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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

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Table of Contents

A. Executive Summary 2

B. Introduction 4

C. The New York State Medicaid Managed Care, Alternative Benefit Plan, and CHIP Programs 5

D. The State Compliance Assessment Process 7

E. Defining Mental Health and Substance Use Disorders, Medical/ Surgical Conditions, and Benefits 8

F. Mental Health and Substance Use Disorder Benefits Under the New York Medicaid State Plan 10

G. Defining Benefits Classifications and Mapping Benefits to the Classifications 10

H. Financial Requirements 12

I. Quantitative Treatment Limitations 13

J. Nonquantitative Treatment Limitations 15

K. Availability of Information 20

L. State MCO Contract Requirements 20

M. Monitoring Parity Compliance 21

N. Posting of State Parity Compliance Documentation 22

O. Appendix 1: New York State MHPAEA Two Year Workplan 24

P. Appendix 2: MMCP (including ABP) and FFS M/S and MH/SUD Benefits Mapping 25

Q. Appendix 3: Child Health Plus Benefits Mapping 31

R. Appendix 4: MHPAEA Testing Workbook for Financial Requirements 33

S. Appendix 5: MHPAEA Testing Workbook for Quantative Treatment Limitations 49

T. Appendix 6: MHPAEA Nonquantitative Treatment Limitations Instructions and Guidance 65

U. Appendix 7: MHPAEA Testing Workbook for Nonquantitative Treatment Limitations 73

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:

1. Medicaid Managed Care Programs (MMCP);
2. 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,
3. 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 (the 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 (the 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 non-quantitative treatment limitations.

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 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 established; and,
4. Review of State-identified priority nonquantitative treatment limitation matters - medical necessity criteria, prior authorization, concurrent review, and formulary design - did not identify:
    a. any inconsistencies with the tenets of the regulatory test for nonquantitative treatment limitations (NQTL); or
    b. that MCOs for these Programs included nonquantitative limitations which were applied only to mental health and substance use disorder benefits.

However, an informed conclusion and ongoing assurance of MCO compliance by the State is dependent on additional actions regarding the assessment of MCO NQTLs. 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 mental health or substance use disorder 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 benefits and coverage. The State will engage in a verification process to substantiate the information submitted by MCOs regarding the four priority NQTLs included in the first evaluation phase. Thereafter, the State will proceed in a phased approach to conduct NQTL evaluations to assess the application of any NQTL to any covered mental health or substance use disorder benefit. Moreover, the State will codify the documentation requirements stipulated by the NQTL evaluation methodology as part of a MCO's contractual responsibilities. Any necessary corrective actions will be implemented should this additional review process yield noncompliant 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. 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. Further, the State will also conduct informational sessions with providers and provider associations to provide guidance on parity requirements and how potential parity violations can be reported to the State.

B. Introduction

I. The final regulations (42 CFR Parts 438, 440 and 457) governing the application of the MHPAEA to coverage offered by Medicaid Managed Care Organizations (MCOs), Alternative Benefit Plan (contained in MMCP), and the Children's Health Insurance Program, stipulate the requirements these programs must comply with to ensure compliance with MHPAEA.

II. The purpose of this report is to:
    1. Detail the State 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 Managed Care Organizations 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** (MMCP) do not provide the full scope of covered mental health and substance use disorder (MH/SUD) services through its contracted Managed Care Organizations; 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** (ABP) is contained within the MMCP. The full scope of the MH/SUD and medical/surgical (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 (CHIP)- Child Health Plus (CHPlus),** while not a Medicaid program, is governed by a different set of contracts than those that govern MMCPs and the ABP. The CHPlus program 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 the CHIP program and demonstrate parity compliance to CMS.

VI. The NYS 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). 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 explained above, partial-cap Medicaid Managed Long Term Care Plans 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 October 2018, there are currently 16 MCOs operating Mainstream MMCPs, 12 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 MMCPs** 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, authorized in the State's Medicaid Redesign 1115 waiver. HIV SNPs cover all the same services covered by other Medicaid managed care plans, 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 is currently in the process of transitioning additional MH/SUD benefit package services for children into managed care in 2019.

A complete list of the M/S and MH/SUD benefits by classification provided through the MMCP programs is contained in Appendix 2[1]. 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 bifurcation of covered MH/SUD benefits 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.

V. **The NYS Children's Health Insurance Program** is New York State's Children's Health Insurance Program. Children who are New York State

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

residents 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, LLC 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 on 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 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 nonquantitative treatment limitations (NQTLs). Milliman completed the final analysis of the MCO documentation submissions in consultation with State personnel. The State's conclusions and pending actions are presented below.

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

I. Applicable regulations require mental health conditions and substance use disorders, and medical surgical 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. <u>Parity Compliance:</u>
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. <u>Actions Required:</u>
None.

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 Required:**
   None.

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.

*New York 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. <u>Parity Compliance:</u>

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 Required:**
   None. 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 Required:**
   None.

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 MMC 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 Home and Community Based Services, 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:

2. 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.

3. HARP Home and Community Based Services (HCBS) 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 was benign as it only exists 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 Required:**
   The State will immediately address the exceptions to compliance by removing the prohibited limitations. Any needed administrative clarifications regarding the ability to exceed stated limits on smoking cessation will be forthcoming, pending any necessary revisions to State law or the State Plan.

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 programs.

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 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 decided to divide the review of NQTLs into 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. 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 also conducted a webinar for all MCOs to review and explain the nature of and how to complete the NQTL analysis steps, and answered questions from the MCOs about aspects of the analyses. The State walked through a completed example for how an MCO could perform the steps for a selected NQTL. This completed example was provided to each MCO in the same type of worksheet that each MCO had to submit for all the NQTLs under analysis. The State provided ongoing technical assistance for numerous MCOs to help them understand how to complete the worksheets and what information and data they needed to obtain from their subcontracted behavioral health organizations (BHO), if they used one, to complete the comparative analyses.

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.

VI. The State reviewed the initial NQTL analysis worksheets submitted by the MMCPs for Medicaid Managed Care (including the ABP), and CHPlus for the NQTLs of:

1. prior authorization;
2. concurrent review;
3. medical necessity criteria; and
4. formulary design.

VII. Conclusions:

1. **Parity Compliance:**

Overall, the State found MCOs were able to complete the worksheets across all product lines, though, many MCOs required extensive individual technical assistance and explanation[2]. All MCOs submitted requested materials, however, each submission exhibited inconsistencies with the methodology as articulated and/or provided insufficient information to varying degrees.

Based on the MCO NQTL submissions, there did not appear to be any parity compliance violations or discernable difference in reporting between the Programs in these NQTL categories. However, there were several cases where the State identified additional information was required to enable appropriate evaluation of parity.

The analysis of the NQTL workbooks revealed that several of the MCOs were not actively analyzing all of their nonquantitative treatment limitations for parity violations. Based on submission quality, it appeared that some MCOs were conducting this level of parity testing for the first time. Therefore, the State will address the quality of documentation and analysis to improve the accuracy of future monitoring and evaluation of parity.

Other additional findings:

i. The CHPlus contractor category did not yield any differential results.

[2] One MCO, small in covered lives magnitude (6,500), missed the workbook submission deadline and therefore is not included in this analysis; the plan's submission remains under review.

ii. The formulary design submissions across the three categories were the most comprehensive and consistent with the methodology and, as noted, did not yield any indications of NQTL parity issues.

iii. Across the Programs analyzed, all MCOs provided evidence that their in-operation processes for the NQTLs examined were comparable in design and function for MH/SUD and M/S. The State will collect further information to verify the results of this analysis, given the following observations:

- An MCO, without a behavioral health subcontractor, used inter-rater reliability audits to determine in-operation comparability and stringency, a best practice approach for testing prior authorization and concurrent review. However, the threshold set for acceptable performance for MH/SUD is 85 percent whereas for M/S it is 90 percent. The State has identified this may indicate a slight, but perceptible instance of prior authorization and concurrent review being applied more stringently and is considering what action it may take to address this finding.
- There were instances in which an MCO provided a sufficient response about its in-operation processes, but it could not be confirmed through the information submitted that the MCO testing of the in-operation component of the analysis was rigorous enough to adequately assert that the NQTL for MH/SUD was applied no more stringently than for M/S.

2. **Actions Required:**

Some of the submitted parity analysis workbooks had inadequate detail to confirm if factors triggering prior authorization and concurrent review are applied similarly and no more stringently to MH/SUD than M/S. The State will provide additional examples of data and metrics that the MCOs should compare going forward to ensure in-operation compliance. Consistent with the CMS commentary that data regarding denial rates across classifications are important information for states to analyze and determine if there are potential issues with parity compliance, the State will also work with MCOs to further integrate use of this data into parity evaluations.

In situations where there is a behavioral health subcontractor, the State will identify additional information and reporting needed to assess

triggering events and service utilization for prior and concurrent review within the same classification of services.

The State will require MCOs to take appropriate corrective action should further investigation result in identifying parity violations related to in-operation processes or NQTL evaluation.

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 Required:**
   While the State 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.

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 Medicaid Managed Care Organizations 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 mental health and substance use disorder 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 State programs stipulated under the CMS criteria for Managed Care contracts.

2. **Actions Required:**
   The State is in the process of amending 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 Required:**
   The State, as part of this overall parity compliance evaluation, is examining potential protocols for these 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 expects the findings from the review process will 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.

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 Required:**
   The analysis and monitoring plan referenced in N. III. 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 2019

Timeframe	Objective
Q1 2019	Parity report submitted to CMS
Q1 2019	Publicly post parity analysis report on Department of Health website
Q1 2019	New services carved in to Children's MMC benefit
Q1 2019	Develop and engage in process to improve/evaluate MCO Phase 1 reports
Q1 2019	Address exceptions of QTL compliance by removing prohibited limitations
Q1 2019	Implement corrective actions for noncompliant NQTLs identified during Phase 1
Q1 2019	Include NQTL evaluation methodology documentation requirements in the State's contracts with MCOs
Q1 2019	Amend MCO contracts for parity clauses, documentation, and reporting for ongoing parity monitoring
Q1 2019	Develop a formal parity compliance ongoing monitoring plan beyond the first two years
Q2 2019	Begin Phase 2 of NQTL testing - distribute instructions and workbooks to MCOs
Q2 2019	Conduct webinars for Phase 2 NQTL testing
Q2 2019	Develop assessment tools for MCO concurrent review
Q2 2019	Conduct parity requirements and violation reporting info sessions with providers and associations
Q2 2019	Deadline for Phase 2 workbook submissions
Q3 2019	Complete analysis of Phase 2 workbooks
Q3 2019	Develop plan to further classify BH schemes and/or assignment of benefits
Q3 2019	Provide additional examples of data and metrics MCO may use to support in-operation compliance
Q3 2019	Review/augment specific parity compliance protocols for use during State operational surveillance of MCOs
Q3 2019	Implement necessary corrective actions for noncompliant NQTLs identified during Phase 2
Q4 2019	Begin Phase 3 of NQTL testing - distribute instructions and workbooks to MCOs
Q4 2019	Initiate parity field audits to test for in-operation components of NQTLs
Q4 2019	Conduct webinars for Phase 3 NQTL testing
Q4 2019	Deadline for Phase 3 workbook submissions
Q1 2020	Complete analysis of Phase 3 workbooks
Q1 2020	Continue to review and assess MCO compliance with parity via workbooks submissions
Q1 2020	Evaluate parity compliance protocols and continue State operational surveillance of MCOs
Q2 2020	Integrate overall State behavioral health service delivery monitoring across classifications into parity evaluations
Q2 2020	Implement necessary corrective actions for noncompliant NQTLs identified during Phase 3
Q3 2020	Summarize and report all findings from parity analysis
Q3 2020	Finalize a plan for the ongoing monitoring of parity for government sponsored programs in New York State

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 SNIP:**
	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 procedures precedes effective date of enrollment	Inpatient Hospital Services when admit date procedures 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, and42 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" form 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.

MHP Quantitative Analysis: Inpatient Classifications (INN, OON)

Insurer: *[Insurer Name]*
Product: *[Product Name]*
State or SERFF Tracking Number: *[PF-2018-xxxxx]*
Plan: *[2019 Plan Name]*

Last updated: MM/DD/2018

Inpatient	In-Network						Out-of-Network *(leave blank if plan has no OON coverage, such as an EPO)*					
Medical/Surgical Benefits and Services	INN Cost Sharing	INN Total Allowed Costs	INN Copay	INN Coinsurance	INN Deductible	No Cost Share	OON Cost Sharing	OON Total Allowed Costs	OON Copay	OON Coinsurance	OON Deductible	No Cost Share

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

	In-Network				Out-of-Network			
Substantially All Analysis (≥2/3)	Total		%	Result	Substantially All Analysis (≥2/3)	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	In-Network				OON Copay	Out-of-Network		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	Total Allowed Costs	Predominance	Result
			NA				NA	
			NA				NA	
			NA				NA	
			NA				NA	
			NA				NA	
Total	**0**				Total	**0**		
INN Coins	In-Network				OON Coins	Out-of-Network		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	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		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	`	Predominance	Result
			NA				NA	
			NA				NA	
			NA				NA	
			NA				NA	
Total	**0**				Total	**0**		

MHP Quantitative Analysis: Outpatient Classifications (INN, OON)

Insurer/Product: *[Insurer Name], [Product Name]*
State Tracking No.: *[PF-2018-xxxxx]*
Plan: *[2019 Plan Name]*
Outpatient Analysis Sub-Classified? *[Yes or No]* *Please select Yes or No from the drop-down list*

Last updated: MM/DD/2018

Outpatient	In-Network						Out-of-Network *(leave blank if plan has no OON coverage, such as an EPO)*					
Medical/Surgical Benefits and Services	INN Cost Sharing	INN Total Allowed Costs	INN Copay	INN Coinsurance	INN Deductible	No Cost Share	OON Cost Sharing	OON Total Allowed Costs	OON Copay	OON Coinsurance	OON Deductible	No Cost Share

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

	In-Network				Out-of-Network			
Substantially All Analysis (≥2/3)	Total		%	Result	Substantially All Analysis (≥2/3)	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	In-Network			OON Copay	Out-of-Network		
Not Applicable	Total Allowed Costs	Predominance	Result	*Not Applicable*	Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	**0**			Total	**0**		
INN Coins	In-Network			OON Coins	Out-of-Network		
Not Applicable	Total Allowed Costs	Predominance	Result	*Not Applicable*	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		
Not Applicable	Total Allowed Costs	Predominance	Result	*Not Applicable*	Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	**0**			Total	**0**		

MHP Quantitative Analysis: Outpatient Office Visit Sub-Classifications (INN, OON)

Insurer/Product: *[Insurer Name], [Product Name]*
State Tracking No.: *[PF-2018-xxxxx]*
Plan: *[2019 Plan Name]*
Outpatient Analysis Sub-Classified? *[Yes or No]* *Please return to the Outpatient tab and select Yes or No from the drop-down list*

Last updated: MM/DD/2018

Outpatient - Office Visits	In-Network						Out-of-Network (leave blank if plan has no OON coverage, such as an EPO)					
Medical/Surgical Benefits and Services	INN Cost Sharing	INN Total Allowed Costs	INN Copay	INN Coinsurance	INN Deductible	No Cost Share	OON Cost Sharing	OON Total Allowed Costs	OON Copay	OON Coinsurance	OON Deductible	No Cost Share

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

	In-Network				Out-of-Network			
Substantially All Analysis (≥2/3)	Total		%	Result	Substantially All Analysis (≥2/3)	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	In-Network				OON Copay	Out-of-Network		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	Total Allowed Costs	Predominance	Result
			NA				NA	
			NA				NA	
			NA				NA	
			NA				NA	
			NA				NA	
Total	**0**				Total	**0**		
INN Coins	In-Network				OON Coins	Out-of-Network		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	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		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	Total Allowed Costs	Predominance	Result
			NA				NA	
			NA				NA	
			NA				NA	
			NA				NA	
Total	**0**				Total	**0**		

MHP Quantitative Analysis: All Other Outpatient Items and Services Sub-Classifications (INN, OON)

Insurer/Product: *[Insurer Name], [Product Name]*
State Tracking No.: *[PF-2018-xxxxx]*
Plan: *[2019 Plan Name]*
Outpatient Analysis Sub-Classified? *[Yes or No]* *Please return to the Outpatient tab and select Yes or No from the drop-down list*

Last updated: MM/DD/2018

Outpatient - All Other Items and Services	In-Network						Out-of-Network (leave blank if plan has no OON coverage, such as an EPO)					
Medical/Surgical Benefits and Services	INN Cost Sharing	INN Total Allowed Costs	INN Copay	INN Coinsurance	INN Deductible	No Cost Share	OON Cost Sharing	OON Total Allowed Costs	OON Copay	OON Coinsurance	OON Deductible	No Cost Share

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

	In-Network				Out-of-Network			
Substantially All Analysis (≥2/3)	Total		%	Result	Substantially All Analysis (≥2/3)	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	In-Network				OON Copay	Out-of-Network		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	Total Allowed Costs	Predominance	Result
			NA				NA	
			NA				NA	
			NA				NA	
			NA				NA	
			NA				NA	
Total	**0**				Total	**0**		
INN Coins	In-Network				OON Coins	Out-of-Network		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	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		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	Total Allowed Costs	Predominance	Result
			NA				NA	
			NA				NA	
			NA				NA	
			NA				NA	
Total	**0**				Total	**0**		

MHP Quantitative Analysis: Emergency Care Classification

Insurer/Product: *[Insurer Name], [Product Name]*
State Tracking No.: *[PF-2018-xxxxx]*
Plan: *[2019 Plan Name]*
Different MH/SUD Cost Sharing? *[Yes or No]* *Please select Yes or No from the drop-down list*

Last updated: MM/DD/2018

Emergency Care	**In-Network & Out-of-Network (OON ER cost sharing must be same as INN. Ins. C. § 10112.7)**					
Medical/Surgical Benefits and Services	**Cost Sharing**	**INN and OON Total Allowed Costs**	**Copay**	**Coinsurance**	**Deductible**	**No Cost Share**

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		

	In-Network & Out-Of-Network		
Substantially All Analysis (≥2/3)	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		
Not Applicable	Total Payments	Predominance	Result
		NA	
		NA	
		NA	
		NA	
		NA	
Total	0		
Coins	In-Network & Out-Of-Network		
Not Applicable	Total Payments	Predominance	Result
		NA	
		NA	
		NA	
		NA	
Total	0		
Ded	In-Network & Out-Of-Network		
Not Applicable	Total Payments	Predominance	Result
		NA	
		NA	
		NA	
		NA	
Total	0		

MHP Quantitative Analysis: Prescription Drugs Classification

Insurer/Product: *[Insurer Name], [Product Name]*

State Tracking No.: *[PF-2018-xxxxx]*

Plan: *[2019 Plan Name]*

Rx Tiers without regard to MH/SUD status? *[Yes or No]*

Please select Yes or No from the drop-down list. Please refer to the special rule in 42 CFR § 438.910(c)(2)(ii).

Note: Complete the Prescription Drugs workbook if necessary. See special rule in 42 CFR § 438.910(c)(2)(ii). Please note the Department may request this analysis in the future if it determines it to be necessary.

Last updated: MM/DD/2018

Prescription Drugs	**In-Network and Out-of-Network**					
Medical/Surgical Benefits and Services	**Cost Sharing**	**INN and OON Total Allowed Costs**	**Copay**	**Coinsurance**	**Deductible**	**No Cost Share**

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

	In-Network & Out-Of-Network		
Substantially All Analysis (≥2/3)	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		
Not Applicable	Total Payments	Predominance	Result
		NA	
		NA	
		NA	
		NA	
		NA	
Total	**0**		
Coins	In-Network & Out-Of-Network		
Not Applicable	Total Payments	Predominance	Result
		NA	
		NA	
		NA	
		NA	
Total	**0**		
Ded	In-Network & Out-Of-Network		
Not Applicable	Total Payments	Predominance	Result
		NA	
		NA	
		NA	
		NA	
Total	**0**		

S. Appendix 5: MHPAEA Testing Workbook for Quantative 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, and42 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" form 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.

MHP Quantitative Analysis: Inpatient Classifications (INN, OON)

Insurer: *[Insurer Name]*
Product: *[Product Name]*
State or SERFF Tracking Number: *[PF-2018-xxxxx]*
Plan: *[2019 Plan Name]*

Last updated: MM/DD/2018

Inpatient	**In-Network**					**Out-of-Network** ***(leave blank if plan has no OON coverage, such as an EPO)***					
Medical/Surgical Benefits and Services	**Limitations**	**INN Total Allowed Costs**	**Day limits**	**Episode limits**	**No limits**	**OON Limitations**	**OON Total Allowed Costs**	**Day limits**	**Episode limits**	**Other limits**	**No Limits**

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

	In-Network					Out-of-Network			
Substantially All Analysis (≥2/3)	Total		%	Result	Substantially All Analysis (≥2/3)	Total		%	Result
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		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	Total Allowed Costs	Predominance	Result
	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		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	Total Allowed Costs	Predominance	Result
	NA NA NA		NA			NA NA NA	NA	
Total		0			Total		0	
INN Other limit	In-Network				OON Other limit	Out-of-Network		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	`	Predominance	Result
			#REF!	#REF!			#REF!	#REF!
			#REF!	#REF!			#REF!	#REF!
			#REF!	#REF!			#REF!	#REF!
			#REF!	#REF!			#REF!	#REF!
Total	#REF!				Total	#REF!		

MHP Quantitative Analysis: Outpatient Classifications (INN, OON)

Insurer/Product: *[Insurer Name], [Product Name]*
State Tracking No.: *[PF-2018-xxxxx]*
Plan: *[2019 Plan Name]*
Outpatient Analysis Sub-Classified? *[Yes or No]* *Please select Yes or No from the drop-down list*

Last updated: MM/DD/2018

Outpatient	In-Network						Out-of-Network *(leave blank if plan has no OON coverage, such as an EPO)*					
Medical/Surgical Benefits and Services	INN Limits	INN Total Allowed Costs	INN visit limits	INN episode limits	INN other limits	No limits	OON Cost Sharing	OON Total Allowed Costs	OON Visit limits	OON episode limits	OON other limits	No limits

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

	In-Network				Out-of-Network			
Substantially All Analysis (≥2/3)	Total		%	Result	Substantially All Analysis (≥2/3)	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	In-Network				OON visit limits	Out-of-Network		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	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		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	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		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	Total Allowed Costs	Predominance	Result
			NA				NA	
			NA				NA	
			NA				NA	
			NA				NA	
Total	**0**				Total	**0**		

MHP Quantitative Analysis: Outpatient Office Visit Sub-Classifications (INN, OON)

Insurer/Product: *[Insurer Name], [Product Name]*
State Tracking No.: *[PF-2018-xxxxx]*
Plan: *[2019 Plan Name]*
Outpatient Analysis Sub-Classified? *[Yes or No]* *Please return to the Outpatient tab and select Yes or No from the drop-down list*

Last updated: MM/DD/2018

Outpatient - Office Visits	In-Network						Out-of-Network (leave blank if plan has no OON coverage, such as an EPO)					
Medical/Surgical Benefits and Services	INN limits	INN Total Allowed Costs	INN visit limits	INN episode limits	INN other limits	No Cost Share	OON limits	OON Total Allowed Costs	OON visit limits	OON episode limits	OON other limits	No Cost Share

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

	In-Network				Out-of-Network			
Substantially All Analysis (≥2/3)	Total		%	Result	Substantially All Analysis (≥2/3)	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	In-Network			OON visit limits	Out-of-Network		
Not Applicable	Total Allowed Costs	Predominance	Result	*Not Applicable*	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		
Not Applicable	Total Allowed Costs	Predominance	Result	*Not Applicable*	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		
Not Applicable	Total Allowed Costs	Predominance	Result	*Not Applicable*	Total Allowed Costs	Predominance	Result
		NA				NA	
		NA				NA	
		NA				NA	
		NA				NA	
Total	**0**			Total	**0**		

MHP Quantitative Analysis: All Other Outpatient Items and Services Sub-Classifications (INN, OON)

Insurer/Product: *[Insurer Name], [Product Name]*
State Tracking No.: *[PF-2018-xxxxx]*
Plan: *[2019 Plan Name]*
Outpatient Analysis Sub-Classified? *[Yes or No]* *Please return to the Outpatient tab and select Yes or No from the drop-down list*

Last updated: MM/DD/2018

Outpatient - All Other Items and Services	In-Network						Out-of-Network (leave blank if plan has no OON coverage, such as an EPO)					
Medical/Surgical Benefits and Services	**INN limits**	**INN Total Allowed Costs**	**INN Visit Limits**	**INN Episode Limits**	**INN Other Limits**	**No Limits**	**OON Limits**	**OON Total Allowed Costs**	**OON Visit Limits**	**OON Episode Limits**	**OON Other Limits**	**No Limits**

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

	In-Network				Out-of-Network			
Substantially All Analysis (≥2/3)	Total		%	Result	Substantially All Analysis (≥2/3)	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	In-Network				OON Visit limits	Out-of-Network		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	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		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	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		
Not Applicable	Total Allowed Costs		Predominance	Result	*Not Applicable*	Total Allowed Costs	Predominance	Result
			NA				NA	
			NA				NA	
			NA				NA	
			NA				NA	
Total	**0**				Total	**0**		

MHP Quantitative Analysis: Emergency Care Classification

Insurer/Product: *[Insurer Name], [Product Name]*
State Tracking No.: *[PF-2018-xxxxx]*
Plan: *[2019 Plan Name]*
Different MH/SUD limits *[Yes or No]* *Please select Yes or No from the drop-down list*

Last updated: MM/DD/2018

Emergency Care	In-Network & Out-of-Network (OON ER cost sharing must be same as INN. Ins. C. § 10112.7)					
Medical/Surgical Benefits and Services	Limits	INN and OON Total Allowed Costs	Day Limits	Episode Limits	Other limits	No Limits

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		

	In-Network & Out-Of-Network		
Substantially All Analysis (≥2/3)	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		
Not Applicable	Total Payments	Predominance	Result
		NA	
		NA	
		NA	
		NA	
		NA	
Total	**0**		
Episode limits	In-Network & Out-Of-Network		
Not Applicable	Total Payments	Predominance	Result
		NA	
		NA	
		NA	
		NA	
Total	**0**		
Other limits	In-Network & Out-Of-Network		
Not Applicable	Total Payments	Predominance	Result
		NA	
		NA	
		NA	
		NA	
Total	**0**		

MHP Quantitative Analysis: Prescription Drugs Classification

Insurer/Product: *[Insurer Name], [Product Name]*

State Tracking No.: *[PF-2018-xxxxx]*

Plan: *[2019 Plan Name]*

Rx Tiers without regard to MH/SUD status? *[Yes or No]*

Please select Yes or No from the drop-down list. Please refer to the special rule in 42 CFR § 438.910(c)(2)(ii).

Note: Complete the Prescription Drugs workbook if necessary. See special rule in 42 CFR § 438.910(c)(2)(ii). Please note the Department may request this analysis in the future if it determines it to be necessary.

Last updated: MM/DD/2018

Prescription Drugs Medical/Surgical Benefits and Services	In-Network and Out-of-Network Limits	INN and OON Total Allowed Costs	Refill limits	Other limits	No limits

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

	In-Network & Out-Of-Network		
Substantially All Analysis (≥2/3)	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		
Not Applicable	Total Payments	Predominance	Result
		NA	
		NA	
		NA	
		NA	
		NA	
Total	**0**		
Other limits	In-Network & Out-Of-Network		
Not Applicable	Total Payments	Predominance	Result
		#REF!	#REF!
		#REF!	#REF!
		#REF!	#REF!
		#REF!	#REF!

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

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

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**
Prior Authorization	Provide the documenation 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
Column 1 - Prompt	**Inpatient Benefits** **Column 2 - Inpatient Benefits**
Benefit/Service(s) to which prior authorization applies.	[List the services to which prior authorization applies]
Step 1: Describe the NQTL's requirements and associated procedures	
• 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]
Step 2: Describe the reason for applying the NQTL	
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. Examples of factors for determining that prior authorization is appropriate 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 condition • Examples of sources for data to identify factors: □ Internal claims analyses □ Internal quality standard studies □ Expert medical review	[Provide the Step 2 documentation]
Step 3: Identify and describe evidentiary standards and other evidence relied upon	
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. 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. Examples of evidentiary standards and their sources are provided in the toolkit.	[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 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. 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 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. 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 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 authorizaiton is imposed.	[Provide the Step 6 documentation]

Outpatient Benefits		Emergency Benefits		Prescription Drugs
Column 3 - Outpatient Benefits		**Column 4 - Emergency Benefits**		**Column 5 - Prescription Drugs**
[List the services to which prior authorization applies]		[List the services to which prior authorization applies]		[List the services to which prior authorization applies]
[Provide the Step 1documentation 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 2 documentation]		[Provide the Step 2 documentation]		[Provide the Step 2 documentation]
[Provide the Step 3 documentation]		[Provide the Step 3 documentation]		[Provide the Step 3 documentation]
[Provide the Step 4 documentation]		[Provide the Step 4documentation]		[Provide the Step 4 documentation]
[Provide the Step 5 documentation]		[Provide the Step 5 documentation]		[Provide the Step 5 documentation]
[Provide the Step 6 documentation]		[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. 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 documenation 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

Column 1 - Prompt	**Inpatient Benefits** **Column 2 - Inpatient Benefits**
Benefit/Service(s) to which concurrent review applies.	[List the services to which concurrent review applies]
Step 1: Describe the NQTL's requirements and associated procedures	
• 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]
Step 2: Describe the reason for applying the NQTL	
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. Examples of factors for determining that concurrent review is appropriate 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 condition • Examples of sources for data to identify factors: □ Internal claims analyses □ Internal quality standard studies □ Expert medical review	[Provide the Step 2 documentation]
Step 3: Identify and describe evidentiary standards and other evidence relied upon	
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. 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. Examples of evidentiary standards and their sources are provided in the toolkit.	[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 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. 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 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. 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 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 authorizaiton is imposed.	[Provide the Step 6 documentation]

Outpatient Benefits	Emergency Benefits	Prescription Drugs
Column 3 - Outpatient Benefits	**Column 4 - Emergency Benefits**	**Column 5 - Prescription Drugs**
[List the services to which concurrent review applies]	[List the services to which concurrent review applies]	[List the services to which concurrent review applies]
[Provide the Step 1documentation 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 2 documentation]	[Provide the Step 2 documentation]	[Provide the Step 2 documentation]
[Provide the Step 3 documentation]	[Provide the Step 3 documentation]	[Provide the Step 3 documentation]
[Provide the Step 4 documentation]	[Provide the Step 4documentation]	[Provide the Step 4 documentation]
[Provide the Step 5 documentation]	[Provide the Step 5 documentation]	[Provide the Step 5 documentation]
[Provide the Step 6 documentation]	[Provide the Step 6 documentation]	[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 necesssity 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 documenation 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
Column 1 - Prompt	**Inpatient Benefits** **Column 2 - Inpatient Benefits**
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]
Step 1: Describe the NQTL's requirements and associated procedures	
NA (proceed to steps 3-6)	N/A
Step 2: Describe the reason for applying the NQTL	
NA (proceed to steps 3-6)	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. 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.	[Provide the Step 3 documentation]
Step 4: Processes and strategies used to design the medical necessity criteria as written	
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. 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 the medical necessity criteria in operation	
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. 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. A key indicator for determining if the medical necessity criteria has been applied comparaby and no more stringently may be an examination and comparison of interrater reliability audits for MH/SUD and medical/surgical utilzation reviewers.	[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 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 reveiw is performed involving the use of the medical necessity criteria.	[Provide the Step 6 documentation]

Outpatient Benefits		Emergency Benefits		Prescription Drugs
Column 4 - Outpatient Benefits		Column 4 - Emergency Benefits		Column 5 - Prescription Drugs
[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]
N/A		N/A		N/A
N/A		N/A		N/A
[Provide the Step 3 documentation]		[Provide the Step 3 documentation]		[Provide the Step 3 documentation]
[Provide the Step 4 documentation]		[Provide the Step 4documentation]		[Provide the Step 4 documentation]
[Provide the Step 5 documentation]		[Provide the Step 5 documentation]		[Provide the Step 5 documentation]
[Provide the Step 6 documentation]		[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 *(as noted in NQTL List)*	
Forumulary Design	

Column 1 - Prompt	Prescription Drugs Column 2 - Prescription Drugs
N/A proceed to step 1	N/A
Step 1: Describe the NQTL's requirements and associated procedures	
• 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?	[Provide the Step 1 documentation and answer the question]
Step 2: Describe the reason for applying the NQTL	
Provide the comparative analysis demonstrating that comparable factors were used to determine how and wheter 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. Examples of factors for determining how and whether medications will be included on the formulary include (these examples are merely illustrative and not exhaustive): □ contract requirement □ Recent prescription drug cost escalation □ Lack of adherence to quality standards in prescribing □ High levels of variation in prescribing practices □ High variability in cost per patient with similar diagnoses □ 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)? Examples of sources include: □ Internal claims analyses □ Internal quality standard studies □ Expert medical review	[Provide the Step 2 documentation]
Step 3: Identify and describe evidentiary standards and other evidence relied upon	
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 bnefits. Describe evidentiary standards that were considered, but rejected.	[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 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. 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 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. 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 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 authorizaiton is imposed	[Provide the Step 6 documentation]