Non-Quantitative Treatment Limitations (NQTL)
Multi-Step Comparative Analysis Audit Tools

By Henry Harbin, MD and Beth Ann Middlebrook, JD[1]

Introduction

These NQTL Multi-Step Audit Tools set forth instructions and requirements for employers/ healthcare purchasers and TPAs/service providers to conduct and appropriately document comparative analyses of NQTLs developed and applied to mental health/substance use disorder (MH/SUD) benefits compared to medical/surgical (M/S) benefits. There are two separate NQTL Multi-Step Audit Tools covering 5 NQTLs:

A. NQTL Multi-Step Audit Tool for: Utilization Management (UM) protocols of (1) Prior Authorization, (2) Concurrent Review and (3) Retrospective Review (pre-claim payment and post-claim payment); and

B. NQTL Multi-Step Audit Tool for: (4) Network Composition/Adequacy and (5) In-Network Reimbursements.

The Mental Health Parity and Addiction Equity Act (MHPAEA) and its regulations require all regulated entities to perform and document detailed comparative analyses for all NQTLs that are applied to MH/SUD benefits. The 5 NQTLs covered by these NQTL Multi-Step Audit Tools ("these Audit Tools") are commonly used NQTLs, which have been the focus of federal and state regulators and are often the basis of complaints and appeals by consumers and providers. The comparative analyses for these specific NQTLs are frequently referenced as insufficient, deficient, or have been found to be non-compliant with MHPAEA. The 2023 MHPAEA Comparative Analysis Report to Congress by the Department of Labor (DOL)/Centers for Medicare and Medicaid Services (CMS) noted these common deficiencies: "*Deficient explanations of the application of a factor were compounded by inadequate definitions of factors and inadequate explanations of how sources were used in selecting, defining, or applying factors*."

These Audit Tools include instructions that focus on key requirements for compliant NQTL comparative analyses as set forth in the MHPAEA statute and regulatory guidance issued by DOL/Health and Human Services (HHS), specifically 2021 FAQs, Part 45 and 2020 MHPAEA Self-Compliance Tool.

Essential elements of these Audit Tools include:

1. Each step that is explicitly required by DOL/HHS guidance;
2. Quotes or summaries of the specific statutory or regulatory guidance issued by DOL/HHS for each step prior to Sept 1, 2024;
3. Tables in which responses are to be provided for each step;

[1] Brief description of authors' parity-related expertise and experience found here: https://www.thebowmanfamilyfoundation.org/advisors

4. Specific examples of the information required for each step, with an emphasis on how to avoid common insufficient or deficient comparative analyses;
5. Embedded Model Data Request Form (MDRF) quantitative outcomes data templates containing definitions, instructions and tables by which to perform "in operation" comparative data analyses;
6. Detailed instructions and examples aimed at:
    a. Promoting efficient and complete analyses and the review of same, with a goal of reducing the need for repeated follow-up requests and analyses.
    b. Reducing analyses that do not address specific requirements of MHPAEA.
    c. Highlighting the type of comparative analyses that would support a conclusion of NQTL compliance.

These NQTL Multi-Step Audit Tools and the MDRF quantitative outcomes data templates linked therein, have been used or referenced, in whole or in part, by various regulators in conducting NQTL compliance activities. The 2023 Report to Congress identified deficiencies in submitted quantitative outcomes data, including: "*Failure to Explain Numerical Inputs, Underlying Methodologies, or Calculations Behind Summary Data Presented as Evidence of Comparable Application*" (Appendix, 5.b.). The quantitative data templates herein are designed to address these deficiencies and provide consistent and reliable methods for data analyses.

DISCLAIMER: The NQTL Multi Step Audit Tools (including without limitation the MDRF quantitative outcomes data templates linked therein), ("these Audit Tools") are made available for informational purposes only and is not intended to and should not be construed as providing legal advice. Each situation is highly fact-specific and requires knowledge of both state and federal laws. Therefore, each "User" (defined as each employer, healthcare purchaser, regulator, plan, third party administrator, carrier or other user) of the these Audit Tools should receive its own professional or legal advice when (1) using these Audit Tools (2) considering whether modifications to these Audit Tools are needed, for example, to address the User's specific circumstances and (3) reviewing and evaluating the responses to these Audit Tools. Each User assumes all risk from any use of the NQTL Multi-Step Audit Tools or any information contained in these Audit Tools, including without limitation, the MDRF quantitative outcomes data templates linked therein. The authors of this NQTL Multi Step Audit Tool, and the Mental Health Treatment and Research Institute LLC (which funded development of the MDRF) and its parent (The Bowman Family Foundation), shall have no responsibility or liability for any errors or omissions, and specifically disclaim any and all representations and warranties, express or implied, regarding these Audit Tools, including without limitation, the ability of these Audit Tools to achieve their intended purpose, the accuracy and completeness of these Audit Tools, the suitability or impact of these Audit Tools with respect to any self-insured or fully insured employer's health plan or any agreement between such employer and a third party administrator or other third party, and the relevance and applicability of these Audit Tools to any specific User.

NQTL Multi-Step Comparative Analysis Audit Tool

Utilization Management Protocols

Henry T. Harbin, M.D. and Beth Ann Middlebrook, J.D.

Instructions and requirements for performing non-quantitative treatment limitation (NQTL) comparative analyses of medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits for utilization management (UM) protocols of: (1) Prior Authorization, (2) Concurrent Review and (3) Retrospective Review (pre-claim payment and post-claim payment).

For the Specified Employee Benefit Plan(s)/Products(s) for CY2024, the TPA/service provider must provide a comprehensive nonquantitative treatment limitation (NQTL) comparative analyses for Utilization Management (UM) Protocols both mental health and substance use disorder (MH/SUD) and medical/surgical (M/S) benefits as further described below. The analysis shall include any and all medical management and administrative services by service providers, such as managed behavioral health organizations and/or other subcontracted vendors.

To the extent that responses are the same for different Specified Employee Benefit Plan(s)/Product(s), indicate that the responses are the same, rather than repeating the same response. **However**, a**ny differences in responses for these separate plan types must be clearly and specifically set forth.**

To the extent that responses for Concurrent Review and/or Retrospective Review are the same as responses for Prior Authorization, it may be indicated that the response is the same rather than repeating the same response. **Any differences, however, must be clearly and specifically set forth.**

In addition, if there are **any differences in CY2025** in any of the information provided for the comparative analyses for CY 2024, **provide such updated information identifying that such information is for CY 2025.**

The requests below are based on FAQs Part 45 and references therein, which may be directly accessed at *FAQs Part 45, issued April, 2021*, as well as the Department of Labor (DOL) Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (2020)**.**

Section 1. Define applicable Utilization Management NQTLs
For purposes of this analysis, the following general definitions apply: **PRIOR AUTHORIZATION**: the requirement by insurers of initial approval of a treatment or service before care is provided in order to secure coverage for such treatment or service. Prior Authorization includes pre-treatment and pre-service reviews. Prior authorization does **not** include any requirements for notification only prior to a service being provided. **Notification only** requirements are to be **identified separately** from prior authorization requirements. **CONCURRENT REVIEW**: the requirement by insurers of review of ongoing treatment and services (both inpatient and outpatient) in order to secure coverage for such continued treatment or service. This would include reauthorizations for continued

treatment. **RETROSPECTIVE REVIEW**: insurer review of submitted claims for treatment or services already rendered, separately for both a) pre-claim payment and b) post-claim payment. Post-claim payment retrospective reviews include those related to any clinical information, as well as to billing or coding errors, fraud, waste and/or abuse. Below, please provide specific plan definitions and related plan language, including citations to the specific sections, pages and language contained in source documents. Such source documents could include Certificate of Coverage, Member Handbook, Summary Plan Description, etc.

Plan definition & plan and/or policy citations	
1) Prior Authorization:	
2) Concurrent review:	
3) Retrospective review, pre-claim payment:	
4) Retrospective review, post-claim payment:	

Section 2. Utilization Management applicability	
Responses to the requests below are to be provided separately for the following ***in-network*** **(INN)** and ***out-of-network*** **(OON)** classifications of benefits***: inpatient (separating acute inpatient and sub-acute inpatient services) and outpatient (separating office visits and all other).*** For each of the classifications: inpatient acute, inpatient sub-acute, outpatient other, and outpatient office. Please provide your definition of each benefits classification listed below:	
Inpatient Acute	
Inpatient Subacute	
Outpatient Other (facility)	
Outpatient Office Visit	
Using the tables below, for CY2024, list the covered services within each classification to which Prior Authorization, Concurrent Review and Retrospective Review (both	

pre-claim payment and post-claim payment) apply. Define each covered service listed as MH/SUD or M/S. Include in this response any information that is different or updates that have been made for CY2025.

Acute Inpatient

PRIOR AUTHORIZATION coverage terms. List all MH/SUD and M/S services for which prior authorization is applied. Also provide a link to the list of services that require Prior Authorization (as contained in the member handbook or otherwise).

Identify separately all MH/SUD and M/S services for which **notification** is required and explain the basis for determining that a service requires notification rather than pre-authorization.

Also identify whether Prior Authorization is applied to acute inpatient benefits if reimbursed according to DRG or other value-based purchasing, or if inpatient admission is emergent/urgent.

MH/SUD services	**M/S services**
MH/SUD penalties applied for failure to obtain Prior Authorization	**M/S penalties applied for failure to obtain Prior Authorization**

CONCURRENT REVIEW coverage terms. List all MH/SUD and M/S services for which Concurrent Review is applied. Also provide a link to the list of services that require Concurrent Review (as contained in the member handbook or otherwise).

Also identify whether Concurrent Review is applied to acute inpatient benefits if reimbursed according to DRG or other value-based purchasing, or if inpatient admission is emergent/urgent**.**

MH/SUD services	**M/S services**
MH/SUD penalties applied for failure to obtain approval via Concurrent Review	**M/S penalties applied for failure to obtain approval via Concurrent Review**

RETROSPECTIVE REVIEW – Pre-claim payment coverage terms. List all MH/SUD

and M/S services for which pre-claim payment Retrospective Review is applied. Also provide a link to the list of services that require pre-claim payment Retrospective Review (as contained in the member handbook or otherwise).	
MH/SUD services	**M/S services**
RETROSPECTIVE REVIEW – Post-claim payment coverage terms. List all MH/SUD and M/S services for which post-claim payment Retrospective Review is applied. Also provide a link to the list of services that require post-claim payment Retrospective Review (as contained in the member handbook or otherwise).	
MH/SUD services	**M/S services**

Sub-acute Inpatient	
PRIOR AUTHORIZATION coverage terms. List all MH/SUD and M/S services for which Prior Authorization is applied. Also provide a link to the list of services that require Prior Authorization (as contained in the member handbook or otherwise). **Identify separately** all MH/SUD and M/S services for which **notification** is required and explain the basis for determining that a service requires notification rather than Prior Authorization.	
MH/SUD services	**M/S services**
MH/SUD penalties applied for failure to obtain Prior Authorization	**M/S penalties applied for failure to obtain Prior Authorization**
CONCURRENT REVIEW coverage terms. List all MH/SUD and M/S services for which Concurrent Review is applied. Also provide a link to the list of services that require Concurrent Review (as contained in the member handbook or otherwise).	
MH/SUD services	**M/S services**
MH/SUD penalties applied for failure to	**M/S penalties applied for failure to**

obtain approval via Concurrent Review	**obtain approval via Concurrent Review**

RETROSPECTIVE REVIEW – Pre-claim payment coverage terms. List all MH/SUD and M/S services for which pre-claim payment Retrospective Review is applied. Also provide a link to the list of services that require pre-claim payment Retrospective Review (as contained in the member handbook or otherwise).	
MH/SUD services	**M/S services**

RETROSPECTIVE REVIEW – Post-claim payment coverage terms. List all MH/SUD and M/S services for which post-claim payment Retrospective Review is applied. Also provide a link to the list of services that require post-claim payment Retrospective Review (as contained in the member handbook or otherwise).	
MH/SUD services	**M/S services**

Outpatient Other (Facility)

PRIOR AUTHORIZATION coverage terms. List all MH/SUD and M/S services for which Prior Authorization is applied. Also provide a link to the list of services that require Prior Authorization (contained in the member handbook or otherwise). **Identify separately** all MH/SUD and M/S services for which **notification** is required and explain the basis for determining that a service requires notification rather than pre-authorization.	
MH/SUD services	**M/S services**
MH/SUD penalties applied for failure to obtain Prior Authorization	**M/S penalties applied for failure to obtain Prior Authorization**

CONCURRENT REVIEW coverage terms. List all MH/SUD and M/S services for which Concurrent Review is applied. Also provide a link to the list of services that require Concurrent Review (as contained in the member handbook or otherwise).

MH/SUD services	**M/S services**
MH/SUD penalties applied for failure to obtain approval via Concurrent Review	**M/S penalties applied for failure to obtain approval via Concurrent Review**

RETROSPECTIVE REVIEW – Pre-claim payment coverage terms. List all MH/SUD and M/S services for which pre-claim payment Retrospective Review is applied. Also provide a link to the list of services that require pre-claim payment Retrospective Review (as contained in the member handbook or otherwise).

MH/SUD services	**M/S services**

RETROSPECTIVE REVIEW – Post-claim payment coverage terms. List all MH/SUD and M/S services for which post-claim payment Retrospective Review is applied. Also provide a link to the list of services that require post-claim payment Retrospective Review (as contained in the member handbook or otherwise).

MH/SUD services	**M/S services**

Outpatient Office Visits

PRIOR AUTHORIZATION coverage terms. List all MH/SUD and M/S services for which Prior Authorization is applied. Also provide a link to the list of services that require Prior Authorization (contained in the member handbook or otherwise).

Identify separately all MH/SUD and M/S services for which **notification** is required and explain the basis for determining that a service requires notification rather than pre-authorization.

MH/SUD services	**M/S services**
MH/SUD penalties applied for failure to obtain Prior Authorization	**M/S penalties applied for failure to obtain Prior Authorization**

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CONCURRENT REVIEW coverage terms. List all MH/SUD and M/S services for which Concurrent Review is applied. Also provide a link to the list of services that require Concurrent Review (as contained in the member handbook or otherwise).	
MH/SUD services	**M/S services**
MH/SUD penalties applied for failure to obtain approval via Concurrent Review	**M/S penalties applied for failure to obtain approval via Concurrent Review**

RETROSPECTIVE REVIEW – Pre-claim payment coverage terms. List all MH/SUD and M/S services for which pre-claim payment Retrospective Review is applied. Also provide a link to the list of services that require pre-claim payment Retrospective Review (as contained in the member handbook or otherwise).	
MH/SUD services	**M/S services**

RETROSPECTIVE REVIEW – Post-claim payment coverage terms. List all MH/SUD and M/S services for which post-claim payment Retrospective Review is applied. Also provide a link to the list of services that require post-claim payment Retrospective Review (as contained in the member handbook or otherwise).	
MH/SUD services	**M/S services**

Section 3.[2] Identify and define factors, sources and evidentiary standards

Using the tables below, for CY 2024, and identifying any information that is different for 2025, **identify and define all the factors** (quantitative and qualitative, and label as appropriate) used to determine that the NQTL will apply to MH/SUD benefits and M/S benefits.

Provide the **evidentiary standards and sources used** to define and support each identified factor. Every factor must be defined, and any other source or evidentiary standard relied upon to design and apply the NQTL to MH/SUD benefits and M/S benefits must be provided. All sources must be specifically identified and cited in the tables below. Any

[2] NQTL requests set forth in Section 3 herein combine Steps 2 and 3 of the 2020 MHPAEA Self-Compliance Tool.

sections, pages, language, data, or other information relied upon from such sources must be specifically identified and cited.

NOTE: If the factor inherently relies on quantitative measures (i.e., high cost, length of stay), provide the threshold or parameters upon which the plan would determine to apply the NQTL to that service and any applicable sources or additional evidentiary standards. Analyses should include specific information, evidence, thresholds, or data that determine whether the NQTL will be applied. (For example, if factors such as safety or efficacy are used, the source and/or evidentiary standard shall be specifically defined, any thresholds or measures, and how such thresholds or measures are used to determine application of the factor, shall be provided).

If medical necessity is a factor, identify the specific medical necessity criteria used for each benefit classification and sub-classification for both M/S and MH/SUD services.

With respect to **Post-Claim Payment Retrospective review**, define and describe the type of information that is reviewed for each category of fraud, waste and abuse separately. Also define and describe whether any clinical or medical information is relied upon for each category.

FAQ 45 Guidance: The FAQ 45

(Q2, #3) guidance stipulates that a sufficient analysis includes:

Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

(Q2, # 4) guidance stipulates that a sufficient response includes:

To the extent the plan defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

(Q3, # 5) states that the following is insufficient:

Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

DOL Checklist Guidance: 2020 MHPAEA Self-Compliance Tool

Examples of specific definitions for factors and evidentiary standards:

- Excessive utilization - utilization is two standard deviations above average utilization per episode of care.

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

For the following, if any of the requested information is different for MH/SUD than for M/S, identify any and all differences. If notification is required rather than Prior Authorization, provide all of the requested information separately for notification.

For all additional factors, please copy and paste and complete the Blank Factor Table located at the end of this document.

Acute Inpatient
NQTL: Prior Authorization Factors
Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support the development and application of Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)
NQTL: Concurrent Review Factors

Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)
NQTL: Retrospective Review - Pre-claim Payment Factors
Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)
NQTL: Retrospective Review - Post-claim Payment Factors
Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)

Sub-acute Inpatient
NQTL: Prior Authorization Factors
Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support the development

and application of Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)
NQTL: Concurrent Review Factors
Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)
NQTL: Retrospective Review - Pre-claim Payment Factors
Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)
NQTL: Retrospective Review - Post-claim Payment Factors
Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)

Outpatient Other (Facility)
NQTL: Prior Authorization Factors

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Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support the development and application of Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)
NQTL: Concurrent Review Factors
Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)
NQTL: Retrospective Review - Pre-claim Payment Factors
Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)
NQTL: Retrospective Review - Post-claim Payment Factors
Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)

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Outpatient Office Visits
NQTL: Prior Authorization Factors
Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support the development and application of Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)
NQTL: Concurrent Review Factors
Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)
NQTL: Retrospective Review - Pre-claim Payment Factors
Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support Factor 1. (e.g., cost escalation of 10 percent or more per year for two years)
NQTL: Retrospective Review - Post-claim Payment Factors
Factor 1, identify and specifically define:
Identify any sources used and specifically how such sources were used to define and/or support Factor 1. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support Factor 1. (e.g., cost

escalation of 10 percent or more per year for two years)

Section 4.[3] Comparative Analyses

Separately for "as written" and "in operation":

For each factor listed in **Section 3**, provide the comparative analyses demonstrating that each factor used to determine the benefits subject to prior authorization/concurrent review/retrospective review, and the evidentiary standards and sources for each such factor, are comparable and applied no more stringently to MH/SUD benefits than to M/S benefits.

Note: In order to conduct complete comparative analyses in Section 4, sufficient and complete responses are required for Sections 2 and 3.

For the "as written" comparative analyses, when providing M/S and MH/SUD Utilization Review (UR) policies and procedures manuals, *comparative analyses and identification of specific sections and page numbers must be included* to demonstrate comparability and no more stringency between the M/S and MH/SUD processes and procedures set forth in such policy and procedure manuals. Providing policy and procedure manuals for either M/S or MH/SUD without specific identification or citation to relevant sections, page numbers, language and any other specific information that support and validate comparative analyses is insufficient.

For the "in operation" comparative analyses, provide copies of any audits, studies, or reports that demonstrate whether the factors, evidentiary standards, sources, policies and procedures, or other processes were applied, in operation, in a comparable and no more stringent manner for MH/SUD benefits compared to M/S benefits. Identify any specific sections, page numbers, language, data or other specific information that support and validate the comparative analyses. Also provide the dates upon which such audits, studies or reports were created and updated, if applicable.

Where applicable, explain who or what entity (i.e., a committee, board, etc.) determines which services require prior authorization/concurrent review/retrospective review and a description of the decision-making process for M/S services and separately for MH/SUD services in each classification of benefits set forth herein. In so doing, provide information about the backgrounds and credentials of individuals identified, whether MH/SUD or M/S.

Identify and define each step in the review process when a denial is made based on prior authorization/concurrent review/retrospective review determinations. Include and define all available procedures for denials and appeals, such as peer-to-peer review, internal and external levels of appeals. Include the required credentials for individuals who conduct reviews for MH/SUD and for individuals who conduct reviews for M/S (e.g., UR, peer to

[3] NQTL requests contained in this Section 4 are set forth in Step 4 of the 2020 Self-Compliance Tool.

peer reviews, and internal appeals). Verify whether only individuals with behavioral health credentials (e.g., certification, licensure) conduct MH/SUD reviews.

FAQ 45 Guidance: The FAQ 45 guidance states that the following is necessary for a sufficient response:

> (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation.
>
> (Q2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
>
> (Q2, #7) If the plan's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and M/S benefits.

FAQ 45 Guidance: The FAQ 45 states that the following constitutes an insufficient response:

> (Q3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
>
> (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
>
> (Q3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
>
> (Q3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Acute Inpatient
PRIOR AUTHORIZATION comparative analysis for each factor
CONCURRENT REVIEW comparative analysis for each factor

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RETROSPECTIVE REVIEW – Pre-Claim Payment comparative analysis for each factor
RETROSPECTIVE REVIEW – Post-Claim Payment comparative analysis for each factor

Sub-acute Inpatient
PRIOR AUTHORIZATION comparative analysis for each factor
CONCURRENT REVIEW comparative analysis for each factor
RETROSPECTIVE REVIEW – Pre-Claim Payment comparative analysis for each factor
RETROSPECTIVE REVIEW – Post-Claim Payment comparative analysis for each factor

Outpatient Other (Facility)
PRIOR AUTHORIZATION comparative analysis for each factor
CONCURRENT REVIEW comparative analysis for each factor

RETROSPECTIVE REVIEW – Pre-Claim Payment comparative analysis for each factor
RETROSPECTIVE REVIEW – Post-Claim Payment comparative analysis for each factor

Outpatient Office Visits
PRIOR AUTHORIZATION comparative analysis for each factor
CONCURRENT REVIEW comparative analysis for each factor
RETROSPECTIVE REVIEW – Pre-Claim Payment comparative analysis for each factor
RETROSPECTIVE REVIEW – Post-Claim Payment comparative analysis for each factor

Section 5. In Operation Quantitative Data
***In Operation Quantitative Data*: Complete the Model Data Request Form (MDRF), Section 4, Denial Rates and Section 5, UM Frequency/ Proportion, with embedded excel worksheets in the files embedded below:** MDRF Sec 4- Denial Rates MDRF Sec 5- UR Frequency/Proportior

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Section 6. Findings and Conclusions
Provide the specific findings and conclusions reached by the Carrier with respect to the comparability and no more stringency, as written and in operation, of each NQTL set forth herein , including any results of the analyses described in the previous steps, and including any in-operation quantitative comparisons that may indicate that the Carrier is or is not in compliance with the MHPAEA NQTL requirements. ***Note that any disparities in operational quantitative data must be addressed and explained.*** **FAQ 45 Guidance:** The FAQ 45 guidance states that a sufficient response should include: (Q2, # 8) A reasoned discussion of the plan's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA. **FAQ 45 Guidance:** The FAQ 45 guidance states that the following constitutes an insufficient response: (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Acute Inpatient	
Findings and Conclusions:	
As Written	**In Operation**
Sub-acute Inpatient	
Findings and Conclusions:	
As Written	**In Operation**

Outpatient Other (Facility)	
Findings and Conclusions:	
As Written	**In Operation**
Outpatient Office Visits	
Findings and Conclusions:	
As Written	**In Operation**

Blank Factor Table - For Section 3, copy and paste the table below as needed to add more factors under particular classifications for each NQTL.

[Classification]
NQTL: [NQTL] Factors
Factor [#], identify and specifically define:

Identify any sources used and specifically how such sources were used to define and/or support Factor [#]. (e.g., internal claims data)
Identify any evidentiary standards used to define and/or support the development and application of Factor [#]. (e.g., cost escalation of 10 percent or more per year for two years)

NQTL Multi-Step Comparative Analysis Audit Tool

Network Composition/Adequacy and INN Reimbursements

Henry T. Harbin, M.D. and Beth Ann Middlebrook, J.D.

Instructions and requirements for the TPA/service provider to perform and appropriately document non-quantitative treatment limitation (NQTL) comparative analyses of medical/surgical (M/S) and mental health/substance use disorder (MH/SUD) benefits for: 1) Network Composition/ Adequacy and 2) In-Network (INN) Reimbursement Rates

For the Specified Employee Benefit Plan(s)/Product(s) for CY2024, the TPA/service provider must provide a comprehensive nonquantitative treatment limitation (NQTL) comparative analyses for Network Composition/Adequacy and In-Network Reimbursement Rates for both mental health and substance use disorder (MH/SUD) and medical/surgical (M/S) benefits as further described below.

To the extent that responses are the same for different Specified Employee Benefit Plan(s)/Product(s), indicate that the responses are the same, rather than repeating the same response. **However, any differences in responses for these separate plan types must be clearly and specifically set forth.**

In addition**, if there are any differences in CY 2025** in any of the information provided for the comparative analyses for CY 2024, **provide such updated information identifying that such information is for CY 2025.**

The requests below are based on FAQs Part 45 and references therein, which may be directly accessed at *FAQs Part 45, issued April, 2021*, as well as the Department of Labor (DOL) Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (2020).

1) Benefit Classification Definitions

Responses to the requests below are to be provided for the following ***in-network*** classifications of benefits***: inpatient (separating acute inpatient and sub-acute inpatient services), outpatient (separating office visits and all other), and emergency care.*** Provide your definition below for each of the classifications – inpatient acute, inpatient sub-acute, outpatient other (facility), outpatient office visits, and emergency care. Provide citations to documents that include the definitions, e.g., Certificates/Evidence of Coverage, provider manual, etc.	
Inpatient Acute	
Inpatient Subacute	
Outpatient Other (Facility)	
Outpatient Office Visits	

Emergency Care	

2) Network Composition/Adequacy

Network Composition/Adequacy refers to health plans developing and maintaining a network of the full range of M/S and MH/SUD provider types in each benefit classification. A plan must establish and monitor compliance with multiple network adequacy standards, such as geographic (geo) access ratios, provider/enrollee ratios, timeliness standards (wait times for emergency, urgent and routine care for new and existing patients), the extent to which contracted providers actually see enrollees, the extent of enrollee out-of-network utilization, etc.

While Plans may use multiple external sources (e.g., federal regulatory and/or accreditation standards) for their Network Composition/Adequacy standards, MHPAEA requires a comparative analysis demonstrating comparability and no more stringency in the development and application of such standards, as written and in operation, for MH/SUD benefits compared to M/S benefits.

If any external sources used by the Plan, such as federal (CMS) regulatory standards, or NCQA, have not identified and provided a comparative analysis demonstrating how the standards were developed, as written, comparably for MH/SUD vs. M/S benefits, the Plan must provide a full NQTL comparative analysis for each standard, as written. If a Plan states that such external source(s) have identified and/or provided a comparative analysis, that comparative analysis must be provided here.

As an example, even when a network adequacy standard is the same for the outpatient office visit classification for MH/SUD and M/S benefits, the Plan needs to provide a comparative analysis for how each standard was developed in a comparable manner, given the differences in capacity, size, caseload, etc. between the average primary care provider (PCP) and the average Psychiatrist/ Psychologist/MH therapist. The National Committee for Quality Assurance (NCQA) has noted, in its brief entitled Improving Accountability for Behavioral Health Care Access, that:

> "Capacity for behavioral health is very different than capacity for medical. A primary care physician generally has 35 patients coming through a day to meet the needed revenue, a psychiatrist is pushing it if it's 15 patients, a therapist is generally 6 to 8 patients a day, and those patients are seen weekly. So the numbers are vastly different, and all it takes is 1 case brought in by the therapist to lock up their capacity right away… It's just very so much more fluid than a primary care practice.
> — stakeholder interviewee"

See Section 3(a) for further examples.

In addition, MHPAEA requires a comparative analysis demonstrating comparability and no more stringency as applied, in operation, for <u>all</u> network adequacy standards. For example,

geo access ratios, provider/enrollee ratios, timeliness standards (wait times for emergency, urgent and routine care for new and existing patients), the extent to which contracted providers actually see enrollees, the extent of enrollee out-of-network utilization, etc. This analysis includes the Plan's criteria and processes for approval of coverage for out-of-network services when not available in-network (e.g., network gap exception coverage).

The Network Composition/Adequacy NQTL comparative analysis Sections 1 – 4 do NOT include telehealth. (See separate Telehealth Network Adequacy section below).

Section 1. List, number, and specifically define all MH/SUD and M/S Network Adequacy standards for the following benefit classifications in the tables below.
Network adequacy standards include, for example, geo access ratios, provider/enrollee ratios, timeliness standards including wait times for emergency, urgent, routine and after-hours care for new and existing patients, percentage of network providers accepting new patients, member grievances, provider and member surveys, etc. If there are any network adequacy standards that apply to specific services, service types or provider types (e.g., prescriber, non-prescriber, high volume, high impact) within a classification or subclassification, identify and list such standards separately. For each classification below, include the criteria and processes for approving members' access to out-of-network providers when in-network services are not available, including defining network gap exception criteria. If the criteria and processes are the same for some or all classifications, please indicate this. (**Note:** The instructions for comparative analyses are set forth in Section 3).

Acute Inpatient	
MH/SUD services	**M/S services**
Sub-acute Inpatient	
MH/SUD services	**M/S services**
Outpatient Other (Facility)	
MH/SUD services	**M/S services**

Outpatient Office Visits	
MH/SUD services	**M/S services**
Emergency Care	
MH/SUD services (behavioral crisis / emergency)	**M/S services**

Section 2. For each Network Composition/Adequacy standard identified in Section 1. above, identify and define the factors, sources and evidentiary standards used to develop and apply such standard. Also clarify whether each standard, and/or factors, sources or evidentiary standards are internally developed or rely on external sources.

Using the tables below, identify and define all the applicable factors, sources and/or evidentiary standards (quantitative and qualitative, and label as appropriate) relied upon to develop and apply each Network Composition/Adequacy standard that applies to MH/SUD benefits and M/S benefits.

All sources and evidentiary standards must be specifically identified and cited in the tables below. Any language, data or other information relied upon from such sources must be specifically identified and cited. How each source supports the network adequacy standard shall also be specifically identified, including the sections and page numbers.

For example, the Plan states that the factor is "the need for adequate network access" and has a wait time standard for urgent care of "within 24 hours." The Plan shall identify the source and evidentiary standard relied upon to establish the 24-hour standard. If this wait time standard is based on external sources such as NCQA or state regulations, the Plan

must specify which specific standard within that source is being relied upon, including the sections and page numbers.

FAQ 45 Guidance: FAQs Part 45

(Q2, #3) guidance stipulates that a sufficient analysis includes:

Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

(Q2, # 4) guidance stipulates that a sufficient response includes:

To the extent the plan defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

(Q3, # 5) states that the following is insufficient:

Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

For the following, if any of the requested information is different for MH/SUD than for M/S, identify any and all differences. (Note: the comparative analyses instructions are set forth in Section 3).

For the tables below, for all additional network adequacy standards beyond the space provided for the first standard in each benefit classification, *please copy, paste and complete the applicable table provided to accommodate additional standards.*

Acute Inpatient	
Network Composition/Adequacy Standard #1:	
Define Factors, and separately, Sources and Evidentiary Standards:	
MH/SUD services	**M/S services**

Sub-acute Inpatient	
Network Composition/Adequacy Standard #1:	
Define Factors, and separately, Sources and Evidentiary Standards:	
MH/SUD services	**M/S services**

Outpatient Other (Facility)	
Network Composition/Adequacy Standard #1:	
Define Factors, and separately, Sources and Evidentiary Standards:	
MH/SUD services	**M/S services**

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Outpatient Office Visits	
Network Composition/Adequacy Standard #1:	
Define Factors, and separately, Sources and Evidentiary Standards:	
MH/SUD services	**M/S services**

Emergency Care	
Network Composition/Adequacy Standard #1:	
Define Factors, and separately, Sources and Evidentiary Standards:	
MH/SUD services (behavioral crisis / emergency)	**M/S services**

Section 3.(a) Comparative Analyses, as Written

(a) As Written:

For each Network Composition/Adequacy standard provided in **Sections 1 and 2**, provide the comparative analyses demonstrating that each standard was developed, as written, in a comparable and no more stringent manner for MH/SUD benefits than for M/S benefits in each classification.

Note: In order to conduct complete comparative analyses in Section 3, sufficient and complete responses are required for Sections 1 and 2.

Example #1: If a standard for M/S is 1 PCP per 10 miles/30 min, and a standard for MH/SUD is 1 Psychiatrist/Psychologist/MH therapist per 10 miles/30 min, the Plan needs to provide an analysis for how these standards were developed comparably given the differences in capacity, size, caseload, etc. between the average PCP and the average Psychiatrist/Psychologist/MH therapist (e.g., a PCP may see 30-40 members per day, whereas a Psychiatrist may see 15-20 per day, Psychologist/MH therapist may see 7-12 per

day).

Example #2: If standards developed are specific to sub-types of M/S inpatient and outpatient facilities, yet standards developed are not specific to sub-types of MH/SUD inpatient and outpatient facilities, the Plan's comparative analysis (as written) would be insufficient. For example, if M/S network adequacy standards developed are specific to cardiac rehabilitation, oncology infusions, joint replacement surgery, etc.; however, MH/SUD standards developed do not specify multiple sub-types of outpatient facilities, such as SUD Partial Hospitalization Program (PHP), SUD Intensive Outpatient Program (IOP), MH IOP, Opioid treatment programs, Applied Behavioral Analysis (ABA), etc., then the network adequacy standards and the Plan's comparative analysis (as written) would be insufficient.

If the external source used, such as NCQA or federal regulatory (CMS) standards, has not identified or provided a comparative analysis as to how the standards were developed between M/S and MH/SUD as required under MHPAEA, the Plan must provide a full NQTL comparative analyses for each standard (as written) to demonstrate that the standard for MH/SUD is comparable and no more stringent than the standard for M/S benefits in each classification. If an external source used has conducted and provided a comparative analysis of MH/SUD and M/S standards (as written) to demonstrate compliance with MHPAEA, the Plan should provide that analysis.

FAQ 45 Guidance: FAQs Part 45

CAA MHPAEA statutory language:

> **"(iv)** The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification."
>
> **(Q2, #3) guidance stipulates that a sufficient analysis includes:**
>
> "Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL."

FAQ 45 Guidance: FAQs Part 45 states that the following constitutes an insufficient response:

> (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
>
> (Q3, # 3) Identification of processes, strategies, sources, and factors without the

required or clear and detailed comparative analysis.

Section 3(a) AS WRITTEN:

For the tables below, for all additional Network Composition/Adequacy standards beyond the space provided for the first standard in each benefit classification, *please copy, paste and complete the applicable table provided to accommodate additional standards.*

Acute Inpatient	
Network Composition/Adequacy Standard #1:	
Comparative Analyses, as written:	
MH/SUD services	**M/S services**
Sub-acute Inpatient	
Network Composition/Adequacy Standard #1:	
Comparative Analyses, as written:	
MH/SUD services	**M/S services**

Outpatient Other (Facility)	
Network Composition/Adequacy Standard #1:	
Comparative Analyses, as written:	
MH/SUD services	**M/S services**

Outpatient Office Visits	
Network Composition/Adequacy Standard #1:	
Comparative Analyses, as written:	
MH/SUD services	**M/S services**

Emergency Care	
Network Composition/Adequacy Standard #1:	
Comparative Analyses, as written:	
MH/SUD services (behavioral crisis / emergency)	**M/S services**

Section 3.(b) Comparative Analysis, in Operation

(b) In Operation

For each Network Composition/Adequacy standard provided in Sections 1 and 2, provide the comparative analyses demonstrating how each standard was applied, in operation, in a comparable and no more stringent manner for MH/SUD benefits than for M/S benefits in each classification.

Note: In order to conduct complete comparative analyses in Section 3, sufficient and complete responses are required for Sections 1 and 2.

Comparative analysis should include: 1) whether each network adequacy standard is applied, in operation, as it was designed and defined, as written; 2) whether each network adequacy standard has been met and complied with in practice, for both MH/SUD and M/S benefits in each classification; 3) identification of the metrics and methodology used to measure compliance with each network adequacy standard; 4) validation that the metrics and methodologies used to measure compliance with each standard are comparable for

MH/SUD as compared to M/S.

Note: The 2023 MHPAEA Comparative Analysis Report to Congress by DOL/CMS noted the following deficiencies in quantitative outcomes reporting: "Failure to Explain Numerical Inputs, Underlying Methodologies, or Calculations Behind Summary Data Presented as Evidence of Comparable Application" (Appendix, 5.b.).

Example #1. For example, the standard of access to urgent care for both MH/SUD and M/S is a wait time of within 24 hours and the method for compliance testing is member and provider surveys. The Plan needs to validate that the provider survey methodology and measures are comparable, e.g., whether: there was a sufficient sample size for MH/SUD and M/S provider respondents; the survey questions were the same; the frequency of the surveys was the same, etc. The Plan also needs to validate that the member survey methodology and measures are comparable, e.g., when a Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey is relied upon for M/S, given that CAHPS for MH/SUD is considered insufficient, the Plan needs to validate that it is using a comparable member survey for MH/SUD; whether there is a sufficient sample size of member respondents; whether the frequency of the surveys was the same, etc.

As part of in operation comparative analysis, provide all audits, studies, reports, data, analyses, etc. conducted for each standard. The Plan shall identify the specific sections, page numbers, language, data or other specific information within each document that apply to each Network Adequacy standard.

FAQ 45 Guidance: FAQs Part 45 guidance states that the following is necessary for a sufficient response:

> (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation.
>
> (Q2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
>
> (Q2, #7) If the plan's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and M/S benefits.

FAQ 45 Guidance: FAQs Part 45 states that the following constitutes an insufficient response:

> (Q3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.

(Q3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

If there are any disparities in the "as written" and/or in "in operation" comparative analyses, *whether qualitative and/or quantitative*, the Plan is required to address such disparities and how such disparities impact the comparability and stringency of Network Composition/Adequacy for MH/SUD benefits vs. M/S benefits.

Section 3(b) IN OPERATION:

For the tables below, for all additional Network Composition/Adequacy standards beyond the space provided for the first standard in each benefit classification, *please copy, paste and complete the applicable table provided to accommodate additional standards.*

Acute Inpatient	
Network Composition/Adequacy Standard #1:	
Comparative Analyses, in operation:	
MH/SUD services	**M/S services**

Sub-acute Inpatient	
Network Composition/Adequacy Standard #1:	
Comparative Analyses, in operation:	
MH/SUD services	**M/S services**

Outpatient Other (Facility)	
Network Composition/Adequacy Standard #1:	
Comparative Analyses, in operation:	
MH/SUD services	**M/S services**

Outpatient Office Visits	
Network Composition/Adequacy Standard #1:	
Comparative Analyses, in operation:	
MH/SUD services	**M/S services**

Emergency Care
Network Composition/Adequacy Standard #1:
Comparative Analyses, in operation:

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MH/SUD services (behavioral crisis / emergency)	M/S services

***In Operation Quantitative Data*: Complete the Model Data Request Form (MDRF) Section 1, Out-of-Network Use, and Section 3, Actual Network Provider Participation with embedded excel worksheets in the files embedded below:**

MDRF Sec 1- OON Use

MDRF Sec 3- Provider Participatior

Section 4. Findings and Conclusions
Provide the specific findings and conclusions reached by the Plan with respect to Network Composition/Adequacy, including any results of the analyses described in the previous steps, both as written and in operation, and including addressing any differences and disparities in the NQTL comparative analyses and data. ***Note that disparities in any operational quantitative data must be addressed and explained, including the data in the linked in operation metrics workbook.*** **FAQ 45 Guidance:** FAQs Part 45 guidance states that a sufficient response should include: (Q2, # 8) A reasoned discussion of the plan's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA. **FAQ 45 Guidance:** FAQs Part 45 guidance states that the following constitutes an insufficient response: (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations. **Note**: The 2023 MHPAEA Comparative Analysis Report to Congress by DOL/ CMS noted these common deficiencies: "Deficient explanations of the application of a factor were compounded by inadequate definitions of factors and inadequate explanations of how sources were used in selecting, defining, or applying factors."

Acute Inpatient	
Findings and Conclusions:	
As Written	**In Operation**

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Sub-acute Inpatient	
Findings and Conclusions:	
As Written	**In Operation**
Outpatient Other (Facility)	
Findings and Conclusions:	
As Written	**In Operation**
Outpatient Office Visits	
Findings and Conclusions:	
As Written	**In Operation**
Emergency Care	
Findings and Conclusions:	
As Written	**In Operation**

Telehealth – Network Adequacy

For both MH/SUD and M/S:

1. Provide the Plan's description of its telehealth network services by provider type (for each designated product if there are any differences).
   Response:

2. Define any applicable network adequacy standards applied to telehealth.
   Response:

3. Describe in detail how the Plan monitors compliance with its telehealth network adequacy standards.
   Response:

4. Describe the Plan's criteria for allowing telehealth providers licensed in other states to provide telehealth services to its members.
   Response:

5. Describe how the Plan addresses network gaps for in-person services using telehealth.
   Response:

6. Describe whether the Plan limits access to in-person care by requiring telehealth for any type of services, either in lieu of in-person care or as a gatekeeper prior to accessing in-person care. If so, identify any differences between MH/SUD and M/S services.
   Response:

7. Provide claims data for the utilization of telehealth services according to each applicable benefit classification for 2024, separately for MH/SUD and M/S, as a percentage of total claims for both telehealth and non-telehealth services.
   Response:

8. Provide data for total spending for telehealth services according to each applicable benefit classification for 2024, separately for MH/SUD and M/S, as a percentage of total spending for both telehealth and non-telehealth services.
   Response:

3) In-Network Reimbursements

In-Network Reimbursements refers to the Plan's rate setting methodology and actual reimbursement rates (allowed amounts). This includes the Plan's policies, procedures, strategies, factors, evidentiary standards, and formulae to develop, negotiate and finalize allowed amounts for providers in each respective benefits classification – acute inpatient, sub-acute inpatient, outpatient other (facility), outpatient office visits, and emergency care.

The In-Network Reimbursements NQTL comparative analysis Sections 1 – 4 INCLUDES telehealth.

Section 1. Identify the specific plan and coverage language and other relevant terms including policies, processes, methodologies, etc. for the development of in-network reimbursement for both base rates and final allowed rates, and the source documents with relevant sections and page numbers.	
Source documents would include, e.g., Certificate of Coverage, Member Handbook, Provider Handbook, Summary Plan Description, etc. Include citations to the specific sections, pages and language contained in source documents.	
Acute Inpatient	
MH/SUD services	**M/S services**

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Network Composition/Adequacy and INN Reimbursements

Sub-acute Inpatient	
MH/SUD services	**M/S services**
Outpatient Other (Facility)	
MH/SUD services	**M/S services**
Outpatient Office Visits	
MH/SUD services	**M/S services**
Emergency Care	
MH/SUD services (behavioral crisis / emergency)	**M/S services**

Section 2. Identify and define all the factors, sources and evidentiary standards used to develop base rates and final allowed rates for MH/SUD and M/S benefits in each classification of benefits.
All factors must be defined and all sources and evidentiary standards must be specifically identified and defined in the tables below. Also clarify whether each factor, source or evidentiary standard is internally developed or relies on external sources. Any language, data or other information relied upon from such sources must be specifically identified and cited. How each source and standard supports, relates, or is relevant to the reimbursement methodology, process or policy shall also be specifically identified. **Example #1**: The Plan states that it uses Medicare DRGs as a source for its base reimbursement rates for M/S acute inpatient and makes adjustments based on identified factors, such as provider shortages in certain geo-zip areas, market demand and range of specialty inpatient service types. Each of these factors must be defined, and any evidentiary standards and sources for each factor must be provided. How each factor is used in making rate adjustments must also be clarified. **FAQ 45 Guidance:** FAQs Part 45 (Q2, #3) guidance stipulates that a sufficient analysis includes: Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination. (Q2, # 4) guidance stipulates that a sufficient response includes: To the extent the plan defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

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Network Composition/Adequacy and INN Reimbursements

(Q3, # 5) states that the following is insufficient:

Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Note: The instructions for comparative analyses are set forth in Section 3.

Acute Inpatient	
Development of base rates and final allowed rates	
Define Factors, and separately, Sources and Evidentiary Standards:	
MH/SUD services	**M/S services**
Sub-acute Inpatient	
Development of base rates and final allowed rates	
Define Factors, and separately, Sources and Evidentiary Standards:	
MH/SUD services	**M/S services**
Outpatient Other (Facility)	
Development of base rates and final allowed rates	
Define Factors, and separately, Sources and Evidentiary Standards:	
MH/SUD services	**M/S services**
Outpatient Office Visits	

Development of base rates and final allowed rates	
Define Factors, and separately, Sources and Evidentiary Standards:	
MH/SUD services	**M/S services**
Emergency Care	
Development of base rates and final allowed rates	
Define Factors, and separately, Sources and Evidentiary Standards:	
MH/SUD services (behavioral crisis / emergency)	**M/S services**

Section 3.(a) Comparative Analyses, as Written

(a) As Written:

For each factor, evidentiary standard and source listed in **Section 2**, provide the comparative analyses demonstrating that each factor, evidentiary standard and source used, **as written**, to develop base rates and final allowed rates, are comparable and applied no more stringently to MH/SUD benefits than to M/S benefits.

Note: In order to conduct complete comparative analyses in Section 3, sufficient and complete responses are required for Sections 1 and 2.

For example, for outpatient office visits, the Plan uses Medicare allowed amounts as a benchmark for specific CPT codes, e.g., 99213, 99214, 90834, 90837. The Plan adjusts the Medicare allowed amounts by provider type and by CPT code. The Plan identifies the factors and evidentiary standards used in making such adjustments and provides an analysis demonstrating the comparability and no more stringency in making such adjustments for MH/SUD providers vs. M/S providers. The Plan identifies the factor of provider shortages for certain M/S and MH/SUD provider types as a basis for increasing the Medicare allowed amount by 15%. The Plan provides a specific definition for provider shortage, such as wait times for urgent care not meeting its Network Adequacy standard of 24 hours for an appointment. The Plan uses this same rationale for increasing both MH/SUD and M/S

provider reimbursements by 15% for this Network Adequacy standard.

FAQ 45 Guidance: FAQs Part 45

CAA MHPAEA statutory language:

> **"(iv)** The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification."
>
> **(Q2, #3) guidance stipulates that a sufficient analysis includes:**
>
> "Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and M/S benefits, are subject to the NQTL."

FAQ 45 Guidance: FAQs Part 45 states that the following constitutes an insufficient response:

> (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
>
> (Q3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.

Section 3(a) AS WRITTEN:

Acute Inpatient	
Development of base rates and final allowed rates	
Comparative Analyses, as written:	
MH/SUD services	**M/S services**
Sub-acute Inpatient	
Development of base rates and final allowed rates	

Comparative Analyses, as written:	
MH/SUD services	**M/S services**
Outpatient Other (Facility)	
Development of base rates and final allowed rates	
Comparative Analyses, as written:	
MH/SUD services	**M/S services**
Outpatient Office Visits	
Development of base rates and final allowed rates	
Comparative Analyses, as written:	
MH/SUD services	**M/S services**
Emergency Care	
Development of base rates and final allowed rates	
Comparative Analyses, as written:	
MH/SUD services (behavioral crisis / emergency)	**M/S services**
Section 3.(b) Comparative Analysis, in Operation	

(b) In Operation

For each factor, evidentiary standard and source listed in Section 2, provide the comparative analyses demonstrating that each factor, evidentiary standard and source used in the application of base rates and final allowed rates comparably and no more stringently, in operation, to MH/SUD benefits than to M/S benefits.

Provide copies of any audits, studies, or reports, that demonstrate in operation comparability and no more stringency in the application of the factors, evidentiary standards, sources, and any other processes or methodologies, in developing base rates and final allowed rates. If audits, studies or reports, etc. are attached or referenced, identify the specific sections, page numbers, language, data or other specific information being relied upon to support and validate the comparative analyses. Also provide the dates upon which such audits, studies or reports were created and updated, if applicable. **Note:** Audits, studies, reports without the identification of specific sections, page numbers, language, data or other specific information will not be considered sufficient information for a compliant comparative analysis.

For example, if factors such as provider negotiating skill, size, leverage or bargaining power, etc. are relied upon, the Plan would need to provide a specific definition for how these factors apply to both M/S and MH/SUD providers, and a comparative analysis to demonstrate that these factors are defined and applied consistently, and provide a valid rationale for any disparities in allowed rates.

FAQ 45 Guidance: FAQs Part 45 guidance states that the following is necessary for a sufficient response:

> (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan between MH/SUD and M/S benefits and, if so, describe the process and factors used for establishing that variation.
>
> (Q2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
>
> (Q2, #7) If the plan's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and M/S benefits.

FAQ 45 Guidance: FAQs Part 45 states that the following constitutes an insufficient response:

> (Q3, # 1) Production of a large volume of documents without a clear explanation of

how and why each document is relevant to the comparative analysis. (Q3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

If there are any disparities in the "as written" and/or in "in operation" comparative analyses, *whether qualitative and/or quantitative*, the Plan is required to address such disparities and how such disparities impact the comparability and stringency of Network Adequacy for MH/SUD benefits vs. M/S benefits.

Section 3(b) IN OPERATION:

Acute Inpatient	
Application of base rates and final allowed rates	
Comparative Analyses, in operation:	
MH/SUD services	**M/S services**
Sub-acute Inpatient	
Application of base rates and final allowed rates	
Comparative Analyses, in operation:	
MH/SUD services	**M/S services**
Outpatient Other (Facility)	
Application of base rates and final allowed rates	

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Comparative Analyses, in operation:	
MH/SUD services	**M/S services**
Outpatient Office Visits	
Application of base rates and final allowed rates	
Comparative Analyses, in operation:	
MH/SUD services	**M/S services**
Emergency Care	
Application of base rates and final allowed rates	
Comparative Analyses, in operation:	
MH/SUD services (behavioral crisis / emergency)	**M/S services**

***In Operation Quantitative Data*: Complete the Model Data Request Form (MDRF), Section 2, INN Reimbursements with embedded excel worksheets, in the file embedded below:**

MDRF Sec 2- INN Reimbursements

Section 4. Findings and Conclusions	
Provide the specific findings and conclusions reached by the Plan with respect to development and application of base rates and final allowed rates, including any results of the analyses described in the previous steps, both as written and in operation, and including any differences or disparities. ***Note that disparities in any operational quantitative data must be addressed and explained in Section 3(b) in operation above and in Section 4, including the data in the linked in operation metrics workbook.*** **FAQ 45 Guidance:** FAQs Part 45 guidance states that a sufficient response should include: (Q2, # 8) A reasoned discussion of the plan's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA. **FAQ 45 Guidance:** FAQs Part 45 guidance states that the following constitutes an insufficient response: (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.	
Acute Inpatient	
Findings and Conclusions:	
As Written	**In Operation**
Sub-acute Inpatient	
Findings and Conclusions:	
As Written	**In Operation**

Outpatient Other (Facility)	
Findings and Conclusions:	
As Written	**In Operation**
Outpatient Office Visits	
Findings and Conclusions:	
As Written	**In Operation**
Emergency Care	
Findings and Conclusions:	
As Written	**In Operation**

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