BEST PRACTICE EXAMPLES OF COMPLIANT NQTL ANALYSES TESTING AND DOCUMENTATION - WITH REGULATORY GUIDANCE EMBEDDED

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

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

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

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

Step 1. ***Describe the NQTL and classification of benefits to which it applies*****.** The plan provides a statement that these NQTLs of pre-authorization and concurrent review for SUD non-hospital inpatient/residential care were applied to both medical/surgical (M/S) and SUD benefits with a list of the non-hospital inpatient/residential rehabilitation services (levels of care, facility type) subject to this NQTL in the same inpatient benefit classification.

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

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

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

See generally: The "Six-Step" Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements: https://www.dol.gov/sites/dolgov/files/ebsa/laws-and-regulations/rules-and-regulations/public-comments/faq-38/00018.pdf

Model Disclosure Form Concerning Treatment Limitations: https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf

Regulatory Guidance: "[T]hese [evidentiary] standards sometimes rely on numerical standards." Self-Compliance Tool for MHPAEA, p. 13

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

a) Based on internal claims data, "high cost growth" was defined as more than 15% annual increases for any non-hospital inpatient/residential rehabilitation services for the plan's two (2) most recent fiscal years, as compared to the benchmark of the plan's fiscal year three (3) years back.

b) "Excessive length of stay" was defined as at least 20% longer than the average length of stay, occurring at least 10% of the time in the plan's most recent fiscal year.

Regulatory Guidance: Self-Compliance Tool for MHPAEA, p. 16:

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

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

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

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

Regulatory Guidance: Model Disclosure Request Form:
"4. Identify the methods and **analysis** used in the development of the limitation(s)."
Self-Compliance Tool for MHPAEA, p. 17:
"*Examples of methods/**analyses** substantiating that factors, evidentiary standards and processes are comparable:*

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

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

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

Regulatory Guidance: Self-Compliance Tool for MHPAEA: "Look for compliance as written **AND IN OPERATION."** p. 17.
"Determine average denial rates and appeal overturn rates for concurrent review and assess the parity between these rates for MH/SUD benefits and medical/ surgical benefits." p.13
"For the period of coverage under review, plans and issuers should be prepared to provide a record of all claims (MH/SUD and medical/surgical) submitted and the number of those denied within each classification of benefits." p. 20
"NOTE: While outcomes are NOT determinative of compliance, rates of denials may be reviewed as a warning sign, or *indicator* of a potential operational parity noncompliance." p. 17

FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION (PART VII) AND MENTAL HEALTH PARITY IMPLEMENTATION issued Nov 17, 2011, **Q3**. "Inpatient benefits for medical/surgical conditions are routinely approved for seven days …On the other hand, for inpatient mental health and substance use disorder benefits, routine approval is given for only one day…" "The plan is imposing a stricter nonquantitative treatment limitation in practice to mental health and substance use disorder benefits than is applied to medical/surgical benefits…"
FAQS ABOUT AFFORDABLE CARE ACT IMPLEMENTATION PART 34 AND MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION issued October 27, 2016, Q6. The "plan requires prior authorization … that buprenorphine is medically necessary for the treatment of my opioid use disorder… due to safety risks associated with buprenorphine. Although there are prescription drugs to treat medical/surgical conditions that have similar safety risks, my plan does not impose similar prior authorization requirements on those drugs."
The prior authorization requirement is applied more stringently to buprenorphine when used to treat opioid use disorder than it is applied to prescription drugs with similar safety risks to treat medical/ surgical conditions…and does not comply with MHPAEA."

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

Step 6. ***Provide* detailed summary explanation of how the analyses of underlying factors, evidentiary standards, strategies and processes led to conclusion that NQTL was compliant as written and in operation.** The plan disclosed a detailed summary explanation of the analyses it had conducted and the results of its testing and audits, that led the plan to conclude that these NQTLs of pre-authorization and concurrent review were developed and applied comparably and no more stringently**.**

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

EXAMPLE 2 – NETWORK ACCESS /SETTING OF REIMBURSEMENT RATES

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

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

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

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

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

> **Regulatory Guidance**: Self-Compliance Tool for MHPAEA:
> "[Evidentiary]standards sometimes rely on **numerical** standards, for example, numerical reimbursement rates…" "[S]tandards for provider admission, **including associated reimbursement rates** to which a participating provider must agree, are to be evaluated in accordance with the rules for NQTLs." p. 13.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Step 6. ***Provide detailed summary explanation of how the analyses of underlying factors, evidentiary standards, strategies and processes led to conclusion that NQTL was compliant as written and in operation.*** The plan disclosed the methodologies by which it applied adjustment factors to MAC. The plan also disclosed internal guidance given to its staff that outlined how NQTLs, including provider reimbursement rates, should be developed in a parity compliant manner, and disclosed that it continued to monitor wait times, the percentage of credentialed network providers providing services to patients, and out-of-network utilization every 6 months.

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

EXAMPLE 3 – PLAN DISCLOSURE

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

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

The plan provided a summary of the items below:

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

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

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

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

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

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

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

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

EXAMPLE 4 – EXCLUSIONS FROM OR LIMITATIONS ON BENEFITS

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

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

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

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

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

Regulatory Guidance:
FAQS ABOUT MENTAL HEALTH AND SUBSTANCE USE DISORDER PARITY IMPLEMENTATION AND THE 21ST CENTURY CURES ACT PART 39 , Q2:
"[T]he plan denied all claims for ABA therapy to treat children with Autism Spectrum Disorder…" based on the treatment being "experimental or investigative." For "medical/surgical conditions, the plan approved treatment when supported by one or more professionally recognized treatment guidelines and two or more controlled randomized trials."
"Is this permissible? **No**…, in practice, [the plan] imposes this exclusion more stringently on MH/SUD benefits, as the plan denies all claims for ABA therapy, despite the fact that professionally recognized treatment guidelines and the requisite number of randomized controlled trials support the use of ABA therapy to treat children with Autism Spectrum Disorder."

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

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

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

Self-Compliance Tool for MHPAEA: FAQ at Page 19:
Summary of Facts: The plan denied treatment for a patient with chronic depression who failed to respond to anti-depressants and was referred for outpatient treatment with repetitive transcranial magnetic stimulation (rTMS), which was approved by the FDA and undergone more than six randomized controlled trials published in peer reviewed journals. The plan's standard for both M/S and MH/SUD benefits required at least two randomized controlled trials showing efficacy of a treatment be published in peer reviewed journals for any new treatment. However, regarding rTMS, a committee of medical experts determined that only one of the articles provided sufficient evidence of efficacy. The plan does not impose this additional level of scrutiny in reviewing medical/surgical treatments.

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

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

Step 6. ***Provide detailed summary explanation of how the analyses of underlying factors, evidentiary standards, strategies and processes led to conclusion that NQTL was compliant as written and in operation.***
The plan disclosed a detailed summary explanation of the analyses it had conducted and the results of its testing and audits, and how the plan concluded that this NQTL was developed and applied comparably and no more stringently, both in writing and in operation.

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

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