

July 24, 2020

Amber M. Rivers, Director
Office of Health Plan Standards and Compliance Assistance
Employee Benefits Security Administration
Department of Labor
200 Constitution Ave. NW
Washington, DC. 20201

Re: Proposed Updates to 2020 MHPAEA Self-Compliance Tool

Dear Ms. Rivers:

Thank you for the opportunity to provide comments on the Department of Labor’s (DOL) proposed update to the 2020 MHPAEA Self-Compliance Tool. These comments are submitted by The Bowman Family Foundation (BFF) and its tax-exempt subsidiary, the Mental Health Treatment and Research Institute LLC (MHTARI). BFF’s primary mission is to improve the lives of people suffering from mental health and substance use disorders. MHTARI effectuates that mission by funding projects, reports, tools and materials intended to assist regulators, accreditation organizations, employers, third-party administrators and others in (i) assessing access to care, quality of care and the cost of care, (ii) compliance with MHPAEA, and (iii) gaining awareness of evidence-based approaches that can improve behavioral healthcare and reduce total healthcare costs.

BFF and MHTARI strongly support the DOL’s proposal to incorporate into the Self-Compliance Tool recent guidance and supplement compliance examples. The proposed revisions will ensure a more uniform interpretation of commonly applied non-quantitative treatment limitations (NQTLs) and will help consumers and regulators enforce MHPAEA’s protections.

We also believe that each health plan and issuer **must have an internal compliance plan** to meet its legal obligation to “not sell a policy, certificate, or contract of insurance that fails to comply with [parity requirements with respect to aggregate lifetime and annual dollar limits, financial requirements, and quantitative and non-quantitative treatment limitations] ... 29 C.F.R. § 2590.712(h). We respectfully suggest that the proposed MHPAEA Compliance Plan is not sufficient to ensure that issuers and plans meet their legal obligation.

I. Recommended Compliance Framework

A stronger compliance framework is needed to ensure rigorous internal plan review prior to the offering of plans and to relieve regulators and consumers of the heavy and unrealistic burden to identify violations when they have limited or no access to essential plan documents.¹

¹ The Maryland Insurance Administration, for example, stated in an order against United HealthCare for MHPAEA violations of reimbursement rate setting practices, that it “investigated Respondents for **a year and seven months** before it obtained all information it needed to understand how Respondents were developing

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We do not believe that the NAIC Market Conduct template, which is identified as a possible tool for data gathering and compliance review, is adequate. The NAIC tool omits key NQTLs, does not constitute a tool for comparative analysis of compliance, and is less rigorous than templates being adopted by state insurance regulators.² **We urge the DOL to identify the Model Data Request Form (MDRF) in Attachment A, the regulatory version of which is currently being used by at least one state regulator (Washington), and is included in the Parity Draft Rules Data Collection Reporting Form for another state (Texas), as a supplement to its guide for compliance testing and reporting.** The “regulatory” version of the MDRF is termed the Model Data Definitions and Methodology form (MDDM), and both forms mirror each other, being substantively the same other than modifications for use by regulators rather than by employers and their third-party administrators. The MDRF/MDDM has been tested and retested in multiple national analyses including the national Milliman Disparities Reports in 2017 and 2019 as well as the National Alliance of Health Care Purchaser Coalitions audit of 8 large commercial health plans which used several of the data analytics contained in the MDRF. In addition, the MDRF has now been adopted by the eValue8 assessment tool to measure, in a quantitative manner, network access and adequacy. Further, a number of national employers are using the MDRF with their third-party administrators to assess network provider access disparities and other parity compliance measures. URAC’s Parity Accreditation Standards recognize and endorse the MDRF as a best practice.

The MDRF/MDDM contains specific, detailed instructions and definitions designed to elicit targeted, consistent and reliable responses from plans on quantitative measures for determining outcomes disparities related to network adequacy and other NQTLs. In particular, the MDRF/MDDM provides a mechanism for the reporting of disparities in three key areas: 1) Out-of-Network Use; 2) Reimbursement Rates; and 3) Denial Rates (for both utilization review and submitted claims). In addition, the MDRF/MDDM provides a mechanism for reporting Network Provider Directory Accuracy. This section is not intended to evaluate compliance with state or federal network provider directory laws, but is instead a valuable tool for determining the actual use, based on claims data, of the network providers listed in those directories. Actual use (or lack thereof) of providers listed in network directories has a direct bearing on network adequacy under parity. Absent specific definitions and methodology for analysis incorporated in the MDRF/MDDM, plans are simply not able to test or report disparities in outcomes in any kind of a consistent, reliable or meaningful manner.

II. Integration of Recent Guidance and Revision of Compliance Examples

BFF and MHTARI fully support the proposed addition of recent guidance and compliance examples. We are particularly supportive of following additions that clarify standards in the following areas:

- Section B – Coverage in all Classifications:

reimbursement rates for OON [out-of-network] providers.” Maryland Insurance Administration v. Optimum Choice, Inc., United Healthcare Ins. Co., and United Healthcare of the Mid-Atlantic, Case Nos. MIA-2020-04-039, MIA-2020-04-040, and MIA-2020-04-041 (April 21, 2020) at 4 (emphasis added).

² See, e.g., 3 Code Colo. Regs. 702-4:4-2-64 and Appendices (2020).

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- the requirement to cover room and board for MH and SUD residential care on the same basis as coverage of intermediate levels of care for medical/surgical services; and
- the impermissibility of a limitation on the coverage of medications for opioid use disorders absent the availability of psychosocial therapies if similar limitations are not imposed on medical/surgical treatment.
- Section F – Nonquantitative Treatment Limitations:
 - identification of reimbursement rate processes, factors and evidentiary standards that may violate MHPAEA;
 - identification of the need to assess the evidentiary standards used to apply a factor (high cost) in designing NQTLs, such as prior authorization; and
 - identification in the Step 4 compliance tips of the need to check sample claims to evaluate the NQTL in operation.
- Section G – Disclosure Requirements:
 - reinforcement of the plan’s obligation to ensure that the provider directory is up-to-date, accurate and complete.

We offer the following suggested revisions.

- Clarification of the NQTL standard: While the Self-Compliance tool makes clear in most sections that the NQTL analysis requires a plan to demonstrate that it applies both comparable processes, strategies, evidentiary standards and other factors *and* no more stringent application of these elements, a reference to the “no more stringent” application standard should be added to several sections, including:

- Illustration regarding P&T Committee operations (p. 12)
- Internal Quality Control Reports (p. 27)

- Clarification that *Evidentiary Standards* are Separate and Distinct from Sources of Factors and are *Always Employed*: The language in the Self-Compliance tool has seemingly merged the concept of evidentiary standards that define factors, with the concept of sources of factors. See Step Three at p. 25, as follows:

Examples of sources of factors include, but are not limited to:

- Internal claims analysis;
- Medical expert reviews;
- State and Federal requirements;
- National accreditation standards;
- Internal market and competitive analysis;
- Medicare physician fee schedules; and
- Evidentiary standards, including any published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits.

The proposed language contained in the Note under Step Three at p. 25 states that “plans and issuers have flexibility in determining the sources of factors to apply to NQTLs (including whether or not to employ evidentiary standards)...” This note suggests that a plan need not employ evidentiary standards when defining the factors used to design an NQTL. **We do not agree with this analysis and recommend that this Note be removed.**

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Evidentiary standards used to define a factor may be qualitative or quantitative in nature. Evidentiary standards may differ depending on the NQTL; however, a plan **will always employ** some type of “evidentiary standard” in order to define each factor relied upon in imposing an NQTL. The source of a factor may also involve a process and/or strategy; however, there must **always be an evidentiary standard that defines a factor**. No factor can have tangible meaning, nor can be compared unless and until it is defined by a quantitative or qualitative evidentiary standard. To take the example provided in the Note on p. 25:

NOTE: Plans and issuers have flexibility in determining the sources of factors to apply to NQTLs (including whether or not to employ evidentiary standards), as long as they are applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits. For example, a plan utilizes a panel of medical experts, with equivalent expertise in both medical/surgical and MH/SUD benefits, to assess whether preauthorization (an NQTL) is appropriate to apply to certain services, **based on the factors of cost and safety**. The panel recommends that the plan require preauthorization for electroconvulsive therapy (ECT), because ECT is **high cost and has legitimate safety concerns**. The plan does not require documentation or studies to support these concerns and instead relies on **established medical best practices**. As long as the plan similarly relies on **established medical best practices due to high cost and legitimate safety concerns** to impose preauthorization requirements on medical/surgical benefits in the same classification, then the NQTL is applied comparably and no more stringently to MH/SUD benefits than to medical/surgical.

Here, with respect to the use of a panel of medical experts applying “established medical best practices” for applying the factors of high cost and safety concerns, the “established medical best practices,” as well as “high cost” and “safety concerns” must be defined by evidentiary standards in order to have any meaning or be susceptible to comparison. Regardless of whether a factor is defined quantitatively by thresholds or other numerical values, or qualitatively by other means, **ALL FACTORS MUST BE DEFINED BY EVIDENTIARY STANDARD(S)**.

In the example provided in the Note above, the failure of the plan to identify some basis on which to determine that “established medical best practices” for determining that ECT is “high cost and has legitimate safety concerns” is, in fact, an established best practice would prevent differentiating between practices that merely further the carrier’s intended result and those that are accepted best practices based on objective and verifiable criteria, such as published literature. The *Wit v. United Behavioral Health* decision makes clear that carriers sometimes adopt an NQTL (i.e. medical necessity criteria) that does not conform to generally accepted medical standards, even though the carrier asserts otherwise. For purposes of an NQTL parity analysis, United Behavioral Health would have been required to identify the evidentiary standards it used to conclude that a set of internally created medical necessity criteria are consistent with accepted medical practices for MH and SUD treatment. The evidence in *Wit* revealed that UBH applied, as its evidentiary standard, the increased cost associated with use of the ASAM criteria rather than medical literature and medical evidence.

Further, the suggestion that an evidentiary standard may not always be employed is inconsistent with other sections of the Self-Compliance Tool and the Departments’ prior regulatory and sub-regulatory guidance. We recommend inclusion in DOL’s guidance of **Best Practice Examples for**

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NQTL Compliance with Regulatory Guidance Embedded in Attachment B, which demonstrate the consistent regulatory guidance with respect to the requirement to identify, analyze and compare evidentiary standards used to define factors, as part of both in writing and in operation NQTL compliance analysis. Absent the required disclosure of evidentiary standards that necessarily define factors, NQTL compliance testing will be implausible and the NQTL rule would be rendered unenforceable.

The following section of the Self-Compliance Tool provides helpful illustrations of evidentiary standards that are quantitative in nature – sometimes referred to as setting thresholds - and exemplifies how, absent the disclosure of such evidentiary standards, NQTL rule compliance could not be determined:

“Examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs include, but are not limited to:

- o Excessive utilization as a factor to design the NQTL when utilization is two standard deviations above average utilization per episode of care.
- o Recent medical cost escalation may be considered as a factor based on internal claims data showing that medical cost for certain services increased 10 percent or more per year for two years.
- o Lack of adherence to quality standards may be considered as a factor when deviation from generally accepted national quality standards for a specific disease category occurs more than 30 percent of the time based on clinical chart reviews.
- o High level of variation in length of stay may be considered as a factor when claims data shows that 25 percent of patients stayed longer than the median length of stay for acute hospital episodes of care.
- o High variability in cost per episode may be considered as a factor when episodes of outpatient care are two standard deviations higher in total cost than the average cost per episode 20 percent of the time in a 12-month period.
- o Lack of clinical efficacy may be considered as a factor when more than 50 percent of outpatient episodes of care for specific diseases are not based on evidence based interventions (as defined by nationally accepted best practices) in a 12- month sample of claims data.”

We recommend that the Self-Compliance Tool include clarifying guidance that when plans use these types of quantitative evidentiary standards, the specific quantitative or numerical values, amounts and/or thresholds must be identified and disclosed as part of the NQTL analysis.

III. Warning Signs

We appreciate the inclusion of the Warning Signs to help plans flag potential violations based on disparate outcome data and the emphasis on specific NQTLs – reimbursement rates, prior authorization requirements for medications for opioid use disorders and authorization for drug

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screening for SUDs – that are used frequently to deny or limit care. We offer the following observations and comments.

Reimbursement Rate Setting and Appendix II Tool³

We agree that Medicare rates are one of the most common evidentiary standards for setting rates and that a comparison of rates for the most frequently used CPT codes is an important starting point for flagging rate setting violations. We have several concerns related to a plan that relies on Medicare rates and note several limitations in the App. II tool.

- Medicare, which is not subject to MHPAEA, does not cover specific provider types that deliver SUD and MH services – including licensed professional counselors – and other facility-based settings that deliver a substantial portion of SUD services. As a result, evidence of rate comparability for the specific providers and CPT codes identified in App. II should not be construed as an indicator of plan compliance for all MH and SUD services.
- The two codes selected for comparison across medical and MH/SUD providers – 99203 and 99213 – cover new and established patients with mid-level complexity and do not examine reimbursement rates for patients with high complexity conditions (CPT Codes 99205 and 99215). A 2017 analysis of Maryland claims data for private commercial insurers revealed far greater disparities in reimbursement for psychiatrists compared to medical and primary care practitioners for patients with high complexity conditions (both new and established) than for patients with mid-complexity conditions. **We recommend that these additional E&M CPT codes be added to the tool to achieve better compliance testing.**

We recommend that DOL clarify that it is not recommending that plans adopt the Medicare fee schedule as a standard, but rather that the guidance illustrates that IF a fee schedule such as Medicare is used, then the guidance with respect to comparability between MH/SUD and medical/surgical is applicable. Further, as previously stated, we strongly recommend guidance that identifies specific instructions, definitions and methods by which to calculate reimbursement rate disparities, such as those set forth in the MDRF. Absent such guidance, it will be impossible to audit or enforce NQTL compliance for this quantitative measure.

We are also concerned that the framing of the Warning Signs suggests that lower reimbursement rates for MH/SUD physicians compared to med/surgical physicians for the same E&M codes could be compliant with MHPAEA. First, it is unclear how **any disparity** between MH/SUD and medical/surgical practitioners could be shown to be parity compliant, since the RVUs for all practitioner types that bill E&M codes are identical, as is the service being delivered. We recognize that a disparate outcome alone is not sufficient to constitute a parity violation and that all factors must be evaluated, including rate differences based on geographical setting. However, disparities data are far more probative of non-compliance with MHPAEA – both as written and in

³ We note that the CPT codes for Occupational Therapy and Physical Therapy have been revised, effective Jan. 1, 2017, and Codes 97001, 97003 and 97004 have been replaced. CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 3654. Available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R3654CP.pdf>. We recommend inclusion of the new codes in App. II.

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operation – than the Warning Signs statement conveys. We recommend that the introductory statement be revised as follows:

Warning Signs: The following plan provisions related to provider reimbursement are ~~may be~~ indicative of noncompliance and warrant further review.

The inclusion of the Warning Signs and additional information about outcomes data raises a separate concern about the final NQTL Compliance Tip (at p. 29). The statement “Do not focus on results” is inconsistent with the requirement that NQTLs be applied “no more stringently,” since outcomes data often reveal standards that are not comparable and more stringently applied. Given the inclusion of additional examples of outcomes data analysis and how disparate outcomes warrant further review of parity compliance, **we recommend that revisions of this phrase would be consistent with the MHPAEA NQTL standard and more effectively guide compliance reviews and enforcement.** We are also concerned about the language in the third sentence of this Compliance Tip. Differences in how a plan or issuer applies processes and strategies do not need to be arbitrary or discriminatory to violate the parity law. The terms arbitrary and discriminatory imply that there are other types of differences that would not raise a red flag or constitute a warning sign. According to DOL’s own guidance, the burden is on plans and issuers to demonstrate NQTL compliance, NOT on the provider or consumer to prove that significant differences are either arbitrary or discriminatory. We recommend the following revision to the Compliance Tip on p. 29 (added language underlined, deleted language stricken through).

Do not focus solely on results. Look at the **underlying processes and strategies** used in applying NQTLs. Are there ~~arbitrary or discriminatory~~ differences in how the plan or issuer is applying those processes and strategies to medical/surgical benefits versus MH/SUD benefits? While results alone are not determinative of non-compliance, measuring results and quantitative outcomes (for example, in assessing in operation comparability and stringency in application) are required and essential to a valid NQTL analysis.

IV. Establishing an Internal MHPAEA Compliance Plan

A. Compliance Plan

We appreciate DOL’s description of common elements of an internal compliance plan and the identification of plan materials that DOL investigators may request in an audit. We are very concerned, however, by the suggestion that an internal compliance plan is *optional* for plans and issuers. **In our view, the implementation of a rigorous compliance plan is the only way in which an issuer or plan can ensure that it is not offering MH and SUD benefits in violation of MHPAEA. 29 C.F.R. § 2590.712(h).** It is well recognized that an enforcement strategy that relies on consumer complaints is not effective because of the complexity of MHPAEA and the lack of access to plan documents and internal decision-making processes. For this reason, a growing number of states are adopting mandatory parity compliance and data reporting requirements to ensure better enforcement of MHPAEA. Any suggestion that federal regulators construe the law as not requiring an internal compliance program would undermine those and future state efforts and hinder uniform implementation of the law. **We urge DOL to remove the phrase “[a]lthough not required by MHPAEA” in the introductory statement to Section H. (at 34).**

B. Data Collection Tool

The DOL has identified the NAIC NQTL chart, developed by the Market Conduct Examination Standards (D) Working Group in 2018, as a template that issuers and plans may wish to use for compliance review purposes. **We urge the DOL to delete the suggestion that the NAIC chart is an appropriate tool for self-compliance review and instead require issuers and plans to base compliance review on the DOL Self-Compliance Tool supplemented with the Model Data Request Form (Attachment A) and the Best Practice Examples for NQTL Compliance with Regulatory Guidance Embedded (Attachment B).**

The NAIC chart is incomplete insofar as it omits key NQTLs including:

- the carrier's standards for network admission
- reimbursement rate setting and methods for determining usual and customary rates and reasonable charges
- network adequacy
- scope of services
- other criteria that limit the scope or duration of benefits (catch-all)

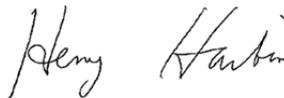
Again, the MDRF is an outcomes data reporting tool with specific and detailed instructions, definitions and methods for obtaining consistent, reliable and credible quantitative disparities outcomes data from plans and issuers. Such outcomes data is invaluable in the auditing and enforcement of NQTLs. Absent this type of recommended reporting tool, NQTL compliance simply cannot be audited or enforced.

Thank you for the opportunity to provide comments. We stand ready to assist and support DOL regarding MHPAEA compliance. Please feel free to contact us at htharbin@aol.com and/or bethannmiddlebrook@gmail.com with any questions.

Sincerely,



Matthias B. Bowman
President
The Bowman Family Foundation
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Henry T. Harbin, M.D.
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MODEL DATA REQUEST FORM (MDRF)
An Employer Tool for Improving In-Network Access for
Mental Health and Substance Use Disorders (MH/SUD)
A Recommendation by the
NATIONAL ALLIANCE OF HEALTHCARE PURCHASER COALITIONS

[Introduction for Employers](#) (The MDRF begins on the following page)

In response to employers' calls for improving in-network access for mental health and substance use disorders, the [Mental Health Treatment and Research Institute LLC](#) ("MHTARI"), a tax-exempt subsidiary of [The Bowman Family Foundation](#), has funded the development of the MDRF for use by self-insured employers. The MDRF provides instructions and data requests that employers can send to their TPAs (or consultants) to obtain meaningful data reporting, set forth in a specified format. This document may be updated from time to time. A current version of the MDRF can be found at http://www.mhtari.org/Model_Data_Request_Form.pdf

The MDRF is intended to allow employers to (a) better understand the experience of their employees when seeking access to MH/SUD providers, (b) assess the adequacy and accuracy of their TPA's MH/SUD provider networks, and (c) request improvements as necessary.

Using the MDRF, employers can have their TPAs report on 4 key parameters as recommended by the [National Alliance of Healthcare Purchaser Coalitions](#) and the [American Psychiatric Association Foundation Center for Workplace Mental Health](#):

- (1) Out-of-Network Use** of MH/SUD providers versus medical/surgical (M/S) providers
- (2) In-Network Reimbursement Rates** for MH/SUD versus M/S providers
- (3) Denial Rates** for MH/SUD versus M/S services
- (4) Network Directory Accuracy for Psychiatrists**

DISCLAIMER - No Legal Advice: The MDRF is made available for informational purposes only and is not intended and should not be construed as providing legal advice. Each situation is highly fact specific. Therefore, each employer or other user ("User") of the MDRF should carefully consider: (1) whether the MDRF would achieve its intended purpose and (2) whether modifications to the MDRF are needed, for example, to address the User's specific circumstances. MHTARI disclaims any and all representations and warranties, express or implied, regarding the MDRF, including without limitation, the ability of the MDRF to achieve its intended purpose.

When sending the MDRF (with appropriate employer-specific modifications, if any) to TPAs or consultants, employers should indicate in a cover letter the health plans ("Specified Plans" including at least one PPO) and geographic regions ("Specified Regions") that should be analyzed. If, for example, 2 Specified Plans and 2 Specified Regions are identified, then 4 separate versions of MDRF tables should be completed, as well as a 5th version containing "aggregate" data.

[End of Introduction. MDRF begins on the following page.](#)

MODEL DATA REQUEST FORM (MDRF)

**An Employer Tool for Improving In-Network Access for
Mental Health and Substance Use Disorders (MH/SUD)**

**A Recommendation by the
NATIONAL ALLIANCE OF HEALTHCARE PURCHASER COALITIONS**

MODEL DATA REQUEST FORM BEGINS HERE.

[To TPA or consultant]:

Would you please provide the plan data analyses set forth below within 60 days of today's date. This information will allow our executives to better understand the experience of our plan members when seeking to access MH/SUD treatment as compared to medical/surgical ("M/S") treatment. For each of the four (4) sections set forth below, please provide the data analyses for the health plans ("Specified Plans") and geographic regions ("Specified Regions") *identified in separate instructional correspondence*. If, for example, there are 2 Specified Plans and 2 Specified Regions, then (unless indicated to the contrary in the detailed instructions below), 4 separate versions of MDRF tables should be completed, plus a 5th version with "aggregate" analysis. Please contact us with any questions.

Please provide all information in a manner compliant with HIPAA's Privacy Rule (45 CFR Part 164) and Confidentiality of Substance Use Disorder Records (42 CFR Part 2), as applicable.

SECTION I: OUT-OF-NETWORK USE (BASED ON CLAIMS ALLOWED)

For the Specified Plans that have Out-of-Network ("OON") benefits, utilizing total claims allowed for both In-Network and Out-of-Network services, complete Table 1 with respect to the percentage of all allowed claims that were for Out-of-Network (OON) services. **Note:** *Claims "allowed" are sometimes referred to as claims "paid", and consist of claims approved for payment by the TPA. In some cases, the actual payment may be the member's responsibility, either in whole or in part (e.g., unmet deductible, copay or coinsurance). However, all claims approved for payment by the TPA are considered "allowed" claims.*

For purposes of this MDRF:

Inpatient facility is defined as a hospital, non-hospital based facility or residential treatment facility and encompasses all medical and surgical admissions to general acute care hospitals, long-term acute care hospitals, inpatient rehabilitation facilities and skilled nursing facilities; all MH/SUD admissions to psychiatric hospitals, general acute care hospitals, non-hospital based inpatient facilities and residential treatment facilities.

Outpatient facility is defined as physical, occupational, speech, and cardiovascular therapy, surgeries, radiology, pathology and pharmacy services for medical or surgical care provided in an outpatient facility setting; intensive outpatient and partial hospitalization services for behavioral health conditions in an outpatient facility setting

Office visit is defined as a non-facility based medical/surgical or MH/SUD office visit.

For Use During 2020
MODEL DATA REQUEST FORM

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Please refer to the following Milliman report for further definitions regarding Out-of-Network analyses:

http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf

Based on the claims for our members, complete a separate version of Table 1 for each Specified Plan with OON benefits in each Specified Region, and for such plans and regions in aggregate.

Table 1 below should be completed with data for Calendar Year 2019, or for the period January 1, 2019, through the latest month in 2019 for which reasonably complete claims data is available.

Table 1 - Plan Data for January 1, 2019 through _____, 2019			
Setting	<u>Column A</u> <u>Medical/Surgical</u> <u>Providers</u> Percentage of all allowed claims that were for OON services	<u>Column B</u> <u>MH/SUD</u> <u>Providers</u> Percentage of all allowed claims that were for OON services	<u>Column C</u> The absolute difference in <u>percentage points</u> between Column A versus Column B
Inpatient Facility Stays	%	%	%
Outpatient Facility Visits	%	%	%
Office Visits	%	%	%

If, in any version of Table 1, the absolute difference in Column C of Out-of-Network use for inpatient facility, outpatient facility or office visits, between M/S services as compared to MH/SUD services, is more than 5 percentage points, with the percentage for MH/SUD being higher (e.g., M/S 2.0% versus MH/SUD 7.1%; or M/S 11.0% versus MH/SUD 16.1%), please provide a Plan of Correction in a separate report within 30 days from the date of your response to this MDRF.

The **Plan of Correction** should include: specific steps you will undertake to reduce OON use of MH/SUD providers, for example: increasing in-network reimbursement rates, by how much and during what time period; reducing utilization review “hassle factors” such as frequency of reviews, time constraints within which peer to peer reviews must be conducted, paperwork (e.g., written treatment plans and updates) not required for M/S providers; overall micromanagement of cases resulting in increased provider administrative costs; length of time it takes for a provider to be credentialed join the network; other delays in network provider admission; restraints on appeals for denied care; etc.

Section I ends here. Section II begins on next page.

For Use During 2020
MODEL DATA REQUEST FORM

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SECTION II: IN-NETWORK REIMBURSEMENT RATES

For In-Network provider office visits only, for the CPT codes provided in Tables 2A and 2B below, and using the methodology described in the instructions set forth below each table, calculate for our plans the weighted average allowed amounts for the following four (4) groups of providers:

- Primary Care Physicians, “PCPs”, defined as general practice, family practice, internal medicine, and pediatric medicine physicians.
- Non-psychiatrist Medical/Surgical Specialist Physicians, defined to include non-psychiatrist specialty physicians, such as orthopedic surgeons, dermatologists, neurologists, etc. This category excludes PCPs.
- Psychiatrists, including child psychiatrists.
- Non-psychiatrist Behavioral Health (“BH”) Professionals, defined as psychologists and clinical social workers.

Based on claims for our members, complete a separate version of Tables 2A and 2B for each Specified Plan in each Specified Region, and for all such plans and regions in aggregate.

All versions of Tables 2A and 2B should be completed with claims data for Calendar Year 2019, or for the period January 1, 2019, through the latest month in 2019 for which reasonably complete claims data is available.

Table 2A - Plan Data for January 1, 2019 through _____, 2019			
Medical/Surgical Physicians compared to Psychiatrists			
	Description	Column A	Column B
	In-Network Office Visits Only (non-facility based)	CPT Code 99213	CPT Code 99214
1	Weighted average allowed amount for primary care physicians (PCPs)	\$	\$
2	Weighted average allowed amount for non-PCP, non-psychiatrist medical/surgical specialist physicians	\$	\$
3	Weighted average allowed amount for PCPs and non-psychiatrist medical/surgical specialist physicians combined	\$	\$
4	Weighted average allowed amount for psychiatrists, including child psychiatrists	\$	\$
5	Ratio of Row 3 to Row 4, expressed as a percentage (Row 3 / Row 4 = __ %)	%	%

Instructions for completing Table 2A follow:

- In Rows 1– 4, insert the weighted average allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for Column A (CPT 99213) and Column

B (99214). This will provide the same result as calculating the sum of the allowed amounts for every claim that was allowed for these providers, and dividing that sum by the total number of claims allowed for such providers.

- In Row 5, insert the ratio of the amount in Row 3 to the amount in Row 4, for both Columns A and B, expressed as a percentage (e.g., $110 / 98 = 112\%$; or $105 / 108 = 97\%$).

Table 2A Comparisons to be conducted:

If, in any version of Table 2A, the ratio in Row 5, Column A and/or. Row 5, Column B is above 100% (indicating that PCPs and non-psychiatrist medical/surgical specialist physicians (combined) receive higher allowed amounts than psychiatrists), provide a Plan of Correction in a separate report within 30 days from the date of your response to this MDRF.

Your **Plan of Correction** should include an explanation of your plan to increase in-network reimbursement rates for psychiatrists (including by how much and during what time period), as an economic incentive for more psychiatrists to join the network.

Please note the following for completion of **Table 2B below**. There is only one National Medicare Physician Fee Schedule allowed amount for all physicians participating in Medicare for the following four (4) CPT codes for which data is requested: *99213, 99214, 90834 and 90837*. The Medicare fee schedule allowed amounts for 2019 for non-facility based services have been provided in the template table that follows.¹ National Medicare fee adjustments are sometimes made for non-physician providers. In this regard, the adjusted fee schedule allowed amount for clinical social workers has been provided in the template table. Provider locality adjustments have not been taken into account for regional markets, as the testing herein is comparative, rather than absolute, and will thus yield useful allowed amount comparative information irrespective of region.

Section II continued on next page.

¹ These amounts can be found at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/> Click on [Medicare Physician Fee Schedule Look-up Tool](#), " accept license for use, select the last complete calendar year, select "Pricing information," select "list of HCPCS codes," select "National payment amount," enter each of the four codes, select "All modifiers," and submit. **Please utilize the "Non-facility Price" column.** Also refer to the one page "[Medicare Physician Fee Schedule \(MPFS\) Quick Reference Search Guide](#)" for a step-by-step summary of how to use the MPFS. Also refer to "Medicare Claims Processing Manual," Chapter 12, "Physicians / Nonphysician Practitioners" to verify any adjustments to the MPFS, at <http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>

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Table 2B - Plan Data for January 1, 2019 through _____, 2019 Medical/Surgical Physicians compared to Psychologists and Clinical Social Workers using Medicare as Benchmark Comparison							
	Description	Col. A	Col. B	Col. C	Col. D	Col. E	
	In-Network Office Visits only (non-facility based)	CPT 99213	CPT 99214	CPT 90834	CPT 90837	Provider allowed amounts relative to National Medicare Fee Schedule Amounts, expressed as a percentage	
1	Plan data: Weighted average allowed amount for primary care physicians (“PCPs”) and non-psychiatrist medical/surgical specialist physicians (combined)	(a) \$	(a) \$			(b) CPT 99213 %	(c) CPT 99214 %
2a	Plan data: Weighted average allowed amount for psychologists			(a) \$	(a) \$	(d) CPT 90834 %	(e) CPT 90837 %
2b	Plan data: Weighted average allowed amount for clinical social workers			(a) \$	(a) \$	(f) CPT 90834 %	(g) CPT 90837 %
3	National Medicare Fee Schedule allowed amount for participating physicians in Row 1	\$75.32	\$110.28				
4a	National Medicare Fee Schedule allowed amount for participating psychologists			\$91.18	\$139.95		
4b	National Medicare Fee Schedule allowed amount for participating clinical social workers			\$68.39	\$104.96		
5a	Ratio of Row 1, Col. E allowed amount to Row 2a, Col. E (Row 1, Col. E / Row 2a, Col. E)					(h) CPT 90834 %	(h) CPT 90837 %
5b	Ratio of Row 1, Col. E allowed amount to Row 2b, Col. E (Row 1, Col. E / Row 2b, Col. E)					(i) CPT 90834 %	(i) CPT 90837 %

Instructions for completing cells marked (a) through (i) of Table 2B follow:

Please do **not** add any data to the other cells in this table. Applicable Medicare allowed amounts have been provided for you in Rows 3, 4a and 4b.

- Cells marked “(a)” = Insert the weighted average allowed amount (weighted by the proportion of claims allowed at each allowed amount level). This will provide the same result as calculating the sum of the allowed amounts for every claim that was allowed for these providers, and dividing that sum by the total number of claims allowed for such providers.
- Cell marked “(b)” = Insert the percentage calculated as: (Row 1 Column A / Row 3 Column A) x 100.

Example 1: If the amount in Row 1 Column A is \$80.09, and the amount in Row 3 Column A is \$75.32, then the percentage is $(80.09 / 75.32) \times 100 = 106\%$.

Example 2: If the amount in Row 1 Column A is \$71.19, and the amount in Row 3 Column A is \$75.32, then the percentage is $(71.19 / 75.32) \times 100 = 95\%$.

- Cell marked “(c)” = Insert the percentage calculated as: (Row 1 Column B / Row 3 Column B) x 100.
- Cell marked “(d)” = Insert the percentage calculated as: (Row 2a Column C / Row 4a Column C) x 100.
- Cell marked “(e)” = Insert the percentage calculated as: (Row 2a Column D / Row 4a Column D) x 100.
- Cell marked “(f)” = Insert the percentage calculated as: (Row 2b Column C / Row 4b Column C) x 100.
- Cell marked “(g)” = Insert the percentage calculated as: (Row 2b Column D / Row 4b Column D) x 100.
- Cells marked “(h)” = Insert the ratio of the amount in Row 1, Column E to the amount in Row 2a, Column E, expressed as a percentage (e.g., $110\% / 98\% = 112\%$, or $105\% / 108\% = 97\%$)
- Cells marked “(i)” = Insert the ratio of the amount in Row 1, Column E to the amount in Row 2b, Column E, expressed as a percentage.

Comparisons to be conducted for Table 2B:

If, in any version of Table 2B, the ratio set forth in Row 5a, Column E and/or in Row 5b, Column E, for CPT 90834 and/or 90837 is above 100%, indicating that PCPs and non-psychiatrist medical/surgical specialist physicians (combined) receive higher allowed amounts relative to the National Medicare Fee Schedule than psychologists and/or clinical social workers, provide a Plan of Correction in a separate report within 30 days from the date of your response to this MDRF.

Your **Plan of Correction** should include an explanation of your plan to increase in-network reimbursement rates for psychologists and/or social workers (including by how much and during what time period), as an economic incentive for more psychologists and/or social workers to join the network.

Section II ends here. Section III begins on next page.

SECTION III: DENIAL RATES

Using the definitions below, in Tables 3A and 3B provide a breakdown of In-Network and Out-of-Network denials for MH/SUD and for M/S services. A **denial** is defined as a refusal to authorize or allow any or all parts of a service requested or performed in any of the following 3 settings: (1) Inpatient facility; (2) Outpatient facility; and (3) Office visits. Please do **not** include as a denial claims for which less than 5% of the cost value of the entire claim was denied. These settings, as well as the term “allow(ed)” are defined in **Section I**. A **denial** is further defined as follows:

Any “modified” authorizations, i.e., for lower-cost services than requested by the provider, are to be considered a denial.

Any “partial denials” i.e., number of days or visits approved are less than what the provider requested, are to be considered a denial unless subsequently approved on concurrent or retrospective review of the full requested number of days or visits.

Please provide information on the number of denials and percent of denials for MH/SUD services compared to M/S services, to be reported separately for (1) lack of medical necessity reasons and (2) administrative reasons, as follows:

(A) Denials for which no claim was submitted (i.e., authorization for coverage of service denied; service either not delivered or self-pay), shown as a percentage (%):

(1) Numerator: Pre-authorization and concurrent review denials based on *lack of medical necessity* for services requested in the particular setting noted.

Denominator: All pre-authorization and concurrent reviews conducted for the particular setting noted.

(2) Numerator: Pre-authorization and concurrent review denials based on *administrative reasons* for services requested in the particular setting noted.

Denominator: All pre-authorization and concurrent reviews conducted for the particular setting noted.

(B) Claim denials (i.e., authorization for coverage of service denied; service delivered; claim submitted and not allowed), shown as a percentage (%) (counted as one denial for each unique claim, not counting denials on resubmissions of the same claim):

(1) Numerator: Claims denied for *lack of medical necessity*, including upon pre-authorization, concurrent review and retrospective review in the particular setting noted.

Denominator: Total claims submitted for the particular setting noted.

(2) Numerator: Claims denied for *administrative reasons*, including upon pre-authorization, concurrent review and retrospective review in the particular setting noted.

Denominator: Total claims submitted for the particular setting noted.

Based on data for our members: For In-Network treatment, complete versions of Tables 3A and 3B for each Specified Plan in each Specified Region, and for all such plans and regions in aggregate. Separately, for Out-of-Network treatment, complete versions of Tables 3A and 3B for each Specified Plan with OON benefits in each Specified Region, and for such plans and regions in aggregate.

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All versions of Tables 3A and 3B should be completed with claims data for Calendar Year 2019, or for the period January 1, 2019, through the latest month in 2019 for which reasonably complete claims data is available.

Table 3A - Denials for which no claim submitted Percentages				
Plan Data for January 1, 2019 through _____, 2019				
Setting	Medical Necessity		Administrative	
	Med/Surg	MH/SUD	Med/Surg	MH/SUD
Inpatient Facility Stays	%	%	%	%
Outpatient Facility Visits	%	%	%	%
Office Visits	%	%	%	%

Table 3B - Claim Denials Percentages				
Plan Data for January 1, 2019 through _____, 2019				
Setting	Medical Necessity		Administrative	
	Med/Surg	MH/SUD	Med/Surg	MH/SUD
Inpatient Facility Stays	%	%	%	%
Outpatient Facility Visits	%	%	%	%
Office Visits	%	%	%	%

If, in any version of Table 3A or 3B, there is a disparity in any category of denial rates for M/S compared to MH/SUD that is more than 5 percentage points (e.g., 10.0% denials for M/S versus 15.1% for MH/SUD; or 15.0% denials for M/S compared to 20.1% for MH/SUD), please provide a Plan of Correction in a separate report within 90 days from the date of your response to this MDRF.

Your **Plan of Correction** should address how you will reduce these disparities, including: the use and application of level of care guidelines that constitute generally accepted standards of care criteria; less stringent application of such guidelines with respect to frequency of reviews, duration of care authorized, application of appropriate guidelines matching specific level of care requested; elimination of exclusions for residential levels of care and provider types; elimination of more stringent geographic exclusions than for M/S benefits, etc.

SECTION IV: NETWORK PROVIDER DIRECTORY ACCURACY

Using Table 4, provide information regarding your MH/SUD provider networks. Based on the claims of only our members, complete a separate version of Table 4 for each Specified Plan in each Specified Region, and for all such plans and regions in aggregate.

Each version of Table 4 should include inpatient facility, outpatient facility and office visit settings (combined) and completed for the “Applicable Six Months” as defined in Table 4 below.

	Table 4 – In-Network Provider Directory Listings – Psychiatrists	Response
1	Total number of psychiatrists (including child psychiatrists) who were listed as participating in your provider network <u>during any time in</u> the most recent 6 months of Calendar Year 2019 for which reasonably complete claims data is available (“Applicable Six Months”):	
2	Number of psychiatrists (including child psychiatrists) who submitted zero –in-network claims during the Applicable Six Months:	
3	Number of psychiatrists (including child psychiatrists) who submitted in-network claims for 1 to 4 unique individuals during the Applicable Six Months:	
4	Number of psychiatrists (including child psychiatrists) who submitted in-network claims for 5 or more unique individuals during the Applicable Six Months:	
5	Please add the numbers in Rows 2 - 4, which should total the same number as entered in Row 1:	
6	Number of psychiatrists who are child psychiatrists:	
7	Total number of our members (insured lives, unique individuals):	
8	Ratio of psychiatrists (including child psychiatrists) to total covered lives under the network (i.e., <u>not</u> just our members), indicated as 1:xxx (calculating xxx by dividing Row 7 by Row 1):	
9	What is your network adequacy standard, e.g., 1 psychiatrist for every xxx covered lives (i.e., <u>not</u> just our members), or every yy miles (based on urban/suburban/rural), etc.:	

If, in any version of Table 4, the number of psychiatrists (including child psychiatrists) who submitted zero claims (Row 2) added to the number of psychiatrists (including child psychiatrists) who submitted claims for 1 - 4 unique individuals (Row 3), constitutes more than 10% of the number of psychiatrists (including child psychiatrists) listed as participating in your provider network during the Applicable Six Months in 2019 (Row 1), please provide a plan of correction in a separate report within 30 days of your response to this MDRF.

Your **Plan of Correction** should show how you will address provider directory inaccuracies, including monitoring actual provider network participation, correcting directory inaccuracies, improving network adequacy standards, including wait times, to ensure sufficient and timely access to network providers, etc.

MODEL DATA REQUEST FORM ENDS HERE.

Attachment B BEST PRACTICE EXAMPLES OF COMPLIANT NQTL ANALYSES

TESTING AND DOCUMENTATION - WITH REGULATORY GUIDANCE EMBEDDED

As a public service, the Mental Health Treatment and Research Institute LLC (“MHTARI”), a tax-exempt subsidiary of The Bowman Family Foundation, has funded the development of the following examples demonstrating NQTL compliant analyses, testing and disclosure. Additional examples may be added as an update to this document from time to time. The current version of this document can be found at https://www.mhtari.org/Best_Practice_Examples_NQTL_Compliance.pdf. These best practice examples are prototypical and are derived from many resources, primarily, regulatory and sub-regulatory guidance issued by the Departments of Labor and Health and Human Services, and the Center for Consumer Information and Insurance Oversight. While there are many ways in which to analyze NQTLs, these examples focus on the importance of quantitative measures and outcomes data, which are essential components of complete and compliant analysis for many key NQTLs.

EXAMPLE 1 – PRE-AUTH AND CONCURRENT REVIEW OF SUD TREATMENT

NQTL Type: The plan uses pre-authorization and concurrent utilization review (UR) processes for non-hospital based inpatient/residential rehabilitation for substance use disorders (SUDs).

Facts: The plan provides the following information and documentation for this NQTL.

Step 1. Describe the NQTL and classification of benefits to which it applies.

The plan provides a statement that these NQTLs of pre-authorization and concurrent review for SUD non-hospital inpatient/residential care were applied to both medical/surgical (M/S) and SUD benefits with a list of the non-hospital inpatient/residential rehabilitation services (levels of care, facility type) subject to this NQTL in the same inpatient benefit classification.

Step 2. Identify the factors and the sources used to determine appropriate to apply the NQTL. The plan identifies two key factors: a) “high cost growth” and b) “excessive length of stay” that were used to develop the NQTLs for both MH/SUD and M/S inpatient benefits. The plan references its own claims data to support these factors.

The plan also identifies and provides references to a national study that discussed and identified high cost growth and excessive lengths of stay for both M/S and SUD non-hospital inpatient/residential rehabilitation services as the rationale for the plan’s use of these factors.

Step 3. Identify and define evidentiary standards for each factor relied upon to design and apply the NQTL. The evidentiary standards used to define these factors for both SUD and M/S non-hospital based inpatient/residential rehabilitation categories of services are as follows:

See generally: The “Six-Step” Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements:

<https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/faq-38/00018.pdf>

Model Disclosure Form Concerning Treatment Limitations:

<https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf>

Regulatory Guidance: “[T]hese [evidentiary] standards sometimes rely on numerical standards.” [Self-Compliance Tool for MHPAEA](#), p. 13

[MHPAEA Final Rules](#), NQTL Rule, p.68272, *Example 2*. A plan applies concurrent review where there are “high levels of variation in length of stay (as measured by a coefficient of variation exceeding 0.8).”

BEST PRACTICE EXAMPLES OF COMPLIANT NQTL ANALYSES

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- a) Based on internal claims data, “high cost growth” was defined as more than 15% annual increases for any non-hospital inpatient/residential rehabilitation services for the plan’s two (2) most recent fiscal years, as compared to the benchmark of the plan’s fiscal year three (3) years back.
- b) “Excessive length of stay” was defined as at least 20% longer than the average length of stay, occurring at least 10% of the time in the plan’s most recent fiscal year.

Step 4. Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, AS WRITTEN.

- The plan listed the testing and audits it had conducted to assess and validate a comparable and no more stringent application of these NQTLs, as written, to both non-hospital inpatient/ residential rehabilitation M/S and SUD services.
- The plan analyzed the above factors and evidentiary standards by use of its own internal data and claims experience, and identified and disclosed the results obtained and the conclusions reached.
- The plan’s analyses and claims review revealed that each of the non-hospital inpatient service types for both M/S and SUD benefits, subjected to pre-authorization and concurrent review, had shown both high cost growth and excessive lengths of stay as defined in Step 3. In addition, the results of these analyses showed that high cost growth occurred in M/S non-hospital inpatient/residential rehabilitation service categories within one (1) standard deviation of high cost growth occurring in SUD non-hospital inpatient/residential rehabilitation service categories.
- The plan also analyzed the comparability and stringency of its written policies and procedures for its pre-authorization and concurrent review processes, e.g., utilization review criteria and criteria hierarchy, UM manuals, UM committee notes, written treatment plan requirements, etc.
- The plan concluded that the factors and evidentiary standards utilized in designing these NQTLs and the written policies and procedures for implementing these NQTLs were comparable and no more stringent.

Regulatory Guidance: [Self-Compliance Tool for MHPAEA](#), p. 16:

While not all evidentiary standards can be quantified numerically, “any threshold at which each factor will implicate the NQTL...should also be identified.”

“For example, if high cost is identified as a factor used in designing a prior authorization requirement, the threshold dollar amount at which prior authorization will be required for any service, should also be identified.”

Regulatory Guidance: Model Disclosure Request Form:

“4. Identify the methods and **analysis** used in the development of the limitation(s).”

[Self-Compliance Tool for MHPAEA](#), p. 17:

*“Examples of methods/**analyses** substantiating that factors, evidentiary standards and processes are comparable:*

- Internal claims database analysis demonstrates that the applicable factors (such as excessive utilization or recent increased costs) were implicated for all MH/SUD and medical/surgical benefits subject to the NQTL
- A consistent methodology for analyzing which MH/SUD and medical/ surgical benefits had “high cost variability” and were therefore subject to the NQTL.”

Step 5. Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, IN OPERATION

BEST PRACTICE EXAMPLES OF COMPLIANT NQTL ANALYSES

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- The plan listed the testing and audits it had conducted to assess and validate a comparable and no more stringent application of these NQTLs, in operation, to both non-hospital inpatient/residential rehabilitation M/S and SUD services.
- The plan conducted an audit of denial rates for these services according to the definitions and methodologies set forth in *Section III on Denial Rates* of the Model Data Request Form (“MDRF”) for employers and the Model Definitions and Methodology form (“MDDM”) for state regulators, which can be found at Appendix B and Appendix C, respectively. The plan analyzed the number and percent of denials for MH/SUD services compared to M/S services by using these consistent definitions and instructions.
- The plan determined that SUD pre-authorization and concurrent reviews resulted in denials (of any type) 23% of the time, and M/S reviews resulted in denials (of any type) 21% of the time, which constituted a disparity in denial rates of less than 5 percentage points, which the plan deemed comparable.
- The plan also listed the results of an audit from a random sample of utilization reviews by its contracted MBHO and its internal UR medical staff, which showed that:
 1. The frequency of reviews was on average every three (3) days for both SUD and M/S, and when approved, an average of three (3) additional days of services were authorized.
 2. The physician-to-physician reviews occurred on average 10% of the total of all admissions for SUD and 8% of the total of all admissions for M/S.
 3. The average time taken for the SUD telephonic reviews was 5 minutes and the average time for M/S telephonic reviews was 3 minutes.
 4. The plan conducted inter-rater reliability surveys for individuals conducting UR for both SUD and M/S and confirmed that all persons conducting UR for the plan for both SUD (MBHO) and M/S (medical UR) had been scored. Any utilization reviewer with deficient scores was required to complete additional training.
 5. The SUD reviews did not require any types of written information that was different from, or more frequently required, than for M/S reviews.

Regulatory Guidance: [Self-Compliance Tool for MHPAEA](#): “Look for compliance as written **AND IN OPERATION.**” p. 17.

“Determine average denial rates and appeal overturn rates for concurrent review and assess the parity between these rates for MH/SUD benefits and medical/ surgical benefits.” p.13
“For the period of coverage under review, plans and issuers should be prepared to provide a record of all claims (MH/SUD and medical/surgical) submitted and the number of those denied within each classification of benefits.” p. 20

“NOTE: While outcomes are NOT determinative of compliance, rates of denials may be reviewed as a warning sign, or indicator of a potential operational parity noncompliance.” p. 17

[FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION \(PART VII\) AND MENTAL HEALTH PARITY IMPLEMENTATION issued Nov 17, 2011, Q3.](#)

“Inpatient benefits for medical/surgical conditions are routinely approved for seven days ...On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given for only one day...” “The plan is imposing a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/surgical benefits...”

[FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 34 AND MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION issued October 27, 2016, Q6.](#)

The “plan requires prior authorization ... that buprenorphine is medically necessary for the treatment of my opioid use disorder... due to safety risks associated with buprenorphine. Although there are prescription drugs to treat medical/surgical conditions that have similar safety risks, my plan does not impose similar prior authorization requirements on those drugs.”
The prior authorization requirement is applied more stringently to buprenorphine when used to treat opioid use disorder than it is applied to prescription drugs with similar safety risks to treat medical/ surgical conditions...and does not comply with MHPAEA.”

BEST PRACTICE EXAMPLES OF COMPLIANT NQTL ANALYSES

TESTING AND DOCUMENTATION - WITH REGULATORY GUIDANCE EMBEDDED

Take Away: Quantitative analyses is essential in analyzing compliance in the application of pre auth requirements, frequency of reviews and denial rates - in operation compliance.

Step 6. Provide detailed summary explanation of how the analyses of underlying factors, evidentiary standards, strategies and processes led to conclusion that NQTL was compliant as written and in operation.

The plan disclosed a detailed summary explanation of the analyses it had conducted and the results of its testing and audits, that led the plan to conclude that these NQTLs of pre-authorization and concurrent review were developed and applied comparably and no more stringently.

Conclusion: The plan is in compliance with NQTL analyses, testing and documentation for the development and application of these NQTLs for non-hospital inpatient/residential rehabilitation services, both as written and in operation.

EXAMPLE 2 – NETWORK ACCESS /SETTING OF REIMBURSEMENT RATES

NQTL type: Provider Reimbursement Rates for Outpatient MH/SUD services

Facts: The plan provided the following analyses and documentation for compliance testing of this NQTL:

Step 1. Describe the NQTL and classification of benefits to which it applies. The plan sets provider rates/fee schedules for in-network, outpatient office visit services for both MH/SUD and M/S benefits.

Step 2. Identify the factors and the sources used to determine appropriate to apply the NQTL. The plan used network adequacy and cost effectiveness as factors for both MH/SUD and M/S outpatient office visits in setting provider reimbursement rates

Step 3. Identify and define evidentiary standards for each factor relied upon to design and apply the NQTL. The plan referenced multiple studies documenting that setting reimbursement rates for providers is essential in assuring network adequacy and cost effectiveness. The plan has multiple processes for setting rates for providers that it compared on a qualitative basis. In addition, for in-network office visits, the plan used quantitative standards such as Medicare Allowable Charges (MAC) and network access assessments, such as average wait times, percentage of credentialed network providers providing services to patients, and out-of-network utilization rates.

The plan made upward adjustments of between 20% and 30% to MAC depending on such network access assessments for both MH/SUD and M/S outpatient providers.

Regulatory Guidance: [Self-Compliance Tool for MHPAEA:](#)

“[Evidentiary]standards sometimes rely on **numerical** standards, for example, numerical reimbursement rates...” “[S]tandards for provider admission, **including associated reimbursement rates** to which a participating provider must agree, are to be evaluated in accordance with the rules for NQTLs.” p. 13.

(Continued on next page...)

BEST PRACTICE EXAMPLES OF COMPLIANT NQTL ANALYSES

TESTING AND DOCUMENTATION - WITH REGULATORY GUIDANCE EMBEDDED

Step 4. Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, AS WRITTEN. The processes and strategies for analyzing the evidentiary standards of similar adjustments to MAC for both M/S and MH/SUD were identified and disclosed, and demonstrated comparability and no more stringency in the written processes, standards and methodologies used by the plan.

In testing the evidentiary standard of similar rate adjustments for office based professionals the plan utilized the consistent definitions, instructions and tables as set forth in Section II on Reimbursement Rates of the Model Data Request Form (“MDRF”) for employers, and the Model Data Definitions and Methodology form (“MDDM”) for state regulators. The plan completed the tables and conducted comparability analyses to ascertain the comparability of rate adjustments it had made.

The plan’s completion of the table for comparing the allowed amounts for PCPs and medical/surgical specialist physicians vs. psychiatrists revealed a disparity of 4 percentage points higher for medical/surgical physicians for the same CPT codes: 99213 and 99214. This disparity could signal that the NQTL of reimbursement rates has not been properly designed, analyzed and/or implemented.

The plan’s completion of the table for comparing the allowed amounts based on the percentages relative to Medicare for PCPs and non-psychiatrist medical/surgical specialist physicians vs. psychologists revealed 6 percentage points and 4 percentage points higher for these medical/surgical providers than psychologists for CPT code 90834 and 90837 respectively; and 11 percentage points and 8 percentage points higher for these medical/surgical providers than clinical social workers for CPT code 90834 and 90837, respectively. This disparity could signal that the NQTL of reimbursement rates has not been properly designed, analyzed and/or implemented.

The plan stated that rate setting for hospital and inpatient rates were individually negotiated and were not amenable to a quantitative analysis of rate comparison. The plan provided a qualitative analysis showing that its hospital rating process was not more stringent for MHSUD vs M/S.

Step 5. Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, IN OPERATION. The plan also conducted essential testing to determine whether the NQTL of provider reimbursement rate adjustments, even though comparable, did lead to comparable network access outcomes between M/S and MHSUD. For example, the plan tested geographic access for both psychiatrists and psychologists as compared to primary care medical and specialty providers. The plan found that wait times

Regulatory Guidance: [FAQS ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE 21ST CENTURY CURES ACT PART 39, Q6:](#)

“For medical/surgical benefits, the difference in reimbursement rates for physicians and non-physician practitioners for the same CPT code varies based on a combination of factors... For MH/SUD benefits, the plan...varies reimbursement rates...based on a combination of similar factors. [H]owever...the plan reduces the reimbursement rate by the same percentage for every CPT code for an MH/SUD service rendered by a non-physician practitioner. The plan does not do so with respect to medical/surgical providers. Is this permissible under MHPAEA?”

“No... in operation, [the plan] ...reduces reimbursement rates by the same percentage for all non-physician practitioners providing MH/SUD services The plan does not use a comparable process with respect to reimbursement of non-physician providers of medical/ surgical and MH/SUD services...[T]he plan’s use of this NQTL does not comply with MHPAEA.”

Regulatory Guidance: [FAQS ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE 21ST CENTURY CURES ACT PART 39,, Q7:](#)

“In setting standards for provider admission to its network, my health plan considers the composition of current in-network [medical/surgical] providers to help ensure the plan has an adequate number of providers. The plan does not take comparable measures...to ensure an adequate network of MH/SUD providers.” Here...the plan’s process to ensure the plan considers network adequacy with respect to providers of medical/surgical services is not comparable to its process with respect to providers of MH/SUD services. **The Departments note that greatly disparate results—for example, a network that includes far fewer MH/SUD providers than medical/ surgical providers—are a red flag that a plan or issuer may be imposing an impermissible NQTL.** Accordingly, further review of the NQTL may be required to determine parity compliance.”

BEST PRACTICE EXAMPLES OF COMPLIANT NQTL ANALYSES

TESTING AND DOCUMENTATION - WITH REGULATORY GUIDANCE EMBEDDED

for access to first appointments were on average 45 days longer for MH/SUD than for M/S providers. The plan further tested its Out-of-Network (OON) use of outpatient services by comparing the percentage of all allowed claims that were for out-of-network services for medical/surgical providers vs. mental health/substance use disorder providers as set forth in an OON use table in the MDRF (employers) / MDDM (state regulators). The results from this testing showed that OON use for mental health/substance use disorder services was more than 2x higher than (or double) the OON use for medical/surgical services. The plan therefore adjusted its psychiatrist, psychologist and social worker rates upward to 130% of the Medicare Allowable Fee Schedule benchmark. This adjustment was comparable to the upward adjusted range the plan had made for PCPs and M/S specialists. Further the plan made significant efforts to recruit more behavioral specialists into the network to reduce wait times.

***Take Away:** Quantitative analyses are essential in analyzing compliance in the development and implementation of provider reimbursement rates.*

Step 6. Provide detailed summary explanation of how the analyses of underlying factors, evidentiary standards, strategies and processes led to conclusion that NQTL was compliant as written and in operation.

The plan disclosed the methodologies by which it applied adjustment factors to MAC. The plan also disclosed internal guidance given to its staff that outlined how NQTLs, including provider reimbursement rates, should be developed in a parity compliant manner, and disclosed that it continued to monitor wait times, the percentage of credentialed network providers providing services to patients, and out-of-network utilization every 6 months.

Conclusion: The plan is in compliance with the development, testing and implementation of its outpatient visit network provider reimbursement rates by using and disclosing the comparable factors and evidentiary standards, by using comparable methodologies to determine compliance, by testing both in writing and operational comparability and stringency in application, and by adjusting its rates for MH/SUD providers based on measures of network access assessments such as wait times, out-of-network use, etc. as it had done for certain outpatient M/S providers.

EXAMPLE 3 – PLAN DISCLOSURE

Provider, as authorized representative for the patient, requested, in writing, disclosure of the following information from an ERISA group health plan that denied all outpatient psychotherapy visits after the 8th visit on concurrent review as not medically necessary:

- Identification of the factors that were, used in the development and design of concurrent review;
- Description of the evidentiary standards used to define and evaluate each factor identified above;
- The methods and analyses used in developing and applying the concurrent review NQTL to both the MH/SUD and medical/surgical outpatient office visits classification of benefits;
- Any evidence to show that the NQTL of concurrent review is comparable and applied no more stringently, both as written and in operation, to MH/SUD benefits versus medical/surgical benefits.

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The plan provided a summary of the items below:

- A list of the **factors** that the plan considered in the development and application of concurrent review for both MH/SUD and medical/surgical outpatient office visit benefits. The factors listed were high cost variability, recent increase in costs of outpatient office visit services, excessive utilization and safety and efficacy of treatment modality.
- A description of the **evidentiary standard** used to define and evaluate each factor. The plan stated that the factor of high costs variability per episode of care had an evidentiary standard of episodes of outpatient office visits for both medical/surgical and MH/SUD that was two standard deviations higher in total costs than the average cost per episode of care more than 20% of the time in the past 2-month period measured. Recent increase in medical costs was defined as certain benefits in the medical/surgical and MH/SUD outpatient office visits class that had increased 10% or more over the last two years. Excessive utilization was defined as two standard deviations or more above average utilization per episode of care. Safety and efficacy of treatment modality was defined as two or more random clinical trials required to establish a treatment is not experimental or investigational.
- **A summary of the specific analyses and results from these analyses.** The plan provided a summary of the quantitative analyses it conducted demonstrating comparability in the application of the evidentiary standards of high cost variability, recent increase in medical costs, excessive utilization, and safety and efficacy of treatment. The plan concluded that all medical services in this benefit classification that exhibited these factors as defined by the above evidentiary standards were subject to the NQTL of concurrent review. In particular, the plan disclosed a summary of an internal claims analysis that documented that all physician visits in the same classification for medical conditions had experienced increased medical costs and high cost variability as defined above. Further, the plan stated that all physician visits in the same classification were subject to the same concurrent review procedures as were applied to outpatient psychotherapy visits.
- **Analyses of audits that were performed to test operational compliance**, which demonstrated that the NQTL of concurrent review was applied for MH/SUD outpatient psychotherapy visits with the same frequency and with a comparable processes and procedure as medical/surgical outpatient visits in the same classification. Further, the plan provided denial rate claim data using the definitions and methodology set forth in the MDRF, which showed the comparability of denial rates from outpatient concurrent reviews between MH/SUD and medical/surgical.

Regulatory Guidance: [FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 31, MENTAL HEALTH PARITY IMPLEMENTATION, AND WOMEN'S HEALTH AND CANCER RIGHTS ACT IMPLEMENTATION, issued on April 20, 2016, Q9.](#)

"[T]he plan must provide any of these documents and plan information to you if requested, when you as a provider are acting as an individual's authorized representative..."

"The specific underlying processes, strategies, evidentiary standards, and other factors (including, but not limited to, all evidence) considered by the plan...in determining that the NQTL will apply to this particular MH/SUD benefit" ... and "to any medical/surgical benefits within the benefit classification at issue."

"Information regarding the application of the NQTL to any medical/ surgical benefits within the benefit classification at issue";

Any analyses performed by the plan and the results from those analyses, as to how the NQTL complies with both the comparability and no more stringently applied tests.

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The plan made complete disclosure for this NQTL. The plan was responsive with respect to **identifying factors** and **describing evidentiary standards**, as well as the sources used to identify same. The plan also provided the **analyses that were conducted** to compare the MH/SUD and medical/ surgical benefits in the same classification that demonstrated that concurrent review **NQTL was developed in a comparable manner**. The plan also provided **summaries of data** that demonstrated that this **NQTL was being applied, in operation, in a comparable and no more stringent manner**.

Take Away: Regulatory guidance on disclosure of NQTL related information is very specific. The analytical steps are fully consistent with the Self-Compliance Tool. **Compliance Tip** for Step 4, which addresses both the “as written and in operation” NQTL compliance requirements, directs plans to “Document your analysis, as a best practice.” (p. 17). Taken together, the regulatory guidance demonstrates that the plan must conduct, document and disclose its analyses.

EXAMPLE 4 – EXCLUSIONS FROM OR LIMITATIONS ON BENEFITS

NQTL Type: Excluding or limiting benefits based on whether a treatment is deemed experimental / investigational.

Facts: The plan provided the following analyses, documentation and testing of this NQTL:

Step 1. Describe the NQTL and classification of benefits to which it applies. The plan states that it requires any new treatment for both MH/SUD and medical/surgical (M/S) to be reviewed in order to determine whether the intervention is deemed experimental or non-experimental for all benefit classifications.

Step 2. Identify the factors and the sources used to determine appropriate to apply the NQTL. The plan identifies the key factor of “assuring safety and efficacy of new treatments” as the rationale for the development of this NQTL.

Step 3. Identify and define the evidentiary standard for each factor relied upon to design and apply the NQTL. The plan defined this factor by the specific evidentiary standard of a requirement that “new” M/S and “new” MH/SUD treatments must have at least two (2) Randomized Controlled Trials (RCTs) published in peer-reviewed journals that demonstrate safety and efficacy in a consistent manner. The plan defined “new” as any treatment that had not been submitted for reimbursement in the past, or had been reviewed in the past by the experimental panel and rejected for reimbursement as experimental. The plan disclosed guidelines for when an RCT was not acceptable, e.g., if the size of the control and treatment groups were not large enough to enable statistically significant results.

Regulatory Guidance:

[FAQS ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE 21ST CENTURY CURES ACT PART 39, Q2:](#)

“[T]he plan denied all claims for ABA therapy to treat children with Autism Spectrum Disorder...” based on the treatment being “experimental or investigative.” For “medical/surgical conditions, the plan approved treatment when supported by one or more professionally recognized treatment guidelines and two or more controlled randomized trials.”

“Is this permissible? **No...**, in practice, [the plan] imposes this exclusion more stringently on MH/SUD benefits, as the plan denies all claims for ABA therapy, despite the fact that professionally recognized treatment guidelines and the requisite number of randomized controlled trials support the use of ABA therapy to treat children with Autism Spectrum Disorder.”

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Step 4. Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, AS WRITTEN. The plan stated that it used the same factor and evidentiary standards for both MH/SUD and M/S services and the same review process consisting of a panel of subject matter experts. The plan also has internal guidelines for how the panel is to conduct the review process for all benefit classifications, which the plan disclosed.

Step 5. Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, IN OPERATION. The plan disclosed that it conducted a number of tests to determine the in operation comparability and stringency with which these reviews were being applied. For example, the plan required each review panel to report on any rejections of proposed interventions from its reviews to determine experimental vs. non-experimental, along with the panel's rationale. The plan conducted an audit of rejections of application/submission rates, as well as claim denial rates, based on "experimental" within the last 12 months. The plan analyzed the number of (a) panel review rejections and (b) utilization review denials, both expressed as a percentage for MH/SUD treatment services compared to M/S treatment services according to the definitions and methodology set forth in the MDRF (for employers) / MDDM (for state regulators).

The plan determined that for MH/SUD, panel reviews resulted in rejections of applications/submissions based on experimental 35% of the time; and that for M/S, panel reviews resulted in rejections of applications/submissions based on experimental 33% of the time, constituting a disparity in rejection rates of less than 5 percentage points, which the plan deemed comparable. The plan reviewed all rejections for MH/SUD services to determine if the criteria of two peer-reviewed publications were being applied comparably with M/S services. The plan also determined that for MH/SUD, utilization review resulted in denials of coverage based on experimental 10% of the time; and that for M/S, utilization review resulted in denials of coverage based on experimental 9% of the time, which likewise constituted a disparity in denial rates of less than 5 percentage points.

The plan also monitored whether there were timely responses to requests for panel reviews and the wait times for the panel reviews to be conducted and determined these were comparable for both MH/SUD and M/S services. Importantly, the plan conducted testing for a sample of current M/S and MH/SUD treatments that were being reimbursed to determine what proportion met the two (2) RCTs test in order to ascertain whether MH/SUD services were being held to a higher standard than M/S, as many MH/SUD treatments had been rejected prior to the federal parity law interim final regulations.

Step 6. Provide detailed summary explanation of how the analyses of underlying factors, evidentiary standards, strategies and processes led to conclusion that NQTL was compliant as written and in operation.

The plan disclosed a detailed summary explanation of the analyses it had conducted and the results of its testing and audits, and how the plan concluded that this NQTL was developed and applied comparably and no more stringently, both in writing and in operation.

[Self-Compliance Tool for MHPAEA: FAQ at Page 19:](#)

Summary of Facts: The plan denied treatment for a patient with chronic depression who failed to respond to anti-depressants and was referred for outpatient treatment with repetitive transcranial magnetic stimulation (rTMS), which was approved by the FDA and undergone more than six randomized controlled trials published in peer reviewed journals. The plan's standard for both M/S and MH/SUD benefits required at least two randomized controlled trials showing efficacy of a treatment be published in peer reviewed journals for any new treatment. However, regarding rTMS, a committee of medical experts determined that only one of the articles provided sufficient evidence of efficacy. The plan does not impose this additional level of scrutiny in reviewing medical/surgical treatments.

Conclusion: The plan's exclusion fails to comply with MHPAEA's NQTL requirements because, in practice, the plan applies an additional level of scrutiny with respect to MH/SUD benefits and therefore the NQTL more stringently to mental health benefits than to medical/surgical benefits without additional justification."

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Conclusion: The plan's documentation, analysis and testing showed compliance with both the development of this NQTL, and its application in operation.

Take away: *A quantitative analysis of the application of a properly developed NQTL, i.e. denials of treatments for both M/S treatments and MH/SUD treatments, is necessary to determine operational compliance. A plan must audit the approvals and denials of both medical/surgical and MH/SUD treatments to establish whether or not the standards are being applied, operationally, in a compliant manner.*

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