LEGAL ACTION CENTER
Breaking Barriers. Defending Dignity.

May 13, 2024

Kathleen Birrane
Commissioner
Maryland Insurance Administration
200 St. Paul Place
Baltimore, Maryland 21202

RE: Comments on NQTL Seven Step Analysis Report Template and Data Supplements

Dear Commissioner Birrane,

Thank you for the opportunity to submit comments on the Maryland Insurance Administration's (MIA) NQTL Seven Step Analysis Data Reporting Instructions, NQTL Analysis Report Template, and Data Supplement Instructions/Templates. These comments are submitted by the Legal Action Center and the six undersigned members of the Maryland Parity Coalition. The Center is a law and policy office that fights discrimination against individuals with substance use disorders, arrest and conviction records, and HIV or AIDS and restores opportunities for these individuals. The Maryland Parity Coalition was actively involved in the development and enactment of HB1074/SB684, which updated the state's reporting standards under the Mental Health Parity and Addiction Equity Act (Parity Act) and state parity standards.

We appreciate the MIA's detailed report instructions and updated data templates to assess carrier compliance with both the design and application requirements for five selected NQTLs as well as for all other NQTLs that the carrier must analyze annually, under §15-144(c)(1). We have offered margin comments and recommended clarifying language in the Seven Step Analysis Instructions and each of the outcomes data template instructions (*See* Attachments A – F). The information below highlights several key recommendations, provides additional background information, as needed, and offers several comments on the NQTL Analysis Report Template (which is not included as an attachment). Additionally, the recent report by RTI International, *Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue*, offers important guidance on assessing disparities in provider/facility reimbursement and strategies for addressing provider shortages. We recommend that the outcomes data templates for these NQTLs include several additional measures to improve the identification of disparities, as explained in RTI's report and referenced below. RTI's report also identifies greater disparities in access to substance use disorder (SUD) benefits as compared to mental health (MH) benefits, which highlights the need for these templates to separate out SUD from MH data for comparative analyses for all measures and outcomes data, consistent with the Parity Act and recommended throughout these comments.

I. Seven Step Analysis Instructions (Attachment A)

The MIA has appropriately incorporated into the instructions most of the new compliance standards that have been adopted under H1074/SB684. We recommend the inclusion of three additional standards:

(1) the requirement to address "legacy" processes, strategies, evidentiary standards and other factors (§15-144(d)(3));
(2) the remedial standard that a carrier's failure to submit a complete comparative analysis constitutes a Parity Act violation (§15-144(L)(2)); and
(3) the requirement to disclose an NQTL analysis upon request to members with individual plans as well as group plans (§15-144(c)(1)(IV) and (e)(7)).

See Data Report Instructions, Margin Comments at 3, 4, 15, 17 and 20.

We recommend that the MIA specifically identify artificial intelligence systems (AIS) as an example of a source of factors and a source for establishing specific evidentiary standards for applying a factor. *See* Data Report Instructions, Margin Comments at 6 and 12. As MIA Bulletin 24-11, Use of Artificial Intelligence in Insurance, makes clear, carriers use AI across all stages of the health insurance life cycle and certainly use algorithms to guide decisions on a full range of plan standards that limit the duration or scope of services, including reimbursement rate setting, network composition and authorization practices. The instructions should put carriers on notice that any AIS must be identified and analyzed in the NQTL analysis.

II. NQTL Analysis Report Template

We are concerned that the Report Template merges information for MH benefits and SUD benefits (designated as MH/SUD) without sufficiently reinforcing that the carrier is obligated to separately analyze parity compliance for MH benefits and SUD benefits. We recognize that the instructions permit a combined comparative analysis for MH and SUD benefits if the design and application of factors, processes, strategies and evidentiary standards are identical for both sets of benefits. The carrier's obligation should be clearly stated in the template, even if the template form does not provide separate cells for SUD and MH benefit analyses.

We note that the MIA has provided examples of NQTLs related to strategies for addressing provider shortages. We recommend the addition of several other common practices that have been adopted to address network shortages: bonus payments for participation, reimbursement at the upper limit of the carrier's reimbursement rate scale, streamlined credentialing, and administrative practice requirements. *See* Report Template at 13.

Finally, the disclosure requirements (third item) should be revised to reflect the new statutory provision that allows a member to request NQTL information for ***individual plans*** as well as group plans at any time. Relatedly, the requirements should also include a fourth item (or clarify in the third item) – the carrier's process for making a comparative analysis available to plan members with individual or group plans. *See* Report Template at 21.

III. Prior Authorization Review and Data Supplement 1 Instructions/Template (Attachment B)

As noted in our Seven Steps Reporting Instruction comments (Attachment A), the prior authorization (PA) data supplement 1 Report Form inappropriately combines data reporting for MH and SUD data. The template should be revised to provide separate cells for MH and SUD data to allow for a proper assessment of compliance for each set of benefits. Unlike the possible use of the same processes, strategies, evidentiary standards and factors for the design and application of an NQTL to MH and SUD benefits, the outcomes data will always be different for the two sets of benefits.

Second, we recommend that Instructions for Data Supplement 1 (Attachment B) include additional information to (1) ensure a uniform methodology for gathering data across carriers. Specifically, as noted in our comments on Report Form 1, we recommend that the MIA identify: (1) the specific source of data for the various "counts" and "fail first" requirements so that all carriers use the same reference source; and (2) the method for counting a PA, specifically to address how an episode of care that involves multiple visits is counted for purposes of a PA. Finally, we recognize that the MIA will require claims data to be used for certain required counts/calculations and wish to confirm that a claim will include information regarding whether PA is required. The plan, contract or evidence of coverage generally identifies the services that are subject to PA, as opposed to the claim.

Third, we urge the MIA to gather outcomes data that will compare the member/provider experience and process for obtaining PA that includes the level of administrative burden (e.g. number of peer-to-peer reviews), appeals of an adverse decision, and determinations (overturn rates) across MH, SUD and medical/surgical benefits.

Finally, we believe the query regarding requests for out-of-network (OON) providers under § 15-830 is more appropriately placed in Data Supplement 4 as it relates directly to provider shortages. We have also recommended two additional queries in Data Supplement 4 to assess the timeliness of the carrier's approval determination and reimbursement for the OON service.

IV. Prescription Drug Formulary Design and Data Supplement 2 Instructions/Template (Attachment C)

As noted in the Instructions for Data Supplement 2 (Attachment C), the report form, Tables 1 and 2, inappropriately combines outcomes data for MH and SUD medications. The outcomes data for formulary exception requests/determinations and cost-sharing protections will clearly differ for MH and SUD medications and cannot be combined.

While the Seven Step Analysis Instructions state appropriately that the carrier's analysis of formulary design must address tier placement, the outcomes data template 2 does not gather any data on tier placement. We urge the MIA to include queries in Table 3 regarding the number of med/surg, MH and SUD medications that have been placed in each payment tier (for generics, brands and specialty medications).

We also recommend that additional outcomes data be gathered to assess the carrier's processes for concurrent and retrospective review of MH and SUD medications, consistent with our request for more granular data on PA processes and timeliness, appeals and outcomes.

V. Provider/Facility Reimbursement and Data Supplement 3 Instructions/Template (Attachment D)

A. NQTL Analysis

As noted in Attachment A, carriers now use third-party contractors to engage MH and SUD providers in carrier networks, enter network contracts and negotiate rates with carriers, and carry out other scheduling and administrative tasks on behalf of practitioners. Headway and Alma are two such entities, and some have compared their role to Pharmacy Benefit Managers. The use of such entities is clearly a process that the carrier employs for rate setting purposes, and that process and the terms for reimbursing MH and SUD practitioners must be assessed as part of the NQTL analysis. Based on reports from practitioners, it appears that the reimbursement rate the provider receives for a service may not be the same as the rate paid by the carrier to the third-party contractor (as reflected in the claim/explanation of benefits). Additionally, the third-party contractor may reduce a practitioner's reimbursement rate over time.

To ensure an accurate assessment of reimbursement rates, we urge the MIA to highlight in the Seven Step Analysis that carriers must conduct an NQTL analysis of their use of third-party contractors for purposes of reimbursement rate setting, rate negotiations and all other related reimbursement actions. Relatedly, the MIA should articulate the data that carriers must use to establish the average reimbursement rate to ensure that the data reflect the practitioner's actual reimbursement as opposed to reimbursement received by the third-party contractor.

B. Reimbursement Data Supplement

RTI International's recently released report, *Behavioral Health Parity – Pervasive Disparities in Access to In-Network Care Continue,* documents the significant disparity in reimbursement of Maryland's MH and SUD practitioners compared to medical/surgical practitioners.[1] RTI's data for Maryland practitioners found:

- In 2021, medical/surgical specialists were reimbursed 23.9% more than psychiatrists and 22.8% more than psychologists relative to Medicare reimbursement for office visits.
- Physician assistants were reimbursed 50% more than therapists.

Low reimbursement is a key contributor to limited network participation by some MH and SUD practitioners and the significantly disparate rate of out-of-network utilization of MH and SUD services by Marylanders. Such disparities demonstrate the need for a thorough evaluation of reimbursement rate setting compliance with the Parity Act, as the Act offers the single tool for

[1] RTI's report examines reimbursement rates for employer-sponsored group plans. While it is impossible to determine the number of state-regulated employer-sponsored plans that are represented in the Maryland data, there is no question that state-regulated carrier entities also act as third-party administrators of self-funded plans and use reimbursement practices that are common across all provider networks (both fully-funded and self-funded plans).

identifying and correcting discriminatory practices and mitigating the significant cost burden on plan members.

RTI's report also offers key recommendations for identifying reimbursement disparities that are a red flag for an underlying Parity Act violation (and would constitute a violation of the Act under the proposed federal Parity regulations).

- RTI conducted an analysis of both the average reimbursement rates for specific practitioners based on E&M codes as well as the average reimbursement indexed to Medicare rates. *See* RTI Report at 35-36.
- RTI found that using a limited set of CPT billing codes will "give only an approximate indication of the scope and size of out-of-network and reimbursement disparities" compared to an analysis that uses all CPT billing codes. *Id* at 37. Even the use of the top 8 or 12 most frequently billed CPT codes "underestimate the actual disparities" between MH, SUD and med/surg reimbursements.[2] *Id.*
- RTI conducted an analysis of the average reimbursement rates for office visits as well as an analysis of reimbursement at the 75th and 95th percentiles for all medical/surgical specialist physicians, primary care physicians, psychiatrists, psychologists, therapists and psychiatric nurses (indexed to Medicare) to assess disparities across the reimbursement distribution and possible incentives to encourage providers to participate in networks. *Id*. at 31-33.

To get a far more accurate assessment of actual reimbursement disparities, we recommend that the MIA incorporate several of RTI's key recommendations for the 2024 data reports and expand the outcomes data analysis to cover addition CPT codes and/or other measurements in future reports.

First, as identified in the Data Supplement 3 (Attachment D), we recommend in Table A that MIA gather rate data for 2 additional E&M codes that are commonly billed by all physicians: 99204 (new patient visit 45-59 minutes) and 99215 (established patient visit, 40-54 minutes). These two additional codes capture reimbursement for new patients and more complex existing patients and were included in one of RTI's analysis. *See* RTI Report at 36, Exh. 17. In addition, we recommend that the MIA require reimbursement rate data for physician assistants in Table A to assess any disparity between psychiatrists and a lower credentialed practitioner, as documented in RTI's report. *See* RTI Report at 36, Exh. 17.[3]

[2] The reason for the underestimation is that the top 12 CPT codes account for a relatively small portion of the billing for medical/surgical specialist physicians (32.8%), medical/surgical clinicians (39.6%), physician assistants (64.7%) and nurse practitioners (61.3%) but account for the overwhelming majority of the payments for MH and SUD practitioners: psychiatrists (89%), psychologists (93.4%), therapists (97.9%) and psychiatric nurses (89.1%). In other words, medical/surgical practitioners have higher reimbursement because they are able to bill far more codes than MH and SUD practitioners. Notably, even when all CPT codes are taken into account and indexed to Medicare, psychiatrists and psychologists were reimbursed less in-network than physician assistants and nurse practitioners in 2021. RTI Report at 34-25.

[3] For each of these 4 CPT codes, physician assistants were paid more than psychiatrists: 99204 (2.5%); 99213 (6.%); 99214 (.2%) and 99215 (9.7%).

Second, consistent with RTI's report, we recommend that the MIA gather data on reimbursement rates for office visits for primary care physicians, specialist physicians, psychiatrists and psychologists at the 75th and 95th percentiles. This data would not only highlight disparities at the upper end of the reimbursement scale, it would also shed light on whether carriers use the most powerful tool to incentivize network participation and address workforce shortages – adequate and competitive reimbursement – on a comparable and no more stringent basis for psychiatrists and psychologist compared to other medical/surgical physicians. This data would inform the MIA's evaluation of the NQTL related to provider shortages.

Third, consistent with RTI's report, we recommend that the MIA gather data on reimbursement rates for Psychiatric Nurse Practitioners (as defined in COMAR §10.27.17.02(B)(2)) and Certified Registered Nurse Practitioners to assess disparities across the above 4 CPT codes. RTI's comparative analysis of reimbursement for these two providers found that Maryland Nurse Practitioners were reimbursed 19% more than Psychiatric Nurses for office visits in 2021 indexed to Medicare (113.8% of the Medicare v. 95% of Medicare).

Fourth, we recommend that the MIA gather reimbursement data for selected MH, SUD and medical/surgical facilities to provide outcomes data to support the carrier's in-operation NQTL analysis – opioid treatment programs (OTPs), community mental health centers (CMHCs) and skilled nursing facilities – and index those rates to the Medicare rate for each facility type. OTPs are essential for the delivery of opioid use disorder treatment, and CMHCs are a significant provider of community-based MH care in Maryland.

Finally, we recommend that the Maryland reimbursement rate benchmark for Medicare be used to index Medicare rates in Table B1 and B2 (and any other additional analysis) rather than the national benchmark. Across all 3 Maryland regions, reimbursement rates for 2023 were higher than the 2023 national rate for each of the above 4 CPT codes. Even if the rates across Maryland's 3 regions were averaged and the average used as the benchmark, those rates would exceed the national rate. We believe this is a far more accurate benchmark of any possible disparity for MH and SUD practitioners.

VI. Strategies to Address Provider Shortages and Data Supplement 4 Instructions/Template (Attachment E)

A. NQTL Analysis

As noted in Attachment A (at 7) and discussed above, one quantifiable metric for a strategy that can be used to address provider shortages is the reimbursement rate the carrier pays at the higher end of the rate scale – the 75th and 95th percentiles. We recommend that the MIA require carriers to address whether they conduct audits of those values and how that data are used to address in-network provider shortages.

As previously mentioned, carriers now use third-party contractors to engage MH and SUD providers in carrier networks, contract and negotiate rates with carriers, and carry out other scheduling and administrative tasks on behalf of practitioners. In addition to comparing reimbursement rate practices as discussed above, we recommend these instructions identify other NQTLs that may be implicated through the use of these third-party contractors that affect

network composition. For example, carriers should identify the practices these contractors employ for MH and SUD provider credentialing, network admission timeframe, claim submission, and timeline for reimbursement and compare them to the practices employed for M/S providers.

Our comments on Attachment A also identify recommendations to clarify several other statements and define specific terms in the provider shortages narrative instructions to ensure uniform data gathering methodologies by all carriers.

B. Provider Shortage Data Supplement

As noted in Data Supplement 4 (Attachment E), all outcomes data in Table 1 and 2 must be separately reported and analyzed for MH and SUD services to comply with the Parity Act. As noted for other NQTLs, the outcomes data will differ for MH and SUD services regardless of whether the same processes, strategies, evidentiary standards and other factors are used in the design and application of NQTLs related to addressing provider shortages. Additionally, because a specific provider type may deliver MH and/or SUD services (e.g. licensed clinical social worker, licensed professional counselor), the MIA must include instructions in Data Supplement 4 to delineate whether a network practitioner delivers MH or SUD services (Table 1) and whether the designated facilities in Table 2 offer MH and/or SUD services. We note that RTI's report includes Place of Service Codes (POS) and Provider Type Codes that can be used for these purposes. *See* RTI Report at A-2 and A-3, Exh. A1 and A2.

RTI's report also demonstrates the need for disaggregating the outcomes data for MH and SUD services. It found that out-of-network (OON) utilization for SUD benefits exceeds OON utilization of MH benefits, reflecting greater shortages of network SUD providers than network MH providers. Those disparities likely reflect different practices for network admissions and addressing shortages for SUD providers. For example, for the metrics that will be reported in Table 2, RTI found:

- SUD care delivered in **acute inpatient facilities** was OON 12.4 times more often than medical/surgical (18.1% v. 1.5%), while MH care was delivered in these settings OON 3.0 times more often than medical/surgical (4.3% v. 1.5%).
- SUD care delivered in **subacute inpatient facilities** was OON 20.7 times more often than medical/surgical care (35.9% v. 1.7%) while MH care was delivered OON 18.2 times more often (31.7% v. 1.7%).
- SUD care delivered in **outpatient facilities** was OON 4.2 times more often than medical/surgical care (35.6% v. 8.5%) while MH care was delivered OON 1.4 times more often (12.2% v. 8.5%).
- SUD care delivered in **office visits** was OON 4.2 times more often than medical/surgical care (15.9% v. 3.8%) while MH care was delivered OON 3.4 times more often (12.9% v. 3.8%).

We urge the MIA to require this same level of detail for MH and SUD services.

Finally, as noted above, we recommend that the queries related to the number of requests for and approvals of an OON provider as a network service under §15-830 is more appropriately placed

in Data Supplement 4. We have also proposed two additional questions to assess the timeliness of the carrier's determination and the reimbursement for the OON service.

VII. Provider Network Directories and Data Supplement 5 Instructions/Template (Attachment F)

A. NQTL Analysis

We have identified several additional inquiries in the Seven Step Analysis (Attachment A) to fully flesh out the carrier's practice for ensuring directory accuracy and currentness, including the carrier's practice for removing practitioners that are not participating in the network and presentation of information about telehealth service availability.

B. Data Supplement 5

The data instructions and template do not make clear that the purpose of the directory data is to provide an accurate count of facilities and providers that have contracts to deliver network services and are actively billing the carrier for services. In other words, the data **should not** include so-called "ghost" providers. The template instructions do not convey this purpose or offer instructions to ensure a count of only contracted and billing practitioners.[4] We urge the MIA to clarify these points in Supplement 5 instructions. To the extent a carrier's directory includes providers that do not have a contract, we recommend a query for Table 2 to identify the count of providers with active contracts as compared to the directory listing of providers.

Second, as noted in Attachment F and consistent with our comments for all other data supplements, the number of MH and SUD providers (Table 2) must be reported and analyzed separately to comply with the Parity Act. The MIA must provide instructions for identifying the respective number of MH and SUD practitioners to ensure uniform methodology by all carriers. We would expect that this information would be based on the contracted services and not reliance on information in the directory itself (to avoid inflated and inaccurate information). To the extent a provider or facility is contracted to deliver both MH and SUD services, the provider/facility should be counted for both sets of benefits.

We also recommend that the list of MH and SUD practitioners in Table 2 be expanded to include several additional practitioners that are authorized to bill, including "licensed professional counselor," "applied behavioral analyst," "licensed alcohol and drug counselors," and "addiction medicine physicians." These provider types are tracked in the travel distance network adequacy standards (COMAR § 31.10.44.05(e)(5)) and their inclusion will provide a more accurate count of network providers.

We agree that network facilities must be reported separately from practitioners and seek to ensure that the instructions set out a uniform methodology that will avoid a duplicate count of a facility and the providers that deliver care in those facilities. As explained in Attachment F, some community-based MH programs are not credentialed as a facility and each practitioner is

[4] We note that the network adequacy regulations require carriers to report the number of complaints about inaccurate provider directory information in their access plans, (COMAR 31.10.44.04.C(4)(c)), but does not require information about other efforts to ensure an accurate directory.

separately credentialed by the carrier.[5] In such circumstances, the practitioner should be counted in Table 2 and the facility should not be counted in Table 1. Similarly, a facility that is credentialed as a facility should be counted in Table 1 and the facility's practitioners should not be counted separately in Table 2 unless they are credentialed to deliver care as an individual practitioner.

Finally, we recommend that one data point be added to help assess the number of members who seek assistance from the carrier to identify a network provider. A national survey conducted by NORC, *Equitable Access to Mental Health and Substance Use Care: An Urgent Need*, found that patients seeking MH and SUD care experienced significantly more trouble obtaining an appointment with a new network provider than members seeking an appointment with a new physical health care provider, as measured by the number of providers the member called before finding an appointment. Marylanders experienced barriers to a larger degree than the national sample of respondents. While the carrier is not in possession of this data, we urge the MIA to identify a quantitative metric that examines the member experience across MH, SUD and medical/surgical benefits.

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Thank you for considering our views. We look forward to working with the MIA to enforce the updated parity compliance reporting standards.

Sincerely,

Ellen M. Weber, JD
Sr. Vice President for Health Initiatives

Institutes for Behavior Resources, Inc.
James' Place, Inc.
Maryland Addiction Director's Council
Maryland Association for the Treatment of Opioid Dependence
Maryland Heroin Awareness Advocates
Maryland Psychological Association

[5] We note that this credentialing practice makes it difficult for plan members to identify MH programs, as the practitioner – not the facility – is listed in the directory. Often a member knows the name of the community-based program not the individual practitioners.

ATTACHMENT A

Mental Health Parity and Addiction Equity Act (MHPAEA) Compliance Reporting Instructions

Non-Quantitative Treatment Limitations (NQTL)

Seven Step Analysis

Data Reporting

Contact: mhpaea.mia@maryland.gov

ATTACHMENT A – Legal Action Center Comments

Table of Contents

Introduction:

The analysis report template and supplements are prepared to satisfy the requirements of §15-144, Insurance Article, Annotated Code of Maryland, to create a standard form for entities to submit the NQTL report in accordance with subsection §15-144(c)-(f). The templates have been updated to reflect only the five NQTLs selected by the Commissioner for the 2024 reporting period. Carriers are encouraged to review the prior versions of the template forms posted on the MIA website for direction on how to document comparative analyses for additional NQTL categories not included on the 2024 template forms. These instructions include general guidance for performing and documenting comparative analyses for all NQTLs, as well as specific guidance related to the five NQTLs selected by the Commissioner for 2024.

Complete analysis reports must include all data and information identified in COMAR 31.10.51 and in these instructions in the manner and format specified. Section 15-144(j) describes the actions the Commissioner may take if a carrier fails to submit a complete report, including imposing administrative penalties, charging the carrier for any additional expenses incurred by the Commissioner to review additional reports, and ordering the carrier to cease or modify the disputed conduct or practice.

Narratives and data shall be entered into the fields of the template or supplemental form.

In completing the analysis report, the analysis for MH may be combined with the analysis for SUD when the description and application of factors, processes, strategies, evidentiary standards, and sources are the same for both. If the description and/or application of factors, processes, strategies, evidentiary standards, or sources is different for mental health benefits vs. substance use disorder benefits as written or in operation, then mental health benefits and substance use disorder benefits shall be reported separately.

The steps outlined in these instructions are sequential and directly related to one another. The benefits, provider type, drugs etc. that are discussed in Step 1 should reflect the covered services listed under the benefit classifications section. Steps 2 and 3 are directly related and both must be addressed in the written policies analyzed in Step 4. Step 5 must consist of results of the reviews conducted to confirm the written policies from step 4 are functioning as intended, including any data and numerical results. Step 6 will summarize the plan's efforts to coordinate with its delegated entities, if any, on MHPAEA analysis activities. In step 7 carriers will summarize the MHPAEA findings from each step of the analysis including the data supplement reports. **Because of this, an incomplete response to any step in the process may render the response for an entire NQTL incomplete.**

The following responses are likely to occur when differences between M/S and MH/SUD covered benefits are not accounted for and may result in a finding that a carrier failed to submit a complete analysis report:

1. Production of documents without a clear explanation of how and why each document pertains to the comparative analysis. This includes how each document has been analyzed in a comparative manner and how the comparability and stringency NQTL tests have been met, both in writing and in operation;

2. Generalized statements concerning factors, processes, standards, procedures, etc., as well as mere recitations of the legal standard and conclusions regarding compliance, without specific supporting evidence and detailed explanations of comparative analyses;

3. Identification of factors, evidentiary standards, and strategies without a clear description of how the factors, evidentiary standards, and strategies are defined and applied for M/S or MH/SUD benefits;

4. Identification of processes, strategies, sources, and factors without the required clear and detailed comparative analyses;

Commented [EW1]: Recommendation: Add language regarding Parity Act violation if the carrier does not submit a complete Parity Act report.

THE FAILURE TO SUBMIT A COMPLETE REPORT IS A VIOLATION OF THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT.

Commented [EW2]: The term "description" in this paragraph should be replaced with "design" to conform to federal law. The carrier has the obligation to demonstrate that the design of the NQTL elements is comparable and no more stringent, not the description.

5. Statements that all factors, evidentiary standards and/or criteria, processes and/or strategies are the same for M/S and MH/SUD without detailed definitions and specific comparative analyses for each factor, evidentiary standard, criteria, process, strategy, etc. that substantiate such statements;

6. Reference to factors, evidentiary standards, and/or criteria that inherently rely on quantitative measures and/or are defined or applied in a quantitative manner, without the precise quantitative definitions; note that the MIA may now require a carrier to establish specific quantitative thresholds for evidentiary standards and perform a new comparative analysis if the report is insufficient in this regard;

7. Responses that do not to include comparative analyses, including results, and information necessary to examine the development and/or application of each NQTL, and do not clarify the methodologies utilized for such comparative analyses**;**

8. Analysis that is not for the applicable time period;

9. Analysis that is obsolete due to the passage of time, a change in plan structure, or for any other reason;

10. Failure to include specific data used in an analysis or audit to determine whether the NQTL is comparable to and no more stringently applied to MH/SUD benefits than to M/S benefits in operation.

Commented [EW3]: Recommendation: Include a requirement to analyze any legacy process, strategy, evidentiary standard or other factor.

ANALYSIS THAT FAILS TO ANALYZE ALL PROCESSES, STRATEGIES, EVIDENTIARY STANDARDS OR OTHER FACTORS (I.E. LEGACY ITEMS) REGARDLESS OF WHETHER IT WAS USED BEFORE THE PARITY ACT WAS ENACTED.

Definitions:

The terms in the instructions and the analysis report are defined in COMAR 31.10.51 or have the meaning indicated below. Use of these definitions in completing the report is mandatory.

"Facility" means a person, other than an individual, that provides health care services. "Facility" includes entities that bill for a bundled set of services that include services provided by staff employed by the facility. Examples of facilities include hospitals, outpatient radiology centers, and residential treatment centers.

Commented [EW4]: Recommendation: Reiterate the requirement identified in each of the Data Supplement Instructions that, to the extent there are disparities in any comparative data analysis, the carrier must explain in detail in Step 7 how these disparities are not evidence of parity non-compliance and whether steps have been or will be taken to reduce disparities.

FAILURE TO EXPLAIN IN DETAIL HOW DISPARITIES IN ANY COMPARATIVE DATA ANALYSIS ARE NOT EVIDENCE OF PARITY NON-COMPLIANCE, AS OUTLINED IN STEP 7.

Commented [EW5]: Recommendation: The examples of a facility should include additional examples of MH and SUD facilities including opioid treatment programs and community mental health centers

"Measures" means the steps, plan, methods, or course of action taken by a carrier to assess compliance in the development and implementation of an NQTL when the carrier has delegated management of covered benefits to another entity. Measures include written policies, procedures, and guidelines, as well as operational controls, checks, audits, and safeguards.

"Plan documents" means all documents under which the plan is established or operated in which a carrier describes a requirement related to an NQTL, or the processes, strategies, evidentiary standards, and other factors used to apply an NQTL, including a policy, certificate of coverage, medical policy, medical necessity criteria or guidelines, or provider manual. Plan documents also include any document reflecting analyses conducted or results from such analyses related to the comparability and stringency of an NQTL for MH/SUD benefits as compared to M/S benefits.

"Prescription Drug Formulary Design" means a continually updated list of prescription drugs approved for reimbursement, including both generic and specialty drugs, and plan features that base reimbursement, cost-sharing, or authorization requirements on the formulary category into which a drug is placed. Prescription Drug Formulary Design may include processes to place drugs on specific tiers, or to exclude a drug from the formulary, as well as processes to impose step therapy requirements or quantity limits.

Commented [EW6]: Recommendation: "Brand" drugs should be identified also.

"Prior authorization" means the process that a carrier or any entity delegated by the carrier to manage mental health, substance use disorder, or medical/surgical benefits on behalf of the carrier requires a member or provider to follow prior to the rendering of services to determine if coverage will be provided based on considerations such as medical necessity, level of care, appropriateness of health care services, provider type, geographic location, or diagnosis exclusions. Prior authorization includes, but is not limited to,

preauthorization, precertification, prospective review, preadmission review, pretreatment review, utilization review, and any requirement that a member or provider notify the carrier or organization prior to receiving or delivering a health care service. Prior authorization includes reauthorization of services or benefits that had received preauthorization, but for which the approval period has lapsed at the time the request is submitted. A request for prior authorization is one received during the reporting period, regardless of whether or when services are delivered or whether or when a claim is submitted.

"Product" has the meaning stated in § 15-1309(a)(3) of the Insurance Article, and means a discrete package of health benefits that are offered using a particular product network type within a geographic service area. "Product" comprises all plans offered within the product.

"Provider Network Directory" means a list of the providers who participate with a carrier as an in-network provider under a particular product. For the purposes of this definition, "provider" includes physicians, non-physician practitioners, facilities, pharmacies, laboratories, and any other person or entity under contract with the carrier to provide covered services, items, or supplies to a member of the carrier. A Provider Network Directory may be online or in printed form, and it includes any provider-specific information disclosed by the carrier in the directory, such as provider name, telephone number, digital contact information, practicing specialty, services offered, quality ratings, physical address of practicing locations, hours of operation, whether the provider is accepting new patients, languages spoken, race, ethnicity, gender; and other demographic and practice information.

"Provider Shortages" means deficiencies in the number or availability of in-network providers with appropriate training and expertise to sufficiently meet the needs of a carrier's members to obtain covered services without unreasonable delay or travel. "Provider Shortages" includes determinations by a carrier that additional providers are required for the product's network based on factors and evidentiary standards in addition to meeting network adequacy standards set by a regulator.

"Reimbursement" means compensation or the amount allowed to a health care provider, member, or other person entitled to reimbursement by a carrier, or the combined amount of the carrier's payment and member's cost-sharing responsibility, for providing health care services, medications, or supplies to members of the health benefit plan. Reimbursement includes, but is not limited to, fee for service payments, capitation payments, bundled or global payments, and bonuses or other incentive payments.

NQTL Analysis Report Template Completion Instructions


NQTL 2024 Analysis Report Template Forn

Specific Guidance for the 5 NQTLs Selected for 2024:

When providing the required comparative analysis information for the 5 NQTLs listed below, carriers must include information on any practice or process that meets the definition of the applicable NQTL, as defined in the preceding section of these instructions. In addition to addressing all of the items provided below for each step of the analysis in the "Important Guidance" section of these instructions, carriers must address the following NQTL-specific issues when completing the 2024 NQTL reports.

Commented [EW7]: To distinguish "reauthorizations" from other utilization review requirements that affect MH and SUD care, including concurrent review or on-going authorization of a service that is time limited, a sentence that states the type of UR not included in PA would be helpful.

Recommendation: Insert - PRIOR AUTHORIZATION DOES NOT INCLUDE CONCURRENT REVIEW OR AUTHORIZATION FOR CONTINUING CARE BASED ON A TIME-LIMITED AUTHORIZATION THAT HAS NOT LAPSED.

Commented [EW8]: Recommendation: Add telehealth availability since some practices may only deliver services via telehealth.

Add after "physical address or practice location": AND TELEHEALTH SERVICES

Commented [EW9]: Recommendation: To lend greater specificity to existing quantitative metrics, we recommend adding a reference to the quantitative network adequacy standards. in MD regs?

Following "delay or travel, add "CONSISTENT WITH COMAR § 31.10.44."

Commented [EW10]: These terms are based in the Parity Act but clarification may help in addition to referencing a carrier's access plan findings.

Recommended language: add after "required for the product's network:
"….based on factors and evidentiary standards IDENTIFIED BY THE CARRIER TO MEASURE NETWORK COMPOSITION OR TO ADDRESS DEFICIENCIES IDENTIFIED IN THE CARRIER'S ACCESS PLAN in addition to meeting network adequacy standards set by a STATE OR FEDERAL regulator.

1) Prior Authorization Review Process

When completing Step 1(b), all services for which prior authorization is required must be listed under the applicable benefit classification or sub-classification. The services listed, and the categorization of a service as either M/S or MH/SUD, must be consistent with the Covered Service information provided in Step (a) of the Benefit Classifications section of the template form.

As required by COMAR 31.10.51.04G(4)(j), an NQTL analysis report must include a description of the consequences or penalties that apply when an NQTL requirement is not met. In the case of prior authorization, the carrier must explain whether failure to obtain prior authorization when required will result in a denial of benefits or an alternative penalty, such as a reduction in the amount of benefits otherwise payable. If the penalty varies based on the requested service or other circumstances, a comparative analysis must be provided to demonstrate comparability and relative stringency in the design and application of the penalty between M/S benefits and MH/SUD benefits.

There are three main components of the Prior Authorization Review Process that every analysis must address:

- First, a comparative analysis must be provided for the process the carrier uses to determine the list of services/benefits that are subject to a prior authorization requirement.
- Second, a comparative analysis must be provided for the administrative processes, including timelines, that the provider/member must use when submitting a prior authorization request, and that the carrier adheres to when processing the request.
- Third, a comparative analysis must be provided for the criteria the carrier uses to determine whether to approve or deny prior authorization requests when reviewing the underlying services for medical necessity, level of care, appropriateness, or other applicable considerations.

Data Supplement 1 must be submitted to support the in operation comparative analysis under Step 5 for the Prior Authorization Review Process NQTL.

2) Prescription Drug Formulary Design

The comparative analysis for the Prescription Drug Formulary Design NQTL should address how formulary decisions, including tier placement, specialty designation, and exclusions are made for the diagnosis and medically necessary treatment of M/S and MH/SUD conditions. Pertinent pharmacy management processes, including, but not limited to, cost-control measures, generic and/or therapeutic substitution, and step therapy must be described. If not addressed in PA NQTL, that information should be included in this NQTL Carriers must identify the disciplines, such as primary care physicians, internists, pediatricians, specialty physicians (e.g., psychiatrists), and pharmacologists, that are involved in the development of the formulary for medications to treat M/S and MH/SUD conditions. An analysis of the exception process for any applicable step therapy requirements or other formulary limitations must also be included.

When completing Step 1(a), a copy of the applicable formulary list must be provided. The version of the formulary provided shall be the most recent version on which the comparative analysis was based, including any in-operation data provided in response to Step 5. The formulary list shall identify the date it was effective.

Commented [EW11]: MH and SUD must be analyzed separately and this presentation as well as the presentation in the Analysis Report Template combine the two sets of benefits. We recognize that the instructions allow carriers to combine the analysis for MH and SUD benefits to the extent the processes, strategies, evidentiary standards and other factors are the same in the design and application, but we are concerned that this presentation overlooks that operational practices may differ and the data points for MH and SUD would differ because different benefits are being assessed.

Commented [EW12]: Since the term "process" has a specific meaning in the context of the Parity Act, we recommend that this statement be expanded to also include "strategies, evidentiary standards and other factors" to include all elements of the analysis.

Commented [EW13]: We note that carriers will often deny a requested service/benefit and identify a different service that it would authorize. This is a common practice for more intensive levels of MH and SUD care, e.g. denying residential care but approving intensive outpatient care. Report Form 1 would count those actions as an "approval" if the provider accepts the modification of the service request. In such circumstances, the patient loses the ability to appeal the decision. We urge the MIA to explore this practice and the extent to which the carrier's practices are comparable and no more restrictive across med/surg, MH and SUD.

Commented [EW14]: Recommendation: In addition to criteria used for PA determinations, we recommend that the carrier be required to identify if AI or other clinical care decision-making tools are being used to review PAs.

Insert after "the criteria" ARTIFICIAL INTELLIGENCE ALGORITHMS OR OTHER CLINICAL DECISION-MAKING TOOLS…."

Commented [EW15]: Additional outcomes data should be collected to evaluate disparities in the carrier's implementation practices including peer-to-peer reviews, number of appeals and the determination/outcome of the appeals. *See* Data Supplement 1.

Commented [EW16]: An example of a utilization management practice that is not included in the PA NQTL would be retrospective review and concurrent review for continued use of a medication.

Recommendation: Provide an example of a utilization management practice that should be addressed in the formulary design analysis.

Data Supplement 2 must be submitted to support the in operation comparative analysis under Step 5 for the Prescription Drug Formulary Design NQTL.

3) Provider (Including Facility) Reimbursement

The comparative analysis for the Provider (Included Facility) Reimbursement NQTL must address the process for determining reimbursement rates for in-network and out-of-network providers. A separate analysis must be provided for practitioner reimbursement vs facility reimbursement under each applicable benefits classification/sub-classification. To the extent there are differences in the process for determining reimbursement rates for physician practitioners vs non-physician practitioners (e.g. physician assistants, nurse practitioners, licensed social workers, and psychologists), separate analyses should be provided at this level as well. Any variance in rates applied by the carrier to account for factors such as the nature of the service, provider type, market dynamics, or market need, or availability (demand) must be comparable and applied no more stringently to MH/SUD benefits than M/S benefits.

Carrier responses must include consideration of any Maryland laws that establish specific rate methodologies for particular services or providers (i.e., §§ 14-205.2 and 15-604 of the Insurance Article and §§ 19-710(e) and 19-710.1 of the Health-General Article). The existence of a statutorily required reimbursement methodology for certain provider types within a benefit classification does not obviate the need for a comparative analysis for that benefit classification, since the Maryland laws do not apply to all providers and services. However, the focus of the comparative analyses in these cases should be on the providers and services not subject to the applicable law.

Data Supplement 3 must be submitted to support the in operation comparative analysis under Step 5 for the Provider (Including Facility) Reimbursement NQTL.

4) Strategies for Addressing Provider Shortages

The comparative analysis for the Strategies for Addressing Provider Shortages NQTL must address all considerations taken into account by the carrier when evaluating whether the provider network is sufficient to meet the needs of members, **other than compliance with state or federal minimum standards for network adequacy**. The analysis must also address any and all adjustments made to provider admission standards when a network deficiency is identified, including increasing reimbursement rates, accelerating/streamlining the credentialing and contracting process, or offering other incentives to join the network. In describing the strategies employed in this area, the carrier must specifically address the following issues for both M/S and MH/SUD providers:

- Does the carrier set its own standards for network sufficiency for any provider types that are in excess of the minimum standards required under Maryland regulations, COMAR 31.10.44? If so, which provider types, and what is the rationale for establishing additional standards for these particular provider types?
- How does the carrier determine if the need for a specific provider type justifies negotiating fee schedules, or offering incentives to join the network?
- How does the carrier determine which provider groups are eligible for performance/quality bonuses?
- Does the carrier negotiate fees or differentiate fee schedules based on provider group size?

Commented [EW17]: Additional data points should be collected to assess the number of medications that are subject to concurrent review and retrospective review and the number of appeals for formulary exceptions and approval for lower cost sharing and determinations respectively.

Commented [EW18]: The instructions should explicitly require an analysis of the process for setting reimbursement rates when contracting through a 3rd party network contractor (e.g. Headway or Alma) or directly with the provider.

Additionally, the description does not address telehealth services. Although state law requires the same reimbursement for telehealth and in person services and bars telehealth services for mental health and substance use disorder care unless in person services are offered, the description should make clear that reimbursement for digital MH and SUD services - including services designated as "virtual" services – must be analyzed.

Commented [EW19]: Data Supplement 3 does not include any analysis of facility reimbursement. We urge the MIA to assess reimbursement for opioid treatment programs and community mental health centers indexed to Medicare for both facility types. We also recommend that MIA include a comparison for residential SUD facility, residential MH facility and skilled nursing facility.

Commented [EW20]: This statement (i.e. "other than") could lead to confusion about whether state and federal standards are to be included in the analysis. We trust that the degree to which a carrier is complying/not complying with those metrics informs the level of network shortages and need for remedial measures.

Recommendation: To clarify this statement, replace "other than" with "IN ADDITION TO".

Commented [EW21]: The RTI report examined payment at the upper tiers of the reimbursement scales and identified large disparities. That data point should be included in the reimbursement data supplement (comments provided in LAC's letter).

Recommendation: Add a bullet: "DOES THE CARRIER AUDIT ITS REIMBURSEMENT RATES AT THE 75TH AND 95TH PERCENTILES TO ASSESS THE RATE THAT WILL INCENTIVIZE PROVIDERS TO JOIN NETWORKS?"

Commented [EW22]: In addition to eligibility criteria for performance/quality bonuses, we recommend that the carrier be required to also identify the process for establishing the amount of the bonus in order to demonstrate comparability and no more stringent standards across MH, SUD and medical/surgical benefits.

- How often does the carrier assess for provider shortages, and what is the process for making the assessment?

Data Supplement 4 must be submitted to support the in operation comparative analysis under Step 5 for the Strategies for Addressing Provider Shortages NQTL.

5) Provider Network Directories

Provider Network Directories function as an NQTL because the ability to locate and receive treatment from an in-network provider, which is contingent on the accuracy of the directory, is essential for ensuring members have meaningful access to benefits. The comparative analysis for the Provider Network Directories NQTL must address all considerations taken into account by the carrier in the design and maintenance of the directory, with a particular focus on the comparability between M/S and MH/SUD in the accuracy of the directory and the level of specificity with which provider information is displayed and searchable. The carrier must specifically address the following issues for both M/S and MH/SUD providers:

- What methods are used for obtaining and verifying each type of provider-specific information displayed in the directory?
- What is the process for updating the directory and correcting inaccurate information?
- How does the carrier determine which specialty, subspecialty, and facility types will be displayed in the directory and which specialty, subspecialty, and facility types will be separately searchable?
- How does the carrier determine which types of specific services offered by providers will be displayed in the directory and which services will be separately searchable? This question is focused on how the carrier selects the universe of possible services that may be listed in the directory, not how the carrier determines which services are offered by a particular provider. Identifying and verifying the services offered by a particular provider should be addressed in response to the first bullet point above.
- Is there a limit on the number of specialty areas or types of services that can be attributed to a single provider listed in the directory?
- What, if any, additional assistance does the carrier provide to members who have difficulty using the directory to locate an available provider with the necessary training and expertise to treat the member without unreasonable delay or travel?

When completing Step 1(a), the carrier must include a complete list of the unique specialty practitioner types and facility types for M/S and MH/SUD that are separately listed and searchable in the provider network directory.

Data Supplement 5 must be submitted to support the in operation comparative analysis under Step 5 for the Provider Network Directories NQTL.

Important Guidance for Completing Template Form:

Product/Plan Information

Provide a brief description of the product, including an explanation of any features or characteristics that differentiate this product from other products offered by the carrier in the same market. Provide

Commented [EW23]: Recommendation: We recommend that the explanation of why the Provider Directory is an NQTL should be clarified so that it provides a foundation in the Data Supplement 5 to gather data on the carrier's practices to ensure an accurate and complete list of only contracted network providers who deliver services.

Revise the first sentence to read: "Provider Network Directories function as an NQTL because the ability to locate and receive treatment, which is contingent on the accuracy of the directory AND THE INCLUSON OF ONLY THOSE PROVIDERS THAT HAVE A NETWORK PROVIDER CONTRACT AND ACTIVELY DELIVER SERVICES, …."

Commented [EW24]: Verification of the provider information is important. The actual participation of the provider in the network is equally important and should be examined separately from the verification of information.

Recommendation: Add additional bullet: WHAT METHODS ARE USED TO VERIFY THE PARTICIPATION OF THE PROVIDER IN THE NETWORK?

Commented [EW25]: Removal of non-participating providers is important and should be separately identified here.

Recommendation: Add after "updating the directory" REMOVING PROVIDERS NOT PARTICIPATING IN THE NETWORK…."

Commented [EW26]: We are concerned that, while carriers may offer comparable assistance to members who have difficulty locating a provider, members needing MH and SUD services do not access services based on this assistance because of ineffective assistance and inaccurate directories. We recommend that the MIA gather data to quantify the number of member requests for assistance and require a description of the steps the carrier takes to track the member's progress in finding a network provider to ensue compliance with appointment wait time metrics.

Commented [EW27]: The availability of telehealth services can affect access to care, both positively and negatively *e.g. steering). The carrier should describe that process.

Recommendation: language for a new bullet: HOW DOES THE CARRIER PRESENT THE AVAILABILITY OF TELEHEALTH SERVICES BY PROVIDERS AND FACILITIES?

the form numbers, approval dates, and SERFF tracking numbers for all forms comprising the entire contract of insurance for the product. If there are separate schedule of benefits forms for each plan within the product, it is only necessary to provide the identifying information for one sample schedule of benefits form.

A separate analysis report shall be submitted for each product. However, if, for any plan within a product, the processes, strategies, evidentiary standards, or other factors used in designing and applying the reported NQTLs to mental health benefits, substance use disorder benefits, or medical/surgical benefits are different, as written or in operation, from the other plans within the product, a separate analysis report shall be submitted for that plan. In this case, the information described above should be provided at the plan level instead of the product level.

Benefit Classifications

(a) List each covered service under the product/plan in the table provided on the template form. Indicate whether the covered service is treated as M/S or MH/SUD, and identify which of the following classifications or sub-classifications the covered service has been assigned to: In Network Inpatient; Out of Network Inpatient; In Network Outpatient (OR: In Network Outpatient-Office; In Network Outpatient-All Other); Out of Network Outpatient (OR: Out of Network Outpatient-Office; Out of Network Outpatient-All Other); Emergency; or Prescription.

Do not list non-medical dental or vision benefits in the list of covered services, and do not include these benefits in the NQTL analyses. Dental care that is customarily covered under medical policies, e.g. injury to sound natural teeth or treatment for cleft lip/cleft palate, should be included as a medical benefit.

For the purposes of the NQTL analyses for each product/plan, a carrier may elect to use the outpatient benefit classifications, or divide benefits furnished on an outpatient basis into the two sub-classifications described in 45 CFR § 146.136(c)(3)(iii)(C) for "office visits" and "all other outpatient items and services." The election to use either the outpatient classifications or the outpatient sub-classifications shall be made at the product/plan level, and may not vary for different NQTLs under the same product/plan.

(b) Explain the methodology used to assign M/S and MH/SUD benefits to each classification and/or sub-classification. Note: Classification of covered services must remain consistent across NQTL analyses within the same product/plan. In determining the classification in which a particular benefit belongs, the same standards must be applied to M/S benefits and to MH/SUD benefits. Intermediate MH/SUD benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment) must be assigned to the existing six classifications in the same way that intermediate medical/surgical benefits are assigned to these classifications. For example, if a product/plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits. If a product/plan treats home health care as an outpatient benefit, then any covered intensive outpatient MH/SUD services and partial hospitalization must be considered outpatient benefits as well

Step 1 NQTL Description, Application and Methodology:

(a) Provide a description of the plan's applicable NQTLs as applied to M/S or MH/SUD benefits in the table provided on the template form.

Describe the specific NQTL plan language and procedures, as applied to M/S benefits and as applied to MH/SUD benefits, including identification of associated triggers, timelines, forms, and requirements.

Provide cross references to plan documents that contain language related to application of the NQTLs (i.e., all member documents, posted medical policies, internal documents and applicable provider manual references which are pertinent to providing notice of and information regarding the NQTL requirements). Note that for the purposes of Step 1(a), the term "plan documents" refers only to the documents describing the NQTL itself, and does not include documents reflecting analyses conducted or results from such analyses related to the comparability and stringency of an NQTL for MH/SUD benefits as compared to M/S benefits.

Copies of the applicable policy or certificate of coverage should be available, but are not required to be included with the submission. Copy the specific language from the policy or certificate into the report. Provide the page number, section number, and form number where the provision can be found in the policy or certificate. For plan documents other than the policy, certificate of coverage, or other form that has been previously filed with the MIA for approval, provide actual copies of the documents or internet links where the documents may be accessed online.

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the area provided on the template form. Indicate whether the NQTL applies to all services within the classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies.

For the purposes of the NQTL analyses for each product/plan, if a carrier has elected not to divide benefits furnished on an outpatient basis into the two sub-classifications described in 45 CFR § 146.136(c)(3)(iii)(C) for "office visits" and "all other outpatient items and services," then the "Outpatient-Office sub-classification" columns shall be used to identify the NQTLs applicable to the outpatient classification in general. In this case, the carrier shall include the following explanation in the "Outpatient-Office sub-classification" columns before identifying whether the listed NQTLs are applicable: "Outpatient sub-classifications were not utilized for the NQTL analysis for this [product/plan]. Responses apply to outpatient classification in general."

Steps 2 – 7 shall be performed for *each* benefit classification and/or sub-classification. Where applicable, responses should be conspicuously separated by benefit classification/sub-classification to clearly delineate differences in factors, sources, evidentiary standards, comparative analyses, etc. from one benefit classification/sub-classification to another. If all elements of the design and application of a particular step in the analysis of an NQTL are the same across one or more benefit classifications/sub-classifications, this must be expressly stated, and must be supported by the evidence and documentation provided.

Step 2 Factors and Sources by Benefit and Classification:

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification, or certain services within such classification or sub-classification for both MH/SUD and M/S benefits respectively. Also, identify factors

that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Include responses in the applicable cells in the chart provided on the template form. Number each factor and corresponding source to clearly identify the sources and factors that go together. If the factors or sources are the same across any benefit classifications/sub-classifications, include a note to this effect instead of repeating all factors and sources. For example, the factor cell for a certain classification may state: "Same as factors for In Network Outpatient-Office" or "Factors 2 and 4 for In Network Outpatient-Office also apply to this classification."

- Identify the factors that the plan uses to determine whether each benefit, service, or procedure/revenue code, as a matter of plan policy, is deemed subject to the NQTLs.

Illustrative examples of factors include, but are not limited to:

- Excessive utilization;
- High cost of treatment;
- Recent medical cost escalation;
- Provider discretion in determining diagnosis, or type or length of treatment;
- Lack of clinical efficiency of treatment or service;
- High variability in cost per episode of care;
- High levels of variation in length of stay;
- High variability in quality of care;
- Lack of adherence to quality standards;
- Claim types with high percentage of fraud;
- Clinical efficacy of the proposed treatment or service;
- Severity or chronicity of the MH/SUD or medical/surgical condition;
- Current and projected demand for services;
- Licensing and accreditation of providers;
- Geographic market (i.e., market rate and payment type for provider type and/or specialty);
- Provider type (i.e., hospital, clinic, and practitioner) and/or specialty;
- Supply of provider type and/or specialty;
- Network need and/or demand for provider type and/or specialty;
- Medicare reimbursement rates;
- Training, experience, and licensure of provider.

- Identify the source of the information the carrier used to assign the factors that the plan refers to when determining whether each service or code is deemed subject to the NQTLs, as a matter of plan policy.

Illustrative 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;
- Internal quality standard studies;
- External healthcare claims database;
- Current Medicare Physician Fee Schedule;
- Medicare RVUs for CPT codes.

- Identify factors that were considered, but rejected. If there were no factors that were considered and later rejected, the response should provide confirmation of this.

- If a factor was given more weight than another, what is the reason for the difference in weighting? Differences in weighting of factors include circumstances where multiple factors must generally be present to trigger the application of the NQTL, but the existence of a particular factor, by itself, will trigger the application of the NQTL, even if other factors are not present. An example of weighting would be if the factors and evidentiary standards are applied in a sequence or hierarchy. If all factors are weighted the same, the response should provide confirmation of this.

- The fact that all services in a particular classification or sub-classification are subject to the NQTL does not eliminate the requirement to identify the factors and sources for each factor.

Step 3 Evidence for Each Factor:

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

For each factor identified in Step 2, identify, define, and provide the source for the evidentiary standard and/or data source, and any other evidence relied upon, to determine that the NQTLs apply to MH/SUD and M/S services. Include responses in the applicable cells in the chart provided on the template form. Number each factor and corresponding evidentiary standard and source to clearly identify the factors, evidentiary standards, and sources that go together.

In some circumstances, the sources listed for an evidentiary standard in Step 3 may be identical to the sources identified for the underlying factor for the evidentiary standard in Step 2. However, it is generally expected that the sources listed for the evidentiary standards in Step 3 will be more specific than the sources listed for the factors in Step 2. The sources identified in Step 3 should be the sources used to establish the specific threshold or definition for the evidentiary standard. For example, if "excessive utilization" is a factor, the source identified in Step 2 may be "internal claims analysis." If the corresponding evidentiary standard in

Commented [EW28]: As MIA Bulletin 24-11, The Use of Artificial Intelligence Systems in Insurance, makes clear, carriers are using AI across all stages of the health insurance life cycle and that use is subject to a range of state and federal laws. The carrier's use of AI should be identified, acknowledged and assessed in the context of NQTL compliance. AI may be used in both the design and application of NQTLs and may be the source of both factors and evidentiary standards as well as a strategy or process.

Recommendation: Identify "artificial intelligence systems" as a source for factors and for evidentiary standards.

Commented [EW29]: As noted in the above comment on AI systems, specific algorithms may constitute the evidentiary standard and must be identified in the analysis.

Step 3 is “utilization that is two standard deviations above average utilization per episode of care,” the source listed in Step 3 would be the particular guideline/article/best practice that established that threshold.

If the factors or evidentiary standards/sources are the same across any benefit classifications/sub-classifications, include a note to this effect instead of repeating all factors and evidentiary standards/sources. For example, the evidentiary standards cell for a certain classification may state: “Same as evidentiary standards for In Network Outpatient-Office” or “evidentiary standard 3 for In Network Outpatient-Office also applies to this classification.”

- Using vague and subjective terms (such as “cost-effective” or “excessive”) within the definitions for factors is not sufficient, unless those terms are further defined with precise parameters identifying the applicable sources and evidentiary standards.
- Identify any threshold or quantitative evidentiary standard at which each factor will implicate the NQTL.
- For example, if high cost is identified as a factor used in designing a prior authorization requirement, the carrier would identify and explain:
    - The threshold dollar amount at which prior authorization will be required for any benefit;
    - The data analyses, and methodology and results used to determine the benefit is "high cost"; and how, if at all, the amount that is to be considered "high cost" is different for MH/SUD benefit as compared with M/S benefits, and how the carrier justifies this difference.
- Examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs include, but are not limited to:
    - Excessive utilization may be considered as a factor to design the NQTL when 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% 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% 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% 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.

- ➢ Clear thresholds are critical to demonstrating comparability and relative stringency for comparative analyses required in Step 4 and Step 5. If specific thresholds are not used to determine when the factor will implicate the NQTL, a specific, detailed, and reasoned explanation of how the carrier ensures the factors are being applied comparably and no more stringently to MH/SUD services must be provided. In accordance with § 15-144(j)(3), the Commissioner may require the carrier to establish specific quantitative thresholds, if appropriate, if the carrier fails to provide a sufficiently reasoned explanation of comparability and relative stringency.

- ➢ Evidentiary standards and processes that a carrier relies on may include any evidence that a carrier considers in developing its medical management techniques, including internal carrier standards, recognized medical literature and professional standards and protocols (such as comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

- ➢ If a source such as NCQA is used in determining comparability, the standards for that source and any analyses developed internally or provided to NCQA or other external agencies must be provided. NCQA standards for health plan accreditation are a roadmap for improvement, for use by organizations to perform a gap analysis and align improvement activities with areas that are most important to states and employers, such as network adequacy and consumer protection. However, using the standards for accreditation does not imply compliance with MHPAEA in terms of comparability

- ➢ Failure to include all of the information described in the instructions for Step 3 will result in a finding that a carrier failed to submit a complete analysis report and may result in the actions specified in § 15-144(j) of the Insurance Article.

Step 4 Comparable Written Policies:

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

- ➢ Conclusory statements that the carrier determined that its processes were comparable and no more stringently applied, without additional explanation of the analysis leading to that conclusion, are not sufficient. Documentation must be provided that a comparative analysis was actually performed, and a clear explanation of the methodology must be included.

- ➢ Indicate how the factors, as defined and explained by the evidentiary standards identified in Step 2 and Step 3, are applied comparably to establish the written policy as to which services, MH/SUD and M/S, are subject to the NQTL.

- ➢ Explain comparability of how the factors are defined and applied between MH/SUD and M/S services (i.e., clearly delineate and explain any differences in factors, definitions of factors, or evidentiary standards used to determine application of the NQTL, and provide an explanation as to why and/or how the factors, definitions of factors, and evidentiary standards are deemed comparable).

- ➢ Include a brief description of each step, and comparative analysis, for the processes used in applying

the NQTLs to MH/SUD and M/S services, and demonstrate comparable and no more stringent application to MH/SUD services at each step.

- ➢ Include information on the composition and deliberations of the decision-making staff responsible for the written policies, including the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

- ➢ Demonstrate that there are not arbitrary or unfairly discriminatory differences in the written standards for applying underlying processes and strategies to NQTLs with respect to medical/surgical benefits versus MH/SUD benefits.

- ➢ Examples of methods/analyses demonstrating that factors, evidentiary standards, and processes are comparable include, but are not limited to:

    - Review of published literature on rapidly increasing cost for services for MH/SUD and medical/surgical conditions and a determination that a key factor(s) was present with similar frequency and magnitude with respect to specific MH/SUD and medical/surgical benefits subject to the NQTL;

    - A consistent methodology (e.g., internal claims analysis) for analyzing which MH/SUD and medical/surgical benefits had "high cost variability" (defined by identical factors and evidentiary standards for all services) and were therefore subject to the NQTL;

    - Analysis that the methodology for setting usual and customary provider rates for both MH/SUD and medical/surgical benefits were the same, both as developed and applied; Internal Quality Control Reports showing that the factors, evidentiary standards and processes with respect to MH/SUD and medical surgical benefits are comparable and no more stringently applied to MH/SUD benefits;

    - Summaries of research (e.g., clinical articles) considered in designing NQTLs for both MH/SUD and medical/surgical benefits, demonstrating that the research was similarly utilized for both MH/SUD and medical/surgical benefits;

    - Internal review of published treatment guidelines by appropriate clinical teams (with comparable compositions and qualifications for both MH/SUD and medical/surgical benefits) to identify (using comparable standards and thresholds for both MH/SUD and medical/surgical benefits) covered treatments or services which lack clinical efficacy;

    - Internal review to determine that the carrier's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.

- ➢ Failure to include all of the information described in the instructions for Step 4 will result in a finding that a carrier failed to submit a complete analysis report and may result in the actions specified in § 15-144(j) of the Insurance Article.

Commented [EW30]: The consequences of failing to submit a complete analysis report should also identify §15-144(L)(2) - a finding that the plan is noncompliant with the Parity Act.

Recommendation: add after "complete analysis report" "AND IS NOT COMPLIANT WITH THE PARITY ACT…"

Step 5 Comparable In-Operation Audits/Reviews:

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

- Provide the Carrier's analyses that demonstrate the comparability of the implementation of the written policies and procedures governing application of the NQTL.

- The analyses should include discussion of quality assurance and oversight policies, processes and metrics that the plan applies to monitor in operation compliance. Examples of information to include are results of comparative assessment of denial rates (both administrative and medical necessity) by service, reviews for correlation between basis for service denials and stated criteria, and internal and/or external appeals and overturn rates.

- **Note:** Disparate results or outcomes between MH/SUD and M/S services are not regarded as dispositive of parity noncompliance; however, disparities constitute a warning sign or red flag of potential noncompliance and warrant further investigation. Conversely, equal or more favorable outcomes for MH/SUD services as compared to M/S is a positive indicator; however, is not necessarily dispositive of parity compliance either.

- To ensure uniformity in reporting, the MIA may ask for data using the Medicare provider fee schedules as a metric to measure whether reimbursement rates are comparable. Carriers may also provide other comparative data in addition to Medicare benchmark data to support the comparability analysis.

- Examples of comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied in operation include, but are not limited to:

    - Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable;

    - Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits;

    - Audit results that demonstrate the process of consulting with expert reviewers for MH/ SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved;

    - Audit results that demonstrate utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews;

    - Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were

comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits;

- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits;
- Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category;
- Audit/review of utilization review documentation requirements;
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines;
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/ surgical reviewers ONLY WHEN it has been demonstrated in the comparative analyses for Step 4 that the development of M/S criteria vs. MH/SUD criteria is comparable and no more stringent. It is the comparability and no more stringency of the criteria themselves, not merely consistency in the interpretation or application of the criteria that is key. For example, an IRR validation would not identify if reviewers were consistently applying a more restrictive fail first standard to MH/SUD vs M/S, or consistently applying acute criteria to sub-acute care for MH/SUD.
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification;
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

- When providing audit results, include specific details about the type and outcome of each audit that was performed. A summary statement alleging that an audit was performed revealing no statistically significant disparities is not sufficient, absent documentation of the review and a description of the methodology, including considerations such as sample size and operational proportionality.
- Failure to include all of the information described in the instructions for Step 5 will result in a finding that a carrier failed to submit a complete analysis report and may result in the actions specified in § 15-144(j) of the Insurance Article.

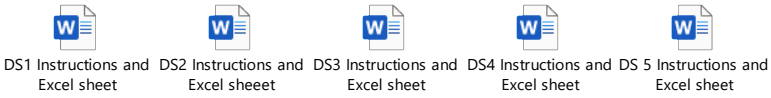
Commented [EW31]: See above recommendation related to a finding of "noncompliance with the Parity Act" when an incomplete report has been submitted.

See Instructions for Data Supplements 1 – 5 which contain requests for additional required data to supplement the responses provided in Step 5 of the NQTL Analysis Report.

Although each of the Data Supplements 1-5 was primarily designed to support the in-operation analysis for a specific NQTL, some of the data points are relevant to multiple NQTLs, and the MIA may request an explanation for disparate results for the same Data Supplement under more than one NQTL.

A separate data supplement must be submitted for each product, except that an additional separate data supplement shall be submitted for any plan within the product for which a separate NQTL report is required to be submitted under § 15-144(c)(4). A separate NQTL report is required for any plan within the product where the processes, strategies, evidentiary standards, or other factors used in designing and applying the reported NQTLs to mental health benefits, substance use disorder benefits, or medical/surgical benefits are different, as written or in operation, from the other plans within the

product. The data reported on each data supplement must be specific to the product or plan for the corresponding NQTL report.



Step 6 Delegated Entities:

Identify the measures used to ensure comparable design, development, and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

This step is only required if administration of a benefit subject to the applicable NQTL has been delegated to another entity, e.g. formulary design of prescription benefits has been delegated to a pharmacy benefits manager.

- If the carrier delegates administration or management of certain benefits to a third party vendor or service provider (for example, a private review agent specializing in mental health and substance use disorder benefits or a pharmacy benefits manager), the carrier is responsible for coordinating with the subcontracted entity on the development and application of NQTLs for MH/SUD and medical/surgical benefits to ensure comparability.

- Include a description of the measures, processes, and standards implemented to ensure collaboration with all vendors and subcontracted entities that exert any influence on the design, development, or application of an NQTL.

- Include any written procedures or guidelines to ensure that that the NQTL is consistently applied to similarly situated individuals.

Step 7 Specific Findings and Conclusions:

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with § 15-144 of the Insurance Article and the Parity Act. (§15-144(e)(6)).

- Explain the basis for the Carrier's conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQTL on medical/surgical benefits in each classification of benefits in which the NQTL is imposed.

- A general or conclusory statement of compliance is not sufficient.

- The analysis required for this section is not a restatement of prior sections of the report. Instead, carriers shall prepare a detailed summary of specific findings and conclusions demonstrating that the product is in compliance with the Parity Act both as written and in operation.

- To the extent there are differences noted between MH/SUD and M/S in the foregoing steps, delineate

these in the summary and note how they were reconciled in the reporting. For example, if different factors were utilized to determine services to which the NQTLs would apply, explain how the processes, strategies, evidentiary standards, and other factors were determined to be comparable and applied no more stringently as written and in operation.

- To the extent there are disparities in any comparative data analyses, including quantitative disparities shown in the required data supplement forms or other in operation analyses, explain in detail how these disparities are not evidence of parity non-compliance, and whether steps will be taken to reduce these disparities. Include whether steps have been taken to ensure/improve access to in-network M/S providers and whether the same or comparable steps have been taken for MH/SUD.

Disclosure Requirements

Identify the process used to comply with the Parity Act Disclosure Requirements for MH/SUD and M/S Benefits.

Describe the process for disclosing the criteria used for a medical necessity determination for MH/SUD benefits to current or potential members, or to a contracting provider, upon request

- Carriers shall report any instructions, guidance or information available to the public concerning the carrier's obligation to respond to disclosure requests, including where requests must be sent and what information is available in response to disclosure requests.

- Carriers shall report whether the designated division and/or individual(s) responsible for responding to disclosure requests.

- Carriers shall indicate whether they responded to any disclosure requests by denying access to the requested information and the basis for such denial.

- Carriers shall report any internal review process used to respond to disclosure requests for medical necessity criteria.

- Carriers shall report any template form response used to explain medical necessity criteria in response to a participant, beneficiary, provider, or authorized representative of the beneficiary or participant.

Describe the process for disclosing the reasons for a denial of benefits for MH/SUD.

- Carriers shall report any internal review process used to respond to disclosure requests for denials of benefits.

- Carriers shall report the criteria for responding to a disclosure request based on a denial of benefits for any applicable plan.

- Carriers shall report the number of disclosure requests received for denials of benefits and the number of instances when it failed to provide a response to a participant beneficiary, provider, or authorized representative of the beneficiary or participant within 30 days of the request.

Describe the process for disclosing plan documents that contain information about the processes, strategies, evidentiary standards and any other factors used to apply a NQTL for MH/SUD and M/S benefits in connection with a member's request for group plan information and for purposes of filing an internal coverage or grievance matter and appeals.

- A carrier shall report how its procedures ensure that the following information is disclosed:
    - any information regarding NQTLs that apply to MH/SUD and/or medical/surgical benefits offered under the applicable plan.
    - any records documenting NQTL processes and how the NQTLs are being applied to both medical/surgical and MH/SUD benefits under any applicable plan.
    - any available details as to how the standards were applied, and any internal testing, review, or analysis done by the applicable plan to support the rationale that the NQTL is being applied comparably and no more stringently to MH/SUD benefits than medical/surgical benefits.

- A carrier shall report how its procedures ensure that any plan materials related to the plan's compliance with MHPAEA are disclosed in compliance with 45 C.F.R § 146.136, including the following:
    - any references to provisions as stated on specified pages of the policy or certificate, or other underlying guidelines or criteria not included in the policy or certificate that the plan has consulted or relied upon;
    - any information regarding specific related factors or guidelines, such as applicable utilization review criteria;
    - any factors, such as cost or recommended standards of care, that are relied upon by an applicable plan for determining which M/S or MH/SUD benefits are subject to a specific requirement or limitation;
    - a description of the applicable requirement or limitation that the applicable plan believes has been used in any given MH/SUD service adverse decision within the relevant classification; and
    - the medical necessity guidelines relied upon for in- and out-of-network medical/surgical and MH/SUD benefits.

- A carrier shall provide a list of the responses provided in the prior calendar year to requests from a member or a member's authorized representative for a copy of the NQTL comparative analysis. The actual responses are not required to be included with the initial submission, but shall be available to the Commissioner upon request.

Commented [EW32]: 15-144(c)(1)(IV) and (e)(7) require disclosure of the comparative analysis and information about processes, strategies, evidentiary standards and other factors, respectively to members with individual plans. That standard should be reflected here.

Recommendation: add "INDIVIDUAL OR" before "group plan information."

ATTACHMENT B

Legal Action Center Comments – Attachment B

Instructions for Completing Data Supplement (DS) 1 Report Form (embedded) for Utilization Review

The instructions provided below pertain to a supplemental request for in-operation data to verify the audits, reviews, and analyses performed pursuant to § 15-144(e)(4) of the Insurance Article.

The NQTL analysis report requires carriers to report the results of the audits, reviews, and analyses performed to ensure compliance with the Parity Act in operation. To verify the narrative responses provided in the NQTL report, this supplemental report of data standardized among carriers is a **required** portion of the NQTL analysis report.

A supplemental data report is required for the NQTL of "Prior Authorization Review Process", including those prior authorizations in the Prescription Drug Benefit Classification. DS 1 includes data relevant to the Prescription Drug Formulary Design NQTL in addition to the Prior Authorization Review Process NQTL.

Carriers are required to enter data in the attached supplemental data report form, organized by classification, based on the definitions and instructions provided below.

Section 15-830 of the Insurance Article requires carriers to have a process for members to request referrals to an out of network provider. Section 15-830(d)(5) of the Insurance Article requires carriers to have a system in place to document all requests to obtain such a referral, and to provide the information to the Commissioner on request. The out of network exceptions requests under line 1 refer to the provisions of § 15-830 of the Insurance Article.

Carriers should refer to the definitions below when preparing the supplemental data report:

"Prior authorization" (PA) means the process that a carrier or any entity delegated by the carrier to manage mental health, substance use disorder, or medical/surgical benefits on behalf of the carrier requires a member or provider to follow prior to the rendering of services to determine if coverage will be provided based on considerations such as medical necessity, level of care, appropriateness of health care services, provider type, geographic location, or diagnosis exclusions. Prior authorization includes, but is not limited to, preauthorization, precertification, prospective review, preadmission review, pretreatment review, utilization review, and any requirement that a member or provider notify the carrier or organization prior to receiving or delivering a health care service. **Prior authorization includes reauthorization of services or benefits that had received preauthorization, but for which the approval period has lapsed at the time the request is submitted. A review of prior authorization is one conducted during the reporting period, regardless of whether or when services are delivered or whether or when a claim is submitted.**

"Approved" means that the service or item was approved in full, or, the provider agreed to accept the carrier's approval of a modification of the requested service or item. **"Approved" does not include a requested item or service for which an adverse decision or coverage decision was issued.**

Commented [EW1]: Additional detail is needed to ensure an accurate count of approved services. Please identify if this is based on claims data or some other record?

"Adverse decision" has the definition in § 15-10A-01(b) of the Insurance Article.

"Hospital inpatient" means inpatient care following admission to a hospital, usually designated with place of service code 21 on a claim.

Legal Action Center Comments – Attachment B

"Other inpatient" means care in an inpatient facility that is not a hospital. Examples include a skilled nursing facility, hospice, or residential treatment center.

Outpatient care is divided into office visits and all other. "Office visits" refers to health care services provided in a health care provider's office, usually designated on a claim with place of service code 11.

"Other outpatient" services are outpatient services that are not provided in a health care provider's office. Examples include an ambulatory surgical center or non-residential substance abuse treatment facility.

"Fail-first" means a protocol established by a carrier that a member must unsuccessfully attempt a different drug or treatment before the health benefit plan provides coverage for the recommended drug or treatment.

In counting the numbers of authorization reviews conducted, use the number of reviews conducted during the prior calendar year (i.e., 2023). The number of adverse decisions shall be those arising from the reported reviews.

In counting the total number of visits/admissions/prescriptions, use the number of claims **submitted** during the prior calendar year.

For the "Prescription Drug Benefit Classification" section, counts for PAs should include initial PA, and also reauthorizations if additional refills are needed.

Data-Supplement 1-Prior Authorization

Any disparities in the data between M/S and MH/SUD should be explained in Step 7 of the NQTL Analysis Report Template for the Prior Authorization NQTL.

Commented [EW2]: To ensure uniformity, please identify the source that is to be used to provide a count of fail-first requirements. The source should be verifiable and subject to review.

Commented [EW3]: To ensure uniformity, please identify the source that is supposed to be used to determine this count. The source should be verifiable and subject to review. Additionally, each carrier may "count" PA requests and authorizations in different ways. We recommend providing additional guidance to achieve uniform methodology.

Commented [EW4]: This instruction raises several concerns and requires additional definitions to ensure uniform data gathering:

- If an episode of care that is subject to PA includes multiple "outpatient "visits," (e.g. 10 OP visits on separate days), should the total number of "visits" be counted as 1 episode of care or the number of visits in the episode of care?
- In using claims data for this count, is each service that requires PA counted separately or, if multiple services are included in one claim, is that counted as a single PA?
- Does the claim include information on whether PA is required and for which services?
- For clarification, the statement should read "…., use the number of claims submitted during the prior calendar year THAT REQUIRED PRIOR AUTHORIZATION."

Commented [EW5]: The definition of authorization includes reauthorizations for all benefits not just prescription drugs. The instructions should reflect this and the data should be captured for all classifications.

Commented [EW6]: We request the inclusion of several additional data points to assess the administrative burden associated with the PA process and the level outcome of grievances:

- Number of PA requests that received a peer-to-peer or physician-to-physician review.
- Number of adverse decisions that were internally appealed.
- Appeal determination (overturned or upheld).

Commented [EW7]: We recommend that the data request for OON exceptions under 15-830 be place in Data Supplement 4, Provider Shortages, as this data point is related to network inadequacy rather than utilization review.

ATTACHMENT C

Legal Action Center – Attachment C

Instructions for Data Supplement 2 (embedded), Prescription Drug Formulary Design

The instructions provided below pertain to a supplemental request for data to verify the NQTLS implemented in Prescription Drug Formulary Design and the audits, reviews, and analyses performed pursuant to § 15-144(e)(4) of the Insurance Article

The NQTL analysis report requires carriers to report the results of the audits, reviews, and analyses performed to ensure compliance with the Parity Act in operation. To verify the narrative responses provided in the NQTL analysis report and the reviews required by the NQTL analysis report, this supplemental report of data standardized among carriers is a required portion of the NQTL analysis report.

A supplemental data report is required for the NQTL of prescription drug formulary design.

Carriers are required to follow the instructions and definitions below in completing the supplemental data report.

Table 1

Section 15-831 of the Insurance Article requires carriers that have formularies to implement procedures for members to request exceptions to the formulary. Section 15-831(c)(1) of the Insurance Article requires carriers to have a procedure to allow a member to receive a prescription drug that is not in the carrier's formulary and is therefore not covered. Section 15-831(c)(2) of the Insurance Article requires carriers to have a procedure to allow a member to continue to receive a prescription drug at lower cost-sharing if the drug is moved to a tier with higher cost-sharing.

Commented [EW1]: The template Tables 1 and 2 do not separate out reporting for MH and SUD medications, as required under the Parity Act. Data may differ dramatically for the two sets of medications and disparities could be masked without separate reporting. Table 3 appropriately requires separate reporting.

The number of requests received refers to requests received **during the prior calendar year**.

The number of adverse decisions refers to the outcome of requests received during the prior calendar year and reported on lines 1 or 2. Note that outcomes in current year from requests received at the end of the prior calendar year should be counted.

Approved means that the request was approved in full.

Commented [EW2]: This definition of "approved" does not track the definition in Form 1 Utilization Review, which includes in the definition of "approved" modifications of the requested service/item that the provider accepts. Does that apply to prescription drugs? In our view, "approved" should only include decisions that approve the medication/service that has been requested by the provider without modifications.

The sum of denied requests, approved requests, and pending requests should total the number of requests received

Adverse decision has the meaning in § 15-10A-01(b) of the Insurance Article.

Tables 3A, 3B, and 3C

Commented [EW3]: To ensure uniform methodology across all carriers, we recommend that the instructions identify the source of information for all data in Table 3, whether that is the carrier's formulary or other source.

"Prior authorization" (PA) means the process that a carrier or any entity delegated by the carrier to manage mental health, substance use disorder, or medical/surgical benefits on behalf of the carrier requires a member or provider to follow prior to the rendering of services to determine if coverage will be provided based on considerations such as medical necessity, level of care, appropriateness of health care services, provider type, geographic location, or diagnosis exclusions. Prior authorization includes, but is not limited to, preauthorization, precertification, prospective review, preadmission review, pretreatment review, utilization review, and any requirement that a member or provider notify the carrier or organization prior to receiving or delivering a health care service. **Prior authorization includes**

reauthorization of services or benefits that had received preauthorization, but for which the approval period has lapsed at the time the request is submitted.

"Step Therapy"/ "Fail-first" means a protocol established by a carrier that a member must unsuccessfully attempt a different drug or treatment before the health benefit plan provides coverage for the recommended drug or treatment.

"Dispensing Limits" means limits placed on "quantity of covered medication per prescription", or "quantity of covered medication in a given time period".

"Generic Substitution" means substitution from the originally-prescribed brand name drug to a generic medication with the same active chemical ingredient, same dosage strength, and same dosage form. An example would be substituting 20 mg of Lipitor to 20 mg of Atorvastatin.

"Therapeutic Substitution" is the replacement of the originally-prescribed drug with an alternative molecule with assumed equivalent therapeutic effect. An example would be substituting 20 mg of Lipitor to 20 mg of Simvastatin.

Data-Supplement (DS) 2-Rx Formulary D

Any disparities in the data between M/S and MH/SUD should be explained in Step 7 of the NQTL Analysis Report Template for the Prescription Drug Formulary Design NQTL.

Commented [EW4]: Additional data points should be included in Tables 1 and 2 to evaluate:

- Number of appeals of adverse decisions
- Determination (upheld or reversed)

Additional data points should be included in Tables 3A, 3B and 3C to assess concurrent and retrospective review for medications, which data are not captured in Data Supplement 1 and result in burdensome administrative processes for previously authorized medications and delayed access to necessary medications.

- Number of medications requiring concurrent review.
- Number of medications requiring retrospective review

ATTACHMENT D

Legal Action Center Comments – Attachment D

Instructions for Data Supplement 3 (embedded), IN-NETWORK REIMBURSEMENT

For In-Network provider office visits only, for the CPT codes provided in Tables A, B (1) and B (2), provide the weighted average allowed amounts for the specific groups of providers listed in the tables.

Please complete Tables A, B (1) and B (2) for claims data for Calendar Year 2023, or *for the period January 1, 2023, through the latest month in 2023 for which reasonably complete claims data is available.*

Instructions for completing Table A follow:

• In Rows 1– 4, insert the weighted average in-network allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for Column A (CPT 99213) and Column B (99214). This calculation will provide the same result as calculating the sum of the allowed amounts for every in-network 99213 and 99214 claim, separately, that was allowed for these providers, and dividing each sum by the total number of such claims allowed for such providers.

• In Row 5, insert the percentage amount (if any) by which the in-network reimbursement for PCPs and other non-psychiatrist M/S specialist physicians (combined) was greater than for psychiatrists.

Instructions for completing Tables B (1) and B (2) follow:

• In Rows 1– 3, Column A of Tables B (1) and B (2), insert the weighted average allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for Column A CPT Codes listed. This calculation will provide the same result as calculating the sum of the allowed amounts for every in-network 99213, 99214, 90834, and 90837 claim, separately, that was allowed for these providers, and dividing each sum by the total number of such claims allowed for such providers.

• Rows 1 - 3, Column C of Tables B (1) and B (2), insert weighted average allowed amount as a percentage of the Medicare Fee schedule amount.

Data-Supplement (DS) 3-Reimbursemen

Any disparities in the following noted below between M/S and MH/SUD providers should be explained in Step 7 of the NQTL Analysis Report Template for the NQTL of Reimbursement for INN Providers, OON Providers, INN Facilities, OON Facilities (separately)

1. Table A: If there is a positive difference (where allowed amount is higher for M/S clinicians compared to psychiatrists) for EITHER CPT code 99213 (column A) or CPT code 99214 (column B)

2. Tables B and C: If the "Plan Weighted Average Allowed Amount as a Percentage of Medicare" (last column in both tables) is greater (more positive) for PCPs and non-psychiatrist M/S specialist physicians (combined) than for psychologists and/or clinical social workers

Commented [EW1]: We **recommend** the following revisions to the template to gather additional and more accurate information for reimbursement and Medicare comparative rates. Justification is provided in our comment letter.
Table A:

- Add 2 additional codes: 99204 (new patient visit 45-59 minutes) and 99215 (established patient visit, 40-54 minutes) to capture new and patients with more complex needs.
- Table A: Add Reimbursement rates for Physician Assistants as a separate provider type (separate from non-psychiatric physicians).
- Table A: examine the 75th and 95th percentile payments for psychiatrists, psychologists and non-psychiatrist medical/surgical physicians.
- Create a separate table to compare reimbursement rates for Nurse Practitioners and Psychiatric Nurses.
- Table B(1) and (2) - Medicare rates should be for Maryland areas not National to reflect the true disparities for our state.

Commented [EW2]: There is no Table C - Should be Table B(1) and B(2) and column C.

ATTACHMENT E

Legal Action Center – Attachment E

Instructions for Completing Data Supplement (DS) 4, (embedded) Provider Shortages

The instructions provided below pertain to a supplemental request for in-operation data to verify the audits, reviews, and analyses performed pursuant to § 15-144(e)(4) of the Insurance Article.

The NQTL analysis report requires carriers to report the results of the audits, reviews, and analyses performed to ensure compliance with the Parity Act in operation. To verify the narrative responses provided in the NQTL report, this supplemental report of data standardized among carriers is a **required** portion of the NQTL analysis report.

A supplemental data report is required for the "Strategies for Addressing Provider Shortages" NQTL

Carriers are required to enter data in the attached supplemental data report form, based on the definitions and instructions provided below.

Commented [EW1]: Additional definitions are needed to ensure a consistent calculation of fees based on a "negotiated" fee schedule, a "standard" fee schedule and a "bonus potential."

Data Supplement 4 must be submitted to support the in operation comparative analysis under Step 5 for the "Strategies for Addressing Provider Shortages" NQTL

Carriers should refer to the definitions below when preparing the supplemental data report:

- *Acute Inpatient facility* is defined as a hospital and encompasses (a) all M/S admissions to general acute care hospitals, long-term acute care hospitals; and (b) all MH/SUD admissions to psychiatric hospitals and general acute care hospitals.
- *Professional provider* is defined as a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services.
- *Sub-acute Inpatient facility* is defined as a non-hospital based facility or residential treatment facility and encompasses (a) all M/S admissions to inpatient rehabilitation facilities, skilled nursing facilities and; (b) all MH/SUD admissions to non-hospital based inpatient facilities and residential treatment facilities.
- *Outpatient facility (other)* is defined as, for example (a) physical, occupational, speech, and cardiovascular therapy, outpatient surgeries, interventional radiology, and infusion therapies for M/S care provided in an outpatient facility setting; and (b) intensive outpatient and partial hospitalization services for MH/SUD conditions in an outpatient facility setting, applied behavioral analysis (ABA), opioid treatment programs (OTPs), medication-assisted programs (MATs).
- *Office visit* is defined as professional services (MH/SUD or M/S) provided in a non-facility based office setting.

Instructions for Completing Table 2 in the embedded Excel sheet

Commented [EW2]: All reports for Table 1 and 2 must separately report MH and SUD providers and instructions must be provided to guide a determination of whether the practitioner delivers MH or SUD services and how to count the practitioner if they deliver both services. Table 2 should be based on the type of setting, where possible, and where needed the services based on the patient's primary diagnosis identified in the claim. Additional justification is provided in LAC's letter.

- In Rows 1–4, Columns A and B, insert the percentage of all submitted claims that were for OON services for M/S Providers (Column A) and for MH/SUD Providers (Column B) for acute inpatient facility stays, sub-acute inpatient facility stays, outpatient facility visits, and office visits, separately.

  "Percentage of submitted claims" is to be based on volume of individual claims (including claims for services delivered via telehealth) and not based on dollar amounts. If there are multiple claims

for an extended admission or treatment course, each claim should be counted individually.

For the percentages in question, the numerator and denominators are defined as:

(1) Numerator for M/S for each setting: **# Out-of-Network** claims **submitted** for medical and surgical services for the specified time period

Denominator for M/S for each setting: **Total # claims** (In and Out-of-Network) that were **submitted** for medical and surgical services for the specified time period

(2) Numerator for MH/SUD for each setting: **# Out-of-Network** claims **submitted** for MH/SUD services for the specified time period

Denominator for MH/SUD for each setting: **Total # claims** (In and Out-of-Network) **submitted** for MH/SUD services for the specified time period

- For Autocalculation in each row in Column C, the percentage in Column A is subtracted from the percentage in Column B.
- For Autocalculation in each row in Column D, the percentage in Column B is divided by the percentage in Column A.

Data-Supplement(DS)
4-Provider Shortages

Any disparities in the data between M/S and MH/SUD should be explained in Step 7 of the NQTL Analysis Report Template for NQTL 4 – Strategies for Addressing provider Shortages

Commented [EW3]: We recommend that the data for OON service requests under 15-830 in Data Supplement 1 be placed in this Data Supplement as it relates to a member's right to access OON services based in inadequacy networks. In addition, we request additional data on following:

- Amount of time from request for OON service to approval
- Amount of time from carrier approval to entering single case agreement.
- Average reimbursement compared to average billed amount.

ATTACHMENT F

Legal Action Center – Attachment F

Instructions for Data Supplement 5 (embedded), Provider Network Directory

The instructions provided below pertain to a supplemental request for in-operation data to verify the audits, reviews, and analyses performed pursuant to § 15-144(e)(4) of the Insurance Article.

The NQTL analysis report requires carriers to report the results of the audits, reviews, and analyses performed to ensure compliance with the Parity Act in operation. To verify the narrative responses provided in the NQTL report, this supplemental report of data standardized among carriers is a **required** portion of the NQTL analysis report.

A supplemental data report is required for the Provider Directory NQTL

Please complete Tables (1) and (2) based on the status of the Provider Directory as of December 31, 2023. .

Instructions for completing Table 1:

- In Rows 2– 4, insert the total numbers requested in each row under the appropriate columns for Medical/Surgical (M/S), Mental Health (MH) and Substance Abuse Disorder (SUD).

Instructions for completing Table 2:

- In Row 11 column G enter the number of unique covered individuals enrolled in the product and/or plan that are represented in the data supplement.
- In Rows 8– 10, insert the total numbers requested in each row under the appropriate columns for Medical/Surgical separately for PCP and Non-PCPs and Behavioral Health separately for Psychiatrics, Psychologists and Clinical Social Workers.

Carriers are required to enter data in the attached supplemental data report form.

Section 15-112(n) of the Insurance Article requires carriers to make the carrier's network directory available to prospective enrollees on the internet and, on request of a prospective enrollee, in printed form. Section 15-112(t) of the Insurance Article requires carriers to update the information provided on the Internet at least once every 15 days. And Section 15-112 (t)(3) (ii) of the Insurance Article requires carriers to contact providers listed in the carrier's network directory who have not submitted a claim in the last 6 months to determine if the providers intend to remain in the carrier's provider network.

Carriers should refer to the definitions below when preparing the supplemental data report:

"Facility" means a person, other than an individual, that provides health care services. "Facility" includes entities that bill for a bundled set of services that include services provided by staff employed by the facility. Examples of facilities include hospitals, outpatient radiology centers, and residential treatment centers.

"Professional Provider" means a health care practitioner or group of health care practitioners licensed, certified, or otherwise authorized by law to provide health care services.

"Provider Network Directory" or "Directory" means a list of the providers who participate with a carrier as an in-network provider under a particular product. For the purposes of this definition, "provider" includes physicians, non-physician practitioners, facilities, pharmacies, laboratories, and any other person or entity under contract with the carrier to provide covered services, items, or supplies to a

Commented [EW1]: We agree that "facilities" must be counted separately. We do not know whether this will accurately capture the facilities that participate in the carrier network as some carriers will not contract with MH and SUD facilities, as a facility, but rather contract with the individual practitioners. To determine any discrepancy, a preliminary question should be included: TOTAL NUMBER OF MH FACILITIES AND SUD FACILITIES WITH CONTRACTS.

Commented [EW2]: Table 2: An additional question to assess the directory listings compared to network contracts for professionals would be: TOTAL NUMBER OF PROFESSIONAL PROVIDERS WITH A NETWORK CONTRACT AS OF DECEMBER 31, 2023.

Commented [EW3]: MH and SUD providers should be reported separately in Table 2. The provider contracts should identify MH, SUD or both services. To capture additional practitioners who ca bill for MH or SUD services, Licensed Professional Counselors, Licensed Drug and Alcohol Counselors, Addiction Medicine and other practitioners identified in our comment letter should be included.

member of the carrier. A Provider Network Directory may be online or in printed form, and it includes any provider-specific information disclosed by the carrier in the directory, such as provider name, telephone number, digital contact information, practicing specialty, services offered, quality ratings, physical address of practicing locations, hours of operation, whether the provider is accepting new patients, languages spoken, race, ethnicity, gender; and other demographic and practice information.

Data-Supplement
(DS) 5-Provider Netwo

Any disparities reflected in rows 12-14 that indicate there is more stringency to locate MH/SUD providers than M/S providers should be explained in Step 7 of the NQTL Analysis Report Template for the Provider Directory NQTL.

Commented [EW4]: We request an additional data point to assess the member's experience in seeking assistance from the carrier to find a network provider.

- Number of members who requested assistance to find a MH provider, SUD provider, medical/surgical provider.