surgical benefits in each applicable classification of benefits.</p>	[Provide the Step 6 documentation]	[Provide the Step 6 documentation]

INSTRUCTIONS: Complete a chart for the application of the NQTL to each classification of benefits. If the NQTL is applied differently for a different benefit package, complete charts for each NQTL for each benefit package.

NQTL Name <i>(as noted in NQTL List)</i>	Plan's Description of NQTL				
Provider Reimbursement	Provide the documentation of and results of the comparative analyses that substantiate that the processes, strategies, evidentiary standards, and factors are comparable and no more stringently applied, as specified in each step				
Prompt	Inpatient Benefits	Outpatient Benefits	Emergency Benefits	Prescription Drugs	
N/A go to step 1	N/A	N/A	N/A	N/A	
Step 1: Describe the NQTL's requirements and associated procedures					
• Describe the provider reimbursement rate determination/negotiation procedures. Include each step, associated triggers, timelines, forms and requirements.	[Provide the Step 1 documentation]	[Provide the Step 1 documentation]	[Provide the Step 1 documentation]	[Provide the Step 1 documentation]	
Step 2: Describe the factors used in setting reimbursement rates					

<p>Demonstrate that comparable factors are used to establish reimbursement /fee schedules for services within each classification or subclassification (including tiering). Include any factors that are quantitative and applied mechanically and any that are qualitative and/or involve discretion in the application of the factor. Below are different types of factors.</p> <ul style="list-style-type: none"> * Payment methodology, which could be MS-DRG, Per Diem, Per Case, Per Visit, Per Unit, Fee schedule * Fee schedule/payment benchmarks such as Medicare PFS rates, FAIR Health data, Competitor fee schedules, Medicare DRGs, Medicare outpatient prospective payment system * Regional/service area market dynamics such as Market studies which measure demand for services and/or supply of provider type and/or specialty * Provider practice size or solo practice adjustments, multispecialty practice or group, hospital or facility based * Type of provider, training, experience and licensure of providers, and/or specialty, adjustments for non-MD providers * Contract factors such as length of contract, built in rate escalators (e.g.; annual CPI adjustments), frequency of rate review, provider ability to negotiate rates 	[Provide the Step 2 documentation]			
<p>Step 3: Define or clarify the factors used in step 2</p> <p>Provide the definition and/or context for each of the factors listed in step 2 and explain how they were used. For example:</p> <ul style="list-style-type: none"> * If the payment methodology factor included fee schedules, specify which ones. * If benchmarking was a factor, explain which unit or units were selected for benchmarking and describe how the benchmarking was determined, ie, 120-135% of Medicare PFS rates * If market dynamics or market studies were factors used, identify which ones and how the results of those dynamics, studies, data, etc informed rate setting * If practice size or type was a factor relied upon, how did it inform rate setting * If provider training, experience, licensure, etc was a factor relied upon, how did it inform rate setting * Define how various contract factors relied upon or what their parameters were (eg frequency of rate review, value of rate escalators, variability in negotiating rates) 	[Provide the Step 3 documentation]			
<p>Step 4: Processes and strategies used to design NQTL as written</p> <p>Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to set reimbursement rates, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to set reimbursement rates, as written, for medical/surgical benefits.</p> <p>These processes and strategies include any written materials delivered, provided, or exchanged with potential network providers, any internal written documents developed and circulated to staff regarding rate setting and negotiating with providers, minutes from staff meetings regarding rate setting, etc.</p>	[Provide the Step 4 documentation]			
<p>Step 5: Processes in implementation of NQTL in operation</p> <p>Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used in operationalizing reimbursement rates and adjusting reimbursement rates for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used in operationalizing preliminary reimbursement rates and negotiating final reimbursement rates for medical surgical benefits. This shall include a comparison of the negotiation processes between the plan and providers as well as any processes in place for adjusting rates for MH/SUD providers and the negotiation processes between the plan and providers as well as any processes in place for adjusting rates for medical/surgical providers.</p>	[Provide the Step 5 documentation]			

Step 6: Summary conclusion of how plan or issuer has determined overall compliance

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to determine reimbursement rates for MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to set reimbursement rates for medical/surgical benefits in each classification of benefits.

[Provide the Step 6 documentation]

INSTRUCTIONS: Complete a chart for the application of the NQTL to each classification of benefits. If the NQTL is applied differently for a different benefit package, complete charts for each NQTL for each benefit package. If the NQTL is not applied to MH/SUD benefits within a classification, stop and do not complete the sheet for that benefit classification. Conversely, if the NQTL does not apply to medical/surgical benefits within a classification but is applied to MH/SUD benefits within that classification, the NQTL will violate MHPAEA and must either be eliminated or applied to medical/surgical benefits. See the accompanying guide for more information.

NQTL Name (as noted in NQTL List)	Plan's Description of NQTL		
Provider Type Exclusions	Provide the documentation of and results of the comparative analyses that substantiate that the processes, strategies, evidentiary standards, and factors are comparable and no more stringently applied, as specified in each step		
Prompt	Inpatient Benefits	Outpatient Benefits	Emergency Benefits
Identify, if any, the benefits/services for which the plan or issuer imposes categorical exclusions for certain provider types. Identify, if any, the provider types for which the plan or issuer imposes categorical exclusions regardless of benefits/services involved.	[List the benefits/services for which categorical exclusions are imposed for certain provider types and list the types of providers for which coverage is always excluded.]	[List the type of providers for which coverage is excluded.]	[List the type of providers for which coverage is excluded.]
Step 1: Describe the NQTL's requirements and associated procedures			
• Describe the procedures governing categorical exclusions of provider types. Include each step, associated triggers, timelines, forms and requirements.	[Provide the Step 1 documentation]	[Provide the Step 1 documentation]	[Provide the Step 1 documentation]
Step 2: Identify factors			
Demonstrate that the factors used to determine the applicability of a categorical exclusion of certain MH/SUD provider types are comparable to the factors used to determine the applicability of a categorical exclusion of certain medical/surgical provider types. List factors considered but rejected. Examples of factors for determining that certain providers be subject to categorical exclusions include (these examples are merely illustrative and not exhaustive): Ø State licensing laws/regulations Ø Supervision requirements Ø Non-MD providers Ø State corporate practice of medicine laws/regulations Ø Historical beneficiary confusion about coverage of services by a provider	[Provide the Step 2 documentation]	[Provide the Step 2 documentation]	[Provide the Step 2 documentation]
Step 3: Identify and describe evidentiary standards and other evidence relied upon			
Demonstrate that the standards or evidence that supports the rationale for applying a categorical exclusion of certain MH/SUD provider types are comparable to and no more stringently applied than the standards or evidence that supports the rationale for applying a categorical exclusion of certain medical/surgical provider types. (e.g., practice guidelines, published research, data analysis, statistics)	[Provide the Step 3 documentation]	[Provide the Step 3 documentation]	[Provide the Step 3 documentation]
Step 4: Processes and strategies used to design NQTL as written			
Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design any categorical exclusions of certain MH/SUD provider types, as written, are comparable to and applied no more stringently than processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used to design any categorical exclusions of certain medical/surgical provider types, as written. Also provide the comparative analysis that any as written processes and strategies used to apply categorical exclusions of certain MH/SUD provider types are comparable to an applied no more stringently than the as written processes and strategies used to apply	[Provide the Step 4 documentation]	[Provide the Step 4 documentation]	[Provide the Step 4 documentation]

categorical exclusions of certain medical/surgical provider types.			
Step 5: Processes in implementation of NQTL in operation			
Provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used in operationalizing any categorical exclusions of certain MH/SUD provider types are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used in operationalizing any categorical exclusions of certain medical surgical provider types.	[Provide the Step 5 documentation]	[Provide the Step 5 documentation]	[Provide the Step 5 documentation]
Step 6: Summary conclusion of how plan or issuer has determined overall compliance			
Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose categorical exclusions of certain MH/SUD provider types are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose categorical exclusions of certain medical/surgical provider types in each classification of benefits.	[Provide the Step 6 documentation]	[Provide the Step 6 documentation]	[Provide the Step 6 documentation]

III. Phase III NQTL Submission Forms

Certification Requirements

Benefits subject to certification requirements.

Services/benefit(s) for which a requirement for provider certification in the absence of licensure apply.

Step 1: Describe the NQTL's requirements and associated procedures

Describe the procedures the plan or issuer uses to determine whether and when to require specialized certifications in the absence of an applicable license. Include each step, associated triggers, timelines, forms and requirements.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 2: Identify factors.

Demonstrate that the factors used to determine whether and when to require specialized certification in the absence of an applicable license for mental health/substance use disorder (MH/SUD) providers are comparable to the factors used to determine when to require specialized certification in the absence of an applicable license for medical/surgical (M/S) providers. List factors considered but rejected.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 3: Identify and describe evidentiary standards and other evidence relied upon.

Demonstrate that the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements are for MH/SUD providers are comparable to and applied no more stringently than the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements for M/S providers. List evidentiary standards considered but rejected.

- What standards or evidence support(s) the rationale for applying the certification requirement to the(se) benefit(s) (e.g., practice guidelines, published research, data analysis, statistics)?

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 4: Comparative analysis of as written processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used to design the certification approval protocol, as written, and any as written processes and strategies used to apply the NQTL for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used to design the certification approval protocol, as written, and any processes and strategies used to apply the NQTL for M/S providers.

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 5: Comparative analysis of in operation processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the certification approval protocol for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used in operationalizing the certification approval protocol for M/S providers.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 6: Summary conclusion of how plan or issuer has determined overall compliance.

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to establish certification requirements for MH/SUD providers are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to establish certification requirements for M/S providers in each classification of benefits.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Exclusions for Court-Ordered Treatment or Involuntary Holds

Benefits subject to court-ordered exclusions.

Identify any benefits subject to a blanket coverage exclusion if ordered by a court.

If all court-ordered benefits are excluded from coverage, indicate as such and specify whether this is the case for both mental health/substance use disorder (MH/SUD) benefits and medical/surgical (M/S) benefits or not.

The plan or issuer does not need to complete the six steps if this is the case.

If there are no benefits subject to a blanket coverage exclusion if ordered by a court indicate as such and do not complete the six steps

Benefits subject to certification requirements.

Services/benefit(s) for which a requirement for provider certification in the absence of licensure apply.

Step 1: Describe the NQTL's requirements and associated procedures

Describe the procedures the plan or issuer uses to determine whether and when to require specialized certifications in the absence of an applicable license. Include each step, associated triggers, timelines, forms and requirements.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 2: Identify factors.

Demonstrate that the factors used to determine whether and when to require specialized certification in the absence of an applicable license for mental health/substance use disorder (MH/SUD) providers are comparable to the factors used to determine when to require specialized certification in the absence of an applicable license for medical/surgical (M/S) providers. List factors considered but rejected.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 3: Identify and describe evidentiary standards and other evidence relied upon.

Demonstrate that the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements are for MH/SUD providers are comparable to and applied no more stringently than the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements for M/S providers. List evidentiary standards considered but rejected.

- What standards or evidence support(s) the rationale for applying the certification requirement to the(se) benefit(s) (e.g., practice guidelines, published research, data analysis, statistics)?

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 4: Comparative analysis of as written processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used to design the certification approval protocol, as written, and any as written processes and strategies used to apply the NQTL for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used to design the certification approval protocol, as written, and any processes and strategies used to apply the NQTL for M/S providers.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 5: Comparative analysis of in operation processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the certification approval protocol for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used in operationalizing the certification approval protocol for M/S providers.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 6: Summary conclusion of how plan or issuer has determined overall compliance.

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to establish certification requirements for MH/SUD providers are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to establish certification requirements for M/S providers in each classification of benefits.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Experimental/Investigational Determinations

Service/benefit(s) which have been subject to review to determine if they are experimental or investigational.

Step 1: Describe the NQTL's requirements and associated procedures

Describe the procedures the plan or issuer uses to determine whether and when to require specialized certifications in the absence of an applicable license. Include each step, associated triggers, timelines, forms and requirements.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 2: Identify factors.

Demonstrate that the factors used to determine whether and when to require specialized certification in the absence of an applicable license for mental health/substance use disorder (MH/SUD) providers are comparable to the factors used to determine when to require specialized certification in the absence of an applicable license for medical/surgical (M/S) providers. List factors considered but rejected.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 3: Identify and describe evidentiary standards and other evidence relied upon.

Demonstrate that the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements are for MH/SUD providers are comparable to and applied no more stringently than the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements for M/S providers. List evidentiary standards considered but rejected.

- What standards or evidence support(s) the rationale for applying the certification requirement to the(se) benefit(s) (e.g., practice guidelines, published research, data analysis, statistics)?

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 4: Comparative analysis of as written processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used to design the certification approval protocol, as written, and any as written processes and strategies used to apply the NQTL for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used to design the certification approval protocol, as written, and any processes and strategies used to apply the NQTL for M/S providers.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 5: Comparative analysis of in operation processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the certification approval protocol for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used in operationalizing the certification approval protocol for M/S providers.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 6: Summary conclusion of how plan or issuer has determined overall compliance.

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to establish certification requirements for MH/SUD providers are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to establish certification requirements for M/S providers in each classification of benefits.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Fail-first

Benefits subject to fail-first.

Benefit/service(s) which require the beneficiary to have tried and failed a lower level of care prior to coverage.

Step 1: Describe the NQTL’s requirements and associated procedures

Describe the procedures the plan or issuer uses to determine whether and when to require specialized certifications in the absence of an applicable license. Include each step, associated triggers, timelines, forms and requirements.

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 2: Identify factors.

Demonstrate that the factors used to determine whether and when to require specialized certification in the absence of an applicable license for mental health/substance use disorder (MH/SUD) providers are comparable to the factors used to determine when to require specialized certification in the absence of an applicable license for medical/surgical (M/S) providers. List factors considered but rejected.

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 3: Identify and describe evidentiary standards and other evidence relied upon.

Demonstrate that the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements are for MH/SUD providers are comparable to and applied no more stringently than the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements for M/S providers. List evidentiary standards considered but rejected.

- What standards or evidence support(s) the rationale for applying the certification requirement to the(se) benefit(s) (e.g., practice guidelines, published research, data analysis, statistics)?

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 4: Comparative analysis of as written processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used to design the certification approval protocol, as written, and any as written processes and strategies used to apply the NQTL for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used to design the certification approval protocol, as written, and any processes and strategies used to apply the NQTL for M/S providers.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 5: Comparative analysis of in operation processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the certification approval protocol for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used in operationalizing the certification approval protocol for M/S providers.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 6: Summary conclusion of how plan or issuer has determined overall compliance.

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to establish certification requirements for MH/SUD providers are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to establish certification requirements for M/S providers in each classification of benefits.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Failure to Complete

Benefits subject to failure to complete.

Benefit/Service(s) for which payment for any portion of treatment requires that the beneficiary has completed the entire treatment regimen (e.g., no payment is made unless entire treatment regimen is completed as ordered).

Step 1: Describe the NQTL's requirements and associated procedures

Describe the procedures the plan or issuer uses to determine whether and when to require specialized certifications in the absence of an applicable license. Include each step, associated triggers, timelines, forms and requirements.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 2: Identify factors.

Demonstrate that the factors used to determine whether and when to require specialized certification in the absence of an applicable license for mental health/substance use disorder (MH/SUD) providers are comparable to the factors used to determine when to require specialized certification in the absence of an applicable license for medical/surgical (M/S) providers. List factors considered but rejected.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 3: Identify and describe evidentiary standards and other evidence relied upon.

Demonstrate that the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements are for MH/SUD providers are comparable to and applied no more stringently than the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements for M/S providers. List evidentiary standards considered but rejected.

- What standards or evidence support(s) the rationale for applying the certification requirement to the(se) benefit(s) (e.g., practice guidelines, published research, data analysis, statistics)?

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 4: Comparative analysis of as written processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used to design the certification approval protocol, as written, and any as written processes and strategies used to apply the NQTL for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used to design the certification approval protocol, as written, and any processes and strategies used to apply the NQTL for M/S providers.

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 5: Comparative analysis of in operation processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the certification approval protocol for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used in operationalizing the certification approval protocol for M/S providers.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 6: Summary conclusion of how plan or issuer has determined overall compliance.

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to establish certification requirements for MH/SUD providers are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to establish certification requirements for M/S providers in each classification of benefits.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Outlier Review

Benefit/Service(s) to which outlier review applies.

Step 1: Describe the NQTL's requirements and associated procedures

Describe the procedures the plan or issuer uses to determine whether and when to require specialized certifications in the absence of an applicable license. Include each step, associated triggers, timelines, forms and requirements.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 2: Identify factors.

Demonstrate that the factors used to determine whether and when to require specialized certification in the absence of an applicable license for mental health/substance use disorder (MH/SUD) providers are comparable to the factors used to determine when to require specialized certification in the absence of an applicable license for medical/surgical (M/S) providers. List factors considered but rejected.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 3: Identify and describe evidentiary standards and other evidence relied upon.

Demonstrate that the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements are for MH/SUD providers are comparable to and applied no more stringently than the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements for M/S providers. List evidentiary standards considered but rejected.

- What standards or evidence support(s) the rationale for applying the certification requirement to the(se) benefit(s) (e.g., practice guidelines, published research, data analysis, statistics)?

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 4: Comparative analysis of as written processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used to design the certification approval protocol, as written, and any as written processes and strategies used to apply the NQTL for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used to design the certification approval protocol, as written, and any processes and strategies used to apply the NQTL for M/S providers.

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 5: Comparative analysis of in operation processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the certification approval protocol for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used in operationalizing the certification approval protocol for M/S providers.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 6: Summary conclusion of how plan or issuer has determined overall compliance.

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to establish certification requirements for MH/SUD providers are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to establish certification requirements for M/S providers in each classification of benefits.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Provider Credentialing

Benefits subject to certification requirements.

Providers for which provider credentialing applies. Simply state "all in-network providers must be credentialed" and

nothing else if that is the case.

Step 1: Describe the NQTL’s requirements and associated procedures

Describe the procedures the plan or issuer uses to determine whether and when to require specialized certifications in the absence of an applicable license. Include each step, associated triggers, timelines, forms and requirements.

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 2: Identify factors.

Demonstrate that the factors used to determine whether and when to require specialized certification in the absence of an applicable license for mental health/substance use disorder (MH/SUD) providers are comparable to the factors used to determine when to require specialized certification in the absence of an applicable license for medical/surgical (M/S) providers. List factors considered but rejected.

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 3: Identify and describe evidentiary standards and other evidence relied upon.

Demonstrate that the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements are for MH/SUD providers are comparable to and applied no more stringently than the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements

for M/S providers. List evidentiary standards considered but rejected.

- What standards or evidence support(s) the rationale for applying the certification requirement to the(se) benefit(s) (e.g., practice guidelines, published research, data analysis, statistics)?

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 4: Comparative analysis of as written processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used to design the certification approval protocol, as written, and any as written processes and strategies used to apply the NQTL for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used to design the certification approval protocol, as written, and any processes and strategies used to apply the NQTL for M/S providers.

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 5: Comparative analysis of in operation processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the certification approval protocol for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used in operationalizing the certification approval protocol for M/S providers.

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 6: Summary conclusion of how plan or issuer has determined overall compliance.

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to establish certification requirements for MH/SUD providers are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to establish certification requirements for M/S providers in each classification of benefits.

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Retrospective Review

List benefits/services subject to retrospective review.

Step 1: Describe the NQTL’s requirements and associated procedures

Describe the procedures the plan or issuer uses to determine whether and when to require specialized certifications in the absence of an applicable license. Include each step, associated triggers, timelines, forms and requirements.

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 2: Identify factors.

Demonstrate that the factors used to determine whether and when to require specialized certification in the absence of an applicable license for mental health/substance use disorder (MH/SUD) providers are comparable to the factors used to determine when to require specialized certification in the absence of an applicable license for medical/surgical (M/S) providers. List factors considered but rejected.

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 3: Identify and describe evidentiary standards and other evidence relied upon.

Demonstrate that the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements are for MH/SUD providers are comparable to and applied no more stringently than the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements for M/S providers. List evidentiary standards considered but rejected.

- What standards or evidence support(s) the rationale for applying the certification requirement to the(se) benefit(s) (e.g., practice guidelines, published research, data analysis, statistics)?

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 4: Comparative analysis of as written processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used to design the certification approval protocol, as written, and any as written processes and strategies used to apply the NQTL for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used to design the certification approval protocol, as written, and any processes and strategies used to apply the NQTL for M/S providers.

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 5: Comparative analysis of in operation processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the certification approval protocol for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used in operationalizing the certification approval protocol for M/S providers.

Simply insert “same as _____” whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 6: Summary conclusion of how plan or issuer has determined overall compliance.

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to establish certification requirements for MH/SUD providers are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to establish certification requirements for M/S providers in each classification of benefits.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Usual, Customary and Reasonable (UCR) Rate Determination

Under which circumstances are providers paid the UCR?

Step 1: Describe the NQTL's requirements and associated procedures

Describe the procedures the plan or issuer uses to determine whether and when to require specialized certifications in the absence of an applicable license. Include each step, associated triggers, timelines, forms and requirements.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 2: Identify factors.

Demonstrate that the factors used to determine whether and when to require specialized certification in the absence of an applicable license for mental health/substance use disorder (MH/SUD) providers are comparable to the factors used to determine when to require specialized certification in the absence of an applicable license for medical/surgical (M/S) providers. List factors considered but rejected.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 3: Identify and describe evidentiary standards and other evidence relied upon.

Demonstrate that the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements are for MH/SUD providers are comparable to and applied no more stringently than the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements for M/S providers. List evidentiary standards considered but rejected.

- What standards or evidence support(s) the rationale for applying the certification requirement to the(se) benefit(s) (e.g., practice guidelines, published research, data analysis, statistics)?

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 4: Comparative analysis of as written processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used to design the certification approval protocol, as written, and any as written processes and strategies used to apply the NQTL for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used to design the certification approval protocol, as written, and any processes and strategies used to apply the NQTL for M/S providers.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 5: Comparative analysis of in operation processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the certification approval protocol for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used in operationalizing the certification approval protocol for M/S providers.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 6: Summary conclusion of how plan or issuer has determined overall compliance.

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to establish certification requirements for MH/SUD providers are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to establish certification requirements for M/S providers in each classification of benefits.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Unlicensed/uncertified Practitioners or Staff

Service provisions by unlicensed/uncertified practitioners:

Benefit/services(s) for which the plan or issuer allows service provisions by unlicensed/uncertified practitioners or staff. The NQTL analysis will involve the comparison of the requirements, processes, and procedures that apply to the provision of services by unlicensed/uncertified providers.

Step 1: Describe the NQTL's requirements and associated procedures

Describe the procedures the plan or issuer uses to determine whether and when to require specialized certifications in the absence of an applicable license. Include each step, associated triggers, timelines, forms and requirements.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 2: Identify factors.

Demonstrate that the factors used to determine whether and when to require specialized certification in the absence of an applicable license for mental health/substance use disorder (MH/SUD) providers are comparable to the factors used to determine when to require specialized certification in the absence of an applicable license for medical/surgical (M/S) providers. List factors considered but rejected.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 3: Identify and describe evidentiary standards and other evidence relied upon.

Demonstrate that the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements are for MH/SUD providers are comparable to and applied no more stringently than the evidentiary standard(s) used to define a factor or other evidence relied upon to establish the certification requirements for M/S providers. List evidentiary standards considered but rejected.

- What standards or evidence support(s) the rationale for applying the certification requirement to the(se) benefit(s) (e.g., practice guidelines, published research, data analysis, statistics)?

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 4: Comparative analysis of as written processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used to design the certification approval protocol, as written, and any as written processes and strategies used to apply the NQTL for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used to design the certification approval protocol, as written, and any processes and strategies used to apply the NQTL for M/S providers.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 5: Comparative analysis of in operation processes and strategies.

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the certification approval protocol for MH/SUD providers are comparable to and no more stringently applied than the processes and strategies used in operationalizing the certification approval protocol for M/S providers.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug:

Step 6: Summary conclusion of how plan or issuer has determined overall compliance.

Based on the responses provided in the steps above, please clearly summarize the basis for the plan or issuer's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to establish certification requirements for MH/SUD providers are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to establish certification requirements for M/S providers in each classification of benefits.

Simply insert "same as ____" whenever an entry is identical to another entry.

Inpatient:

Outpatient:

If subclassifications are used

Office visit:

Outpatient other:

Emergency:

Prescription drug: