KAISER PERMANENTE®

MENTAL HEALTH PARITY NQTL COMPARATIVE ANALYSIS
COMMERCIAL HMO LINE OF BUSINESS

Subject Matter: 2022 Mental Health Parity Comparative Analyses Annual Report

Dear Commissioner of Insurance and Safety Fire,

Kaiser Foundation Health Plan of Georgia, Inc. and each of its subsidiaries that issue health plan coverage (severally "Kaiser") acknowledge its obligation to comply with MHPAEA and the CAA for fully insured plans. Kaiser is providing the Non-Quantitative Treatment Limit (NQTL) comparative analyses for the following areas prioritized by the Department of Labor in FAQ 45 as applicable.

- Prior Authorization
- Concurrent Review
- Provider Credentialing
- Provider Reimbursement

In these comparative analyses, Kaiser evaluates each NQTL across the six benefit classifications specified in the MHPAEA rules for HMO coverage for the commercial line of business: Outpatient In/Out Network, Inpatient In/Out Network, Emergency Services, and Pharmacy.

Kaiser continues to review applicable NQTLs to conduct and document the comparative analyses in accordance with the guidance in FAQ 45. In addition, the documentation is subject to change based on any additional guidance from our state and federal regulators.

We hope these materials are helpful. Please contact us if we can assist you further.

Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)

About This Tool

The goal of this self-compliance tool is to help group health plans, plan sponsors, plan administrators, group and individual market health insurance issuers, state regulators, and other parties determine whether a group health plan or health insurance issuer complies with the Mental Health Parity and Addiction Equity Act (MHPAEA) and additional related requirements under the Employee Retirement Income Security Act of 1974 (ERISA) that apply to group health plans. The requirements described in this tool generally apply to group health plans, group health insurance issuers, and individual market health insurance issuers. However, requirements that do not apply as broadly are so noted.

This tool does not provide legal advice. Rather, it gives the user a basic understanding of MHPAEA to assist in evaluating compliance with its requirements. For more information on MHPAEA, or related guidance issued by the Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (collectively, the Departments), please visit https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

Furthermore, as directed by Section 13001(a) of the 21st Century Cures Act, this publicly available tool is a compliance program guidance document intended to improve compliance with MHPAEA. DOL will update the self-compliance tool biennially to provide additional guidance on MHPAEA's requirements, as appropriate.

MHPAEA, as a federal law, sets minimum standards for group health plans and issuers with respect to parity requirements. However, many states have enacted their own laws to advance parity between mental health and substance use disorder benefits and medical/surgical benefits by supplementing the requirements of MHPAEA. Insured group health plans and issuers should consult with their state regulators to understand the full scope of applicable parity requirements.

This tool provides a number of examples that demonstrate how the law applies in certain situations and how a plan or issuer might or might not comply with the law. Additional examples are included in the Appendix I. The fact patterns used as examples are intended to help group health plans and health insurance issuers identify and address important MHPAEA issues.

Examples of MHPAEA enforcement actions that the DOL has undertaken are included in the MHPAEA Enforcement Fact Sheets, available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity. Examples of MHPAEA enforcement actions that HHS has taken are included in the Department of Health and Human Services' MHPAEA Reports at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#mental-health-parity.

Introduction

MHPAEA, as amended by the Patient Protection and Affordable Care Act (the Affordable Care Act), generally requires that group health plans and health insurance issuers offering group or individual health insurance coverage ensure that the financial requirements and treatment limitations on mental health or substance use disorder (MH/SUD) benefits they provide are no more restrictive than those on medical or surgical benefits. This is commonly referred to as providing MH/SUD benefits in parity with medical/surgical benefits.

MHPAEA generally applies to group health plans and group and individual health insurance issuers that provide coverage for MH/SUD benefits in addition to medical/surgical benefits. DOL has primary enforcement authority with regard to MHPAEA over private sector employment-based group health plans, while HHS has primary enforcement authority over non-federal governmental group health plans, such as those sponsored by state and local government employers. HHS also has primary enforcement authority for MHPAEA over issuers selling products in the individual and fully insured group markets in states that have notified HHS' Centers for Medicare & Medicaid Services that they do not have the authority to enforce or are not otherwise enforcing MHPAEA. In all other states, generally the state is responsible for directly enforcing MHPAEA with respect to issuers.

Unless a plan is otherwise exempt, MHPAEA generally applies to both grandfathered and non-grandfathered group health plans and large group health insurance coverage. Also, the Affordable Care Act requires all issuers offering coverage in the individual and small group markets to cover certain essential health benefits (EHB), including MH/SUD benefits. Final rules issued by HHS implementing EHB requirements specify that MH/SUD benefits must be consistent with the requirements of the MHPAEA regulations. *See 45 CFR 156.115(a)(3).*

Under the MHPAEA regulations, if a plan or issuer provides MH/SUD benefits in any classification described in the MHPAEA final regulation, MH/SUD benefits must be provided in every classification in which medical/surgical benefits are provided. Under PHS Act section 2713, as added by the Affordable Care Act, non-grandfathered group health plans and group and individual health insurance coverage are required to cover certain preventive services with no cost-sharing, which include, among other things, alcohol misuse screening and counseling, depression screening, and tobacco use screening. However, the MHPAEA regulations do not require a group health plan or a health insurance issuer that provides MH/SUD benefits only to the extent required under PHS Act section 2713, to provide additional MH/SUD benefits in any classification. *See 29 CFR 2590.712(e)(3)(ii), 45 CFR 146.136(e)(3)(ii), 26 CFR 54.9812-1(e)(3)(ii).*

Definitions

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan or health insurance coverage for any coverage unit.

Annual dollar limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan or health insurance coverage for any coverage unit.

Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on certain accumulated amounts, and they include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.)

Cumulative quantitative treatment limitations are treatment limitations that determine whether or to what extent benefits are provided based on certain accumulated amounts, such as annual or lifetime day or visit limits.

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Medical/surgical benefits means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law, but not including MH/SUD benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or state guidelines).

Mental health benefits means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or state guidelines).

NOTE: If a plan defines a condition as a mental health condition, it must treat benefits for that condition as mental health benefits for purposes of MHPAEA. For example, if a plan defines autism spectrum disorder (ASD) as a mental health condition, it must treat benefits for ASD as mental health benefits. Therefore, for example, any exclusion by the plan for experimental treatment that applies to ASD should be evaluated for compliance as a nonquantitative treatment limitation (NQTL) (and the processes, strategies, evidentiary standards, and other factors used by the plan to determine whether a particular treatment for ASD is experimental, as written and in operation, must be comparable to and no more stringently applied than those used for exclusions of experimental treatments of medical/surgical conditions in the same classification). *See FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century*

Cures Act Part 39, *Q1, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf*. Additionally, if a plan defines ASD as a mental health condition, any aggregate annual or lifetime dollar limit or any quantitative treatment limitation (QTL) imposed on benefits for ASD (for example, an annual dollar cap on benefits for Applied Behavioral Analysis (ABA) therapy for ASD of $35,000, or a 50-visit annual limit for ABA therapy for ASD) should also be evaluated for compliance with MHPAEA.

Substance use disorder benefits means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable federal and state law. Any disorder defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or state guidelines).

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both QTLs, which are expressed numerically (such as 50 outpatient visits per year), and NQTLs, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

SECTION A. APPLICABILITY

Question 1. Is the group health plan or group or individual health insurance coverage exempt from MHPAEA? If so, please indicate the reason (e.g. retiree-only plan, excepted benefits, small employer exception, increased cost exception, HIPAA opt-out).

Comments: No

If a group health plan or group or individual health insurance coverage provides either MH/SUD benefits, in addition to medical/surgical benefits, the plan may be subject to the MHPAEA parity requirements. However, **retiree-only group health plans**, self-insured non-federal governmental plans that have elected to exempt the plan from MPHAEA, and group health plans and group or individual health insurance coverage offering only **excepted benefits**, are generally not subject to the MHPAEA parity requirements. (***Note***: if under an arrangement(s) to provide medical care benefits by an employer or employee organization, any participant or beneficiary can simultaneously receive coverage for medical/surgical benefits and MH/SUD benefits, the MHPAEA parity requirements apply separately with respect to each combination of medical/surgical benefits and MH/SUD benefits and all such combinations are considered to be a single group health plan. *See 26 CFR 54.9812-1(e), 29 CFR 2590.712(e), 45 CFR 146.136(e)*).

Under ERISA, the MHPAEA requirements do not apply to **small employers**, defined as employers who employed an average of at least 2 but not more than 50 employees on business days during the preceding calendar year and who employ at least 1 employee on the first day of the plan year. *See 26 CFR 54.9812-1(f)(1), 29 CFR 2590.712(f)(1*), *45 CFR 146.136(f)(1).* However, under HHS final rules governing the Affordable Care Act requirement to provide EHBs, non-grandfathered health insurance coverage in the individual and small group markets must provide all categories of EHBs, including MH/SUD benefits. The final EHB rules require that such benefits be provided in compliance with the requirements of the MHPAEA rules. *45 CFR 156.115(a)(3); see also ACA Implementation FAQs Part XVII, Q6, available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-xvii.pdf.* In practice, this means that employees in group health plans offered by small employers who purchase non-grandfathered health insurance coverage in the small group market (within the meaning of section 2791 of the PHS Act) that must provide EHBs have coverage that is subject to the requirements of MHPAEA.

MHPAEA also contains an **increased cost exemption** available to group health plans and issuers that meet the requirements for the exemption. The MHPAEA regulations establish standards and procedures for claiming an increased cost exemption. *See 26 CFR 54.9812-1(g), 29 CFR 2590.712(g), 45 CFR 146.136(g)*.

Sponsors of self-funded, non-federal governmental plans are permitted to elect to exempt those plans from certain provisions of the PHS Act, including MHPAEA. An exemption election is commonly called a "HIPAA opt-out." The HIPAA opt-out election was authorized under section 2722(a)(2) of the PHS Act (42 USC § 300gg-21(a)(2)). *See also* 45 CFR 146.180. The

procedures and requirements for self-funded, non-federal governmental plans to opt out may be found at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources#Self-Funded%20Non-Federal%20Governmental%20Plans.

Question 2. If not exempt from MHPAEA, does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in addition to providing medical/surgical benefits?

Comments: Yes

Unless the group health plan or group or individual health insurance coverage is exempt from MHPAEA or does not provide MH/SUD benefits, continue to the following sections to examine compliance with requirements under MHPAEA.

SECTION B. COVERAGE IN ALL CLASSIFICATIONS

Question 3. Does the group health plan or group or individual health insurance coverage provide MH/SUD benefits in every classification in which medical/surgical benefits are provided?

Comments: Yes

Under the MHPAEA regulations, if a plan or issuer provides mental health or substance use disorder benefits in any classification described in the MHPAEA final regulation, mental health or substance use disorder benefits must be provided in every classification in which medical/surgical benefits are provided. *See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).*

Under the MHPAEA regulations, the six classifications* of benefits are:

1) inpatient, in-network;
2) inpatient, out-of-network;
3) outpatient, in-network;
4) outpatient, out-of-network;
5) emergency care; and
6) prescription drugs.

See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).

**See special rules related to the classifications discussed below.*

> ***NOTE***: If a plan or coverage generally excludes all benefits for a particular mental health condition or substance use disorder, but nevertheless includes prescription drugs for treatment of that condition or disorder on its formulary, the plan or coverage covers MH/SUD benefits in only one classification (prescription drugs). Therefore, the plan or coverage would generally be required to provide mental health or substance use disorder benefits with respect to that condition or disorder for each of the other five classifications for which the plan also provides medical/surgical benefits. However, if a prescription drug that may be used for a particular MH/SUD condition and may also be used for other unrelated conditions is included on a plan's or coverage's formulary, the drug's inclusion on the formulary alone would not be considered to override the plan or coverage's general exclusion for a particular mental health condition or substance use disorder unless the plan or coverage covers prescription drugs specifically to treat that condition.

ILLUSTRATION: A Plan provides for medically necessary medical/surgical benefits as well as MH/SUD benefits. While the Plan covers medical/surgical benefits in all benefit classifications, it does not cover outpatient services for MH/SUD benefits for either in-network or out-of-network providers. In this example, since the Plan fails to provide MH/SUD benefits in outpatient, in-network and outpatient, out-of-network classifications in which medical/surgical benefits are provided, the Plan fails to meet MHPAEA's parity requirements. The Plan could

come into compliance by covering outpatient services for MH/SUD benefits both in- and out-of-network in a manner comparable to covered medical/surgical outpatient in- and out-of-network services.

Classifying benefits. In determining the classification in which a particular benefit belongs, a group health plan or group or individual market health insurance issuer must apply the same standards to medical/surgical benefits as to MH/SUD benefits. *See 26 CFR 54.9812-1(c)(2)(ii)(A), 29 CFR 2590.712(c)(2)(ii)(A), 45 CFR 146.136(c)(2)(ii)(A).* This rule also applies to intermediate services provided under the plan or coverage. Plans and issuers must assign covered intermediate MH/SUD benefits (such as residential treatment, partial hospitalization, and intensive outpatient treatment) to the existing six classifications in the same way that they assign intermediate medical/surgical benefits to these classifications. For example, if a 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 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. A plan or issuer must also comply with MHPAEA's NQTL rules, discussed in Section F, in assigning any benefits to a particular classification. *See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4).*

Medication Assisted Treatment (MAT) is subject to MHPAEA

Plans and issuers that offer MAT benefits to treat opioid use disorder are subject to MHPAEA requirements, including the special rule for multi-tiered prescription drug benefits that applies to the medication component of MAT. The behavioral health services components of MAT should be treated as outpatient benefits and/or inpatient benefits as appropriate for purposes of MHPAEA. Plans and issuers should ensure there are NO impermissible QTLs, such as visit limits, or impermissible NQTLs, such as limits on treatment dosage and duration. For example, a limitation providing that coverage of medication for the treatment of opioid use disorder is contingent upon the availability of behavioral or psychosocial therapies or services or upon the patient's acceptance of such services would generally not be permissible unless a comparable process was used to determine limitations for the coverage of medications for the treatment of medical/surgical conditions.

ILLUSTRATION: An issuer did not cover methadone for opioid addiction, though it did cover methadone for pain management. The issuer failed to demonstrate that the processes, strategies, evidentiary standards, and other factors used to develop the methadone treatment exclusion for opioid addiction are comparable to and applied no more stringently than those used for medical/surgical conditions. The issuer re-evaluated the medical necessity of methadone-maintenance treatment programs and developed medical-necessity criteria that mirrors federal guidelines (including the Substance Abuse and Mental Health Services Administration treatment improvement protocol 63 for medication for opioid use disorder) for opioid treatment programs to replace the methadone-maintenance treatment exclusion.

ILLUSTRATION: A plan uses nationally recognized clinical standards to determine coverage for prescription drugs to treat medical/surgical benefits based on the recommendations of a Pharmacy and Therapeutics (P&T) committee. However, the plan deviates from such standards

for buprenorphine/naloxone to treat opioid use disorder based on the P&T committee's recommendations. This deviation should be evaluated for compliance with MHPAEA's NQTL standard in practice, including the determination of (1) whether the P&T committee has comparable expertise in MH/SUD conditions as it has in medical/surgical conditions, and (2) whether the committee's evaluation of the nationally-recognized clinical standards and decision processes to deviate from those standards for MH/SUD conditions is comparable to and no more stringent than the processes it follows for medical/surgical conditions.

Treatment for eating disorders is subject to MHPAEA

Eating disorders are mental health conditions, and treatment of an eating disorder is a "mental health benefit" as that term is defined by MHPAEA. *See ACA Implementation FAQs Part 38, Q1, available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-38.pdf*. Section 13007 of the 21st Century Cures Act provides that if a plan or an issuer provides coverage for eating disorders, including residential treatment, they must provide these benefits in accordance with MHPAEA requirements. For example, an exclusion under a plan of all inpatient, out-of-network treatment outside of a hospital setting for eating disorders would generally not be permissible if the plan did not employ a comparable process to determine if a similar limitation on treatment outside hospital settings for medical/surgical benefits warranted. *See FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q8, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf*.

Compliance Tips

- If the plan or issuer does not contract with a network of providers, all benefits are out-of-network. If a plan or issuer that has no network imposes a financial requirement or treatment limitation on inpatient or outpatient benefits, the plan or issuer is imposing the requirement or limitation within classifications (inpatient, out-of-network or outpatient, out-of-network), and the rules for parity will be applied separately for the different classifications. *See 26 CFR 54.9812-1(c)(2)(ii)(C), 29 CFR 2590.712(c)(2)(ii)(C), 45 CFR 146.136(c)(2)(ii)(C) Example 1.*
- If a plan or issuer covers the full range of medical/surgical benefits (in all classifications, both in-network and out-of-network), beware of exclusions on out-of-network MH/SUD benefits.
- Benefits for intermediate services (such as non-hospital inpatient and partial hospitalization) must be assigned to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits.

***_NOTE_: Special rules related to classifications**

1. **Special rule for outpatient sub-classifications:**

   - For purposes of determining parity for outpatient benefits (in-network and out-of-network), a plan or issuer may divide its benefits furnished on an outpatient basis into two sub-classifications: (1) office visits; and (2) all other outpatient items and services, for purposes of applying the financial requirement and treatment limitation rules. *26 CFR 54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), 45 CFR 146.136(c)(3)(iii)*.

     - After the sub-classifications are established, the plan or issuer may not impose any financial requirement or QTL on MH/SUD benefits in any sub-classification (*i.e.*, office visits or non-office visits) that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the sub-classification using the methodology set forth in the MHPAEA regulations. *See 26 CFR 54.9812-1(c)(3)(i), 29 CFR 2590.712(c)(3)(i), 45 CFR 146.136(c)(3)(i), 45 CFR 146.136(c)(3)(iii).*

   - Other than as explicitly permitted under the final rules, sub-classifications are not permitted when applying the financial requirement and treatment limitation rules under MHPAEA. Accordingly, separate sub-classifications for generalists and specialists are not permitted.

2. **Special rule for prescription drug benefits:**

   - There is a special rule for multi-tiered prescription drug benefits. Multi-tiered drug formularies involve different levels of drugs that are classified based primarily on cost, with the lowest-tier (Tier 1) drugs having the lowest cost-sharing. If a plan or issuer applies different levels of financial requirements to different tiers of prescription drug benefits, the plan complies with the mental health parity provisions if it establishes the different levels of financial requirements based on reasonable factors determined in accordance with the rules for NQTLs and without regard to whether a drug is generally prescribed for medical/surgical or MH/SUD benefits. Reasonable factors include cost, efficacy, generic versus brand name, and mail order versus pharmacy pick-up. *See 26 CFR54.9812-1(c)(3)(iii), 29 CFR 2590.712(c)(3)(iii), 45 CFR 146.136(c)(3)(iii).*

3. **Special rule for multiple network tiers:**

   - There is a special rule for multiple network tiers. If a plan or issuer provides benefits through multiple tiers of in-network providers (such as in-network preferred and in-network participating providers), the plan or issuer may divide its benefits furnished on an in-network basis into sub-classifications that reflect network tiers, if the tiering is based on reasonable factors determined in accordance with the rules for NQTLs (such as quality, performance, and market standards) and without regard to whether a provider provides services with respect to medical/surgical benefits or MH/SUD

benefits. After the tiers are established, the plan or issuer may not impose any financial requirement or treatment limitation on MH/SUD benefits in any tier that is more restrictive than the predominant financial requirement or treatment limitation that applies to substantially all medical/surgical benefits in the tier.

***NOTE*:** As explained in the Introduction to this section, nothing in MHPAEA requires a non-grandfathered group health plan or health insurance coverage that provides MH/SUD benefits only to the extent required under PHS Act section 2713 to provide additional MH/SUD benefits in any classification.

SECTION C. LIFETIME AND ANNUAL LIMITS

Question 4. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding lifetime and annual dollar limits on MH/SUD benefits?

Comments:	Yes

A plan or issuer generally may not impose a lifetime dollar limit or an annual dollar limit on MH/SUD benefits that is lower than the lifetime or annual dollar limit imposed on medical/surgical benefits. *See 26 CFR 9812-1(b), 29 CFR 2590.712(b), 45 CFR 146.136(b).* (This prohibition applies only to dollar limits on what the plan would pay, and not to dollar limits on what an individual may be charged.) If a plan or issuer does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits, or it includes one that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit on MH/SUD benefits. *26 CFR 54.9812-1(b)(2), 29 CFR 2590.712(b)(2), 45 CFR 146.136(b)(2).*

ILLUSTRATION: Plan Z limits outpatient substance use disorder treatments to a maximum of $1,000,000 per calendar year. With the exception of a $500,000 per year limit on chiropractic services (which applies to less than one-third of all medical/surgical benefits), Plan Z does not impose such annual dollar limits with respect to other outpatient medical/surgical benefits. In this example, Plan Z is in violation of MHPAEA since the outpatient substance use disorder dollar limit is not in parity with outpatient medical/surgical dollar limits.

Compliance Tip

- There is a different rule for cumulative limits other than aggregate lifetime or annual dollar limits discussed later in this checklist at **Question 6.** A plan or issuer may impose annual out-of-pocket dollar limits on participants and beneficiaries if done in accordance with the rule regarding cumulative limits.

***NOTE*:** These provisions are affected by section 2711 of the PHS Act, as amended by the Affordable Care Act. Specifically, PHS Act section 2711 generally prohibits lifetime and annual dollar limits on EHB, which includes MH/SUD services. Accordingly, the parity requirements regarding lifetime and annual dollar limits apply only to the provision of MH/SUD benefits that are not EHBs.

Note also that, for plan years beginning in 2021, the annual limitation on an individual's maximum out-of-pocket (MOOP) costs in effect under the Affordable Care Act is $8,550 for self-only coverage and $17,100 for coverage other than self-only coverage. The annual limitation on out-of-pocket costs is increased annually by the premium adjustment percentage described under Affordable Care Act section 1302(c)(4), and this updated amount is detailed each year in regulations issues by the Department of Health and Human Services.

SECTION D. FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS

Question 5. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding financial requirements or QTLs on MH/SUD benefits?

Comments:	Yes

- A plan or issuer may not impose a financial requirement or QTL applicable to MH/SUD benefits in any classification that is more restrictive than the predominant financial requirement or QTL of that type that is applied to substantially all medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(2), 29 CFR 2590.712(c)(2), 45 CFR 146.136(c)(2).*
    - Types of financial requirements include deductibles, copayments, coinsurance, and out-of-pocket maximums. *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
    - Types of QTLs include annual, episode, and lifetime day and visit limits, for example, number of treatments, visits, or days of coverage. *See 26 CFR 54.9812-1(c)(1)(ii), 29 CFR 2590.712(c)(1)(ii), 45 CFR 146.136(c)(1)(ii).*
- The six classifications and the sub-classifications outlined in Section B, above, are the only classifications that may be used when determining the predominant financial requirements or QTLs that apply to substantially all medical/surgical benefits. *See 26 CFR 54.9812-1(c)(2)(ii), 29 CFR 2590.712(c)(2)(ii), 45 CFR 146.136(c)(2)(ii).* A plan or issuer may not use a separate sub-classification under these classifications for generalists and specialists. *See 26 CFR 54.9812-1(c)(3)(iii)(C), 29 CFR 2590.712(c)(3)(iii)(C), 45 CFR 146.136(c)(3)(iii)(C).*

Compliance Tips

- Ensure that the plan or issuer does not impose financial requirements or QTLs that are applicable only to MH/SUD benefits.
- Identify all benefit packages and health insurance coverage to which MHPAEA applies.

Detailed steps for applying this rule:

To determine compliance, each type of financial requirement or QTL within a coverage unit must be analyzed separately within each classification. *See 26 CFR 54.9812-1(c)(2)(i), 29 CFR 2590.712(c)(2)(i), 45 CFR 146.136(c)(2)(i).* Coverage unit refers to the way in which a plan groups individuals for purposes of determining benefits, or premiums or contributions, for example, self-only, family, or employee plus spouse. *See 26 CFR 54.9812-1(c)(1)(iv), 29 CFR 2590.712(c)(1)(iv), 45 CFR 146.136(c)(1)(iv).* If a plan applies different levels of a financial requirement or QTL to different coverage units in a classification of medical/surgical benefits (for example, a $15 copayment for self-only and a $20 copayment for family coverage), the predominant level is determined separately for each coverage unit. *See 26 CFR 54.9812-1(c)(3)(ii), 29 CFR 2590.712(c)(3)(ii), 45 CFR 146.136(c)(3)(ii).*

- **STEP ONE ("substantially all" test):** First determine if a particular type of financial requirement or QTL applies to substantially all medical/surgical benefits in the relevant classification of benefits.

  - Generally, a financial requirement or QTL is considered to apply to substantially all medical/surgical benefits if it applies to at least two-thirds of the medical/surgical benefits in the classification. *See 26 CFR 9812-1(c)(3)(i)(A), 29 CFR 2590.712(c)(3)(i)(A), 45 CFR 146.136(c)(3)(i)(A).* This two-thirds calculation is generally based on the dollar amount of plan payments expected to be paid for the plan year within the classification. *See 26 CFR 54.9812-1(c)(3)(i)(C), 29 CFR 2590.712(c)(3)(i)(C), 45 CFR 146.136(c)(3)(i)(C).* Any reasonable method can be used for this calculation. *See 26 CFR 54.9812-1(c)(3)(i)(E), 29 CFR 2590.712(c)(3)(i)(E), 45 CFR 146.136(c)(3)(i)(E).*

- **STEP TWO ("predominant" test):** If the type of financial requirement or QTL applies to at least two-thirds of medical/surgical benefits in that classification, then determine the predominant level of that type of financial requirement or QTL that applies to the medical/surgical benefits that are subject to that type of financial requirement or QTL in that classification of benefits. (***Note*:** If the type of financial requirement or QTL does not apply to at least two-thirds of medical/surgical benefits in that classification, it cannot apply to MH/SUD benefits in that classification.)

  - Generally, the level of a financial requirement or QTL that is considered the predominant level of that type is the level that applies to more than one-half of the medical/surgical benefits in that classification subject to the financial requirement or QTL. *See 26 CFR 54.9812-1(c)(3)(i)(B)(1), 29 CFR 2590.712(c)(3)(i)(B)(1), 45 CFR 146.136(c)(3)(i)(B)(1).* If there is no single level that applies to more than one-half of medical/surgical benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan can combine levels until the combination of levels applies to more than one-half of medical/surgical benefits subject to the financial requirement or QTL in the classification. In that case, the least restrictive level within the combination is considered the predominant level. *See 26 CFR 54.9812-1(c)(3)(i)(B)(2), 29 CFR 2590.712(c)(3)(i)(B)(2), 45 CFR 146.136(c)(3)(i)(B)(2).* For a simpler method of compliance, a plan may treat the

least restrictive level of financial requirement or treatment limitation applied to medical/surgical benefits as predominant.

Compliance Tip: Book of Business

- When performing the "substantially all" and "predominant" tests for financial requirements and QTLs, basing the analysis on an issuer's entire book of business is generally not a reasonable method if a plan or issuer has sufficient claims data regarding a specific plan for a reasonable projection of future claims costs for the substantially all and predominant analysis. However, there may be insufficient reliable claims data for a group health plan, in which case the analyses will require utilizing reasonable data from outside the group health plan. A plan or issuer must always use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice. *See ACA Implementation FAQs Part 34, Q3, available at* https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-34.pdf.

ILLUSTRATION: Plan Z requires copayments for out-patient, in-network MH/SUD benefits. In order to determine if the plan meets the parity requirements, take the following steps:

1. **STEP ONE: Determine if the particular type of financial requirement applies to substantially all (that is, 2/3 of) medical /surgical benefits in the relevant classification**.

   Based on its prior claims experience, Plan Z expects $1 million in medical/surgical benefits to be paid in the outpatient, in-network classification and $700,000 of those benefits are expected to be subject to copayments. Because the amount of medical/surgical benefits expected to be subject to a copayment, which is $700,000, is at least 2/3 of the $1 million total medical/surgical benefits expected to be paid, a copayment can be applied to outpatient, in-network MH/SUD benefits.

2. **STEP TWO: Determine what level of the financial requirement is predominant (that is, the level that applies to more than half the medical/surgical benefits subject to the financial requirement in the relevant classification).**

   In the outpatient, in-network classification where $1 million in medical/surgical benefits is expected to be paid, $700,000 of those benefits are expected to be subject to copayments. Out of the $700,000, Plan Z expects that 25 percent will be subject to a $15 copayment and 75 percent will be subject to a $30 copayment. Since 75 percent is more than half, the $30 copayment is the predominant level.

   CONCLUSION: Plan Z cannot impose a copayment on MH/SUD benefits in this classification that is higher than $30.

Warning Sign: If a plan or issuer applies a specialist copayment requirement for all MH/SUD benefits within a classification but applies a specialist copayment only for certain medical/surgical benefits within a classification, this may be indicative of noncompliance and warrant further review. See "Compliance Tips" below for further guidance on specialist copay requirements.

Compliance Tips

- Ensure that when conducting the predominant/substantially all tests, the dollar amount of all plan payments for medical/surgical benefits expected to be paid in that classification for the relevant plan year are analyzed.
- A plan may be able to impose the specialist level of a financial requirement or QTL to MH/SUD benefits in a classification (or an office visit sub-classification) if it is the predominant level that applies to substantially all medical/surgical benefits within the office visit sub-classification. For example, if the specialist level of copay is the predominant level of copay that applies to substantially all medical/surgical benefits in the office visit, in-network sub-classification, the plan may apply the specialist level copay to MH/SUD benefits in the office visit, in-network sub-classification. *See 26 CFR 54.9812-1(c)(3), 29 CFR 2590.712(c)(3).*

SECTION E. CUMULATIVE FINANCIAL REQUIREMENTS AND TREATMENT LIMITATIONS

Question 6. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding cumulative financial requirements or cumulative QTLs for MH/SUD benefits?

Comments:	Yes

- A plan or issuer may not apply any cumulative financial requirement or cumulative QTL for MH/SUD benefits in a classification that accumulates separately from any cumulative financial requirement or QTL established for medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(3)(v), 29 CFR 2590.712(c)(3)(v), 45 CFR 146.136(c)(3)(v).* For example, a plan may not impose an annual $250 deductible on medical/surgical benefits in a classification and a separate $250 deductible on MH/SUD benefits in the same classification.

- Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums (but do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements). *See 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a).*

- Cumulative QTLs are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits. *See 26 CFR 54.9812-1(a), 29 CFR 2590.712(a), 45 CFR 146.136(a).*

ILLUSTRATION: A plan offers three benefit options, all of which provide medical/surgical as well as MH/SUD benefits. For all three benefit options, the plan provides for in-network treatment limitations of 30 days per year with respect to inpatient mental health services, and in-network treatment limitations of 20 visits per year with respect to outpatient mental health services. No such limitations are imposed on outpatient or inpatient, in-network medical/surgical benefits in any of the three benefit options.

In this example, the plan improperly imposes cumulative treatment limitations on the number of visits for outpatient and inpatient, in-network and out-of-network mental health benefits in all three benefit options. The plan could come into compliance by removing the day and visit limits for mental health services.

SECTION F. NONQUANTITATIVE TREATMENT LIMITATIONS

Question 7. Does the group health plan or group or individual market health insurance issuer comply with the mental health parity requirements regarding NQTLs on MH/SUD benefits?

Comments:	Yes, based on the NQTL comparative analyses performed to date, Kaiser Permanente believes it is in compliance with the mental health parity NQTL requirements. Kaiser is following the guidance issued by the U.S. Department of Labor in FAQ 45 to conduct and document the NQTL comparative analysis. The attached documentation is subject to change based on additional guidance from state and federal regulators. Any disparities that may be found will undergo further review and evaluation to validate whether corrective action is needed

An NQTL is generally a limitation on the scope or duration of benefits for treatment. The MHPAEA regulations prohibit a plan or an issuer from imposing NQTLs on MH/SUD benefits in any classification unless, under the terms of the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the limitation with respect to medical/surgical benefits in the same classification. *See 26 CFR 54.9812-1(c)(4)(i), 29 CFR 2590.712(c)(4)(i), 45 CFR 146.136(c)(4)(i).*

The following is an illustrative, non-exhaustive list of NQTLs:

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Prior authorization or ongoing authorization requirements;
- Concurrent review standards;
- Formulary design for prescription drugs;
- For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- Standards for provider admission to participate in a network, including reimbursement rates;
- Plan or issuer methods for determining usual, customary, and reasonable charges;
- Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as "fail-first" policies or "step therapy" protocols);
- Exclusions of specific treatments for certain conditions;
- Restrictions on applicable provider billing codes;
- Standards for providing access to out-of-network providers;
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage.

See 26 CFR 54.9812-1(c)(4)(ii), 29 CFR 2590.712(c)(4)(ii), 45 CFR 146.136(c)(4)(ii). For additional examples of plan provisions that may operate as NQTLs see *Warning Signs, available at* https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-parity/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf.

While NQTLs are generally defined as treatment limitations that are not expressed numerically, the application of an NQTL in a numerical way does not modify its nonquantitative character. For example, standards for provider admission to participate in a network are NQTLs because such standards are treatment limitations that typically are not expressed numerically. *See 29 CFR 2590.712 (c)(4)(ii), 45 CFR 146.136(c)(4)(ii).* Nevertheless, these standards sometimes rely on numerical standards, for example, numerical reimbursement rates. In this case, the numerical expression of reimbursement rates does not modify the nonquantitative character of the provider admission standards; accordingly, standards 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.

A group health plan or issuer may consider a wide array of factors in designing medical management techniques for both MH/SUD benefits and medical/surgical benefits, such as cost of treatment; high cost growth; variability in cost and quality; elasticity of demand; provider discretion in determining diagnosis, or type or length of treatment; clinical efficacy of any proposed treatment or service; licensing and accreditation of providers; and claim types with a high percentage of fraud. Based on application of these or other factors in a comparable fashion, an NQTL, such as prior authorization, may be required for some (but not all) MH/SUD benefits, as well as for some (but not all) medical/ surgical benefits. *See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), 45 CFR 146.136(c)(4), Example 8.*

> ***NOTE*** – To comply with MHPAEA, a plan or issuer must be able to demonstrate that it follows a comparable process in determining reimbursement rates for in-network and out-of-network providers for both medical/surgical and MH/SUD benefits. For example, if reimbursement rates for medical/surgical benefits are determined by reference to the Medicare Physician Fee Schedule, reimbursement rates for MH/SUD benefits must also be determined comparably and applied no more stringently by reference to the Medicare Physician Fee Schedule. Any variance in rates applied by the plan or issuer 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 medical/surgical benefits.
>
> ***NOTE*** - Plans and issuers may attempt to address shortages in medical/surgical specialist providers and ensure reasonable patient wait times for appointments by adjusting provider admission standards, through increasing reimbursement rates, and by developing a process for accelerating enrollment in their networks to improve network adequacy. To comply with MHPAEA, plans and issuers must take measures that are comparable to and no more stringent than those applied to medical/surgical providers to help ensure an adequate network of MH/SUD providers, even if ultimately there are disparate numbers of MH/SUD and medical/surgical providers in the plan's network. The Departments note that substantially 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. *See FAQs Part 39, Q6 and Q7, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf.*

Warning Signs: The following plan provisions related to provider reimbursements may be indicative of noncompliance and warrant further review:

1. *Inequitable reimbursement rates established via a comparison to Medicare:* A plan or issuer generally pays at or near Medicare reimbursement rates for MH/SUD benefits, while paying much more than Medicare reimbursement rates for medical/surgical benefits. For assistance comparing a plan or coverage's reimbursement schedule to Medicare, see the PROVIDER REIMBURSEMENT RATE WARNING SIGNS in Appendix II.

2. *Lesser reimbursement for MH/SUD physicians for the same evaluation and management (E&M) codes:* A plan or issuer reimburses psychiatrists, on average, less than medical/surgical physicians for the same E&M codes.

3. *Consideration of different sets of factors to establish reimbursement rates*: A plan or issuer generally considers market dynamics, supply and demand, and geographic location to set reimbursement rates for medical/surgical benefits, but considers only quality measures and treatment outcomes in setting reimbursement rates for MH/SUD benefits.

In order to determine compliance with MHPAEA, the following analysis should be applied to each NQTL identified under the plan or coverage:

Step One:

- Identify the NQTL.

Comments:	Please refer to step A in the attached documentation.

Identify in the plan documents all the services (both MH/SUD and medical/surgical) to which the NQTL applies in each classification.

NOTE: NQTLs may also be included in other documents, such as internal guidelines or provider contracts.

Compliance Tips

- Ask for information about what medical/surgical benefits are also subject to these requirements or restrictions.
- If a benefit includes multiple components (*e.g.*, outpatient and prescription drug classifications), and each component is subject to a different type of NQTL (*e.g.*, prior authorization and limits on treatment dosage or duration), each NQTL must be analyzed separately.
- Find out how these requirements are implemented, who makes the decisions, and what the decision-maker's qualifications are.

Determine which benefits are treated as medical/surgical and which are treated as MH/SUD, and analyze the NQTLs under each benefit classification. Plans and issuers should clearly define which benefits are treated as medical/surgical and which benefits are treated as MH/SUD under the plan. Benefits (such as inpatient treatment at a skilled nursing facility or other non-hospital facility and partial hospitalization) must be assigned to classifications using a comparable methodology across medical/surgical benefits and MH/SUD benefits.

Compliance Tip

- Any separate NQTL that applies to only the MH/SUD benefits within any particular classification does not comply with MHPAEA.

NOTE: If a plan classifies covered intermediate levels of care, such as skilled nursing care and residential treatment, as inpatient benefits, and covers room and board for all inpatient medical/surgical care, including skilled nursing facilities and other intermediate levels of care, but imposes a restriction on room and board for MH/SUD residential care, the plan imposes an impermissible restriction only on MH/SUD benefits and therefore violates MHPAEA.[1] The plan could come into compliance by covering room and board for intermediate levels of care for MH/SUD benefits comparably with medical/surgical inpatient treatment.

[1] See 29 CFR 2590.712(c)(iii) Ex. 9.

Step Two:

- Identify the factors considered in the design of the NQTL.

Comments:	Please refer to step B in the attached documentation.

Examples of factors include but are not limited to the following:

- Excessive utilization;
- Recent medical cost escalation;
- Provider discretion in determining diagnosis;
- Lack of clinical efficiency of treatment or service;
- High variability in cost per episode of care;
- High levels of variation in length of stay;
- Lack of adherence to quality standards;
- Claim types with high percentage of fraud; and
- Current and projected demand for services.

Compliance Tips

- If only certain benefits are subject to an NQTL, such as meeting a fail-first protocol or requiring preauthorization, plans and issuers should have information available to substantiate how the applicable factors were used to apply the specific NQTL to medical/surgical and MH/SUD benefits.
- Determine whether any factors were given more weight than others and the reason(s) for doing so, including evaluating the specific data used in the determination (if any).

Step Three:

- Identify the sources (including any processes, strategies, or evidentiary standards) used to define the factors identified above to design the NQTL.

Comments: Please refer to step C in the attached documentations

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

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

If these factors are utilized, they must be applied comparably to MH/SUD and medical/surgical benefits.

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

Compliance Tips

- Evidentiary standards and processes that a plan or issuer relies upon may include any evidence that a plan or issuer considers in developing its medical management techniques, including recognized medical literature and professional standards and protocols (including comparative effectiveness studies and clinical trials), and published research studies.
- If there is any variation in the application of a guideline or standard being relied upon by the plan or issuer, the plan or issuer should explain the process and factors relied upon for establishing that variation.
- If the plan or issuer relies on any experts, the plan or issuer should assess the experts' qualifications and the extent to which the expert evaluations in setting recommendations are ultimately relied upon regarding both MH/SUD and medical/surgical benefits.

NOTE: When identifying the sources of the factors considered in designing the NQTL, also identify any threshold 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 threshold dollar amount at which prior authorization will be required for any service should also be identified. You may also wish to consider the following:

- What data, if any, are used to determine if the benefit is "high cost"?
- How, if at all, is the amount that is to be considered "high cost" or the calculation for determining that amount different for MH/SUD benefits as compared to medical/surgical benefits, and how is the difference justified?

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

- Excessive utilization 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 percent or more per year for two years.
- Lack of adherence to quality standards may be considered as a factor when deviation from generally accepted national quality standards for a specific disease category occurs more than 30 percent of the time based on clinical chart reviews.
- High level of variation in length of stay may be considered as a factor when claims data shows that 25 percent of patients stayed longer than the median length of stay for acute hospital episodes of care.
- High variability in cost per episode may be considered as a factor when episodes of outpatient care are two standard deviations higher in total cost than the average cost per episode 20 percent of the time in a 12-month period.
- Lack of clinical efficacy may be considered as a factor when more than 50 percent

of outpatient episodes of care for specific diseases are not based on evidence-based interventions (as defined by nationally accepted best practices) in a 12-month sample of claims data.

Step Four:

- Are the processes, strategies, and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and medical/surgical benefits, both as written and in operation?

Comments:	Please refer to steps D and E in the attached documentation.

Plans and issuers should demonstrate any methods, analyses, or other evidence used to determine that any factor used, evidentiary standard relied upon, and process employed in developing and applying the NQTL are comparable and applied no more stringently to MH/SUD services and medical/surgical services.

Compliance Tips

- If utilization review is conducted by different entities or individuals for medical/surgical and MH/SUD benefits provided under the plan or coverage, ensure that there are measures in place to ensure comparable application of utilization review policies.
- Determine what consequences or penalties apply to the benefits when the NQTL requirement is not met.

These are 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.
- 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 with respect to specific 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.
- 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 regarding MH/SUD and medical/surgical benefits are comparable and no more stringently applied to MH/SUD benefits.

- Summaries of research or peer-reviewed medical journal articles, if considered in designing NQTLs for both MH/SUD and medical/surgical benefits, demonstrating that the research was utilized similarly for both MH/SUD and medical/surgical benefits.

Compliance Tips

- Look for compliance as written **AND IN OPERATION**.
- Determine whether there are exception processes available and when they may be applied.
- Determine how much discretion is allowed in applying the NQTL and whether such discretion is afforded comparably for processing MH/SUD benefit claims and medical/surgical benefits claims.
- Determine who makes denial determinations and if the decision-makers have comparable expertise with respect to MH/SUD and medical/surgical benefits.
- Check sample claims to determine whether a particular NQTL warrants additional review. A plan may have written processes that are compliant on their face, but those processes may not be compliant in practice.
- 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.
- Document your analysis, as a best practice.

NOTE: While outcomes are NOT determinative of compliance, rates of denials may be reviewed as a warning sign, or indicator of a potential operational MHPAEA parity noncompliance. For example, if a plan has a 34 percent denial rate on concurrent reviews of psychiatric hospital stays in a 12-month period and a 5 percent denial rate on concurrent review for medical hospital stays in that same 12-month period, the concurrent review process for both psychiatric and medical hospital stays should be carefully examined to ensure that the concurrent review standard is not being applied more stringently to MH/SUD benefits than to medical/surgical benefits in operation.

Warning Signs: The following plan provisions related to NQTLs may be indicative of noncompliance and warrant further review:

1. *Prior authorization for medication for opioid use disorder*: A plan or issuer imposes prior authorization for medications for opioid use disorder but does not require prior authorization for comparable medications for medical/surgical conditions.

2. *Different medical necessity review requirements*: A plan or issuer imposes medical necessity review requirements on outpatient MH/SUD benefits after a certain number of visits, despite permitting a greater number of visits before requiring any such review for outpatient medical/surgical benefits.

Compliance Tip

- **Do not focus solely on results.** Look at the **underlying processes and strategies** used in applying NQTLs. Are there arbitrary or discriminatory differences in how the plan or issuer is applying those processes and strategies to medical/surgical benefits versus MH/SUD benefits? While results alone are not determinative of noncompliance, measuring and evaluating results and quantitative outcomes can be helpful to identify potential areas of noncompliance.

SECTION G. DISCLOSURE REQUIREMENTS

Question 8. Does the group health plan or group or individual health insurance issuer comply with the MHPAEA disclosure requirements?

Comments: Yes

- The plan administrator or health insurance issuer must make **available the criteria for medical necessity determinations** made under a group health plan or group or individual health insurance coverage with respect to MH/SUD benefits to any current or potential participant, beneficiary, enrollee, or contracting provider **upon request**. *See 29 CFR 2590.712(d)(1), 45 CFR 146.136 (d)(1).*

  The plan administrator (or health insurance issuer) must make available **the reason for any denial** under a group health plan or group or individual health insurance coverage of reimbursement or payment for services with respect to MH/SUD benefits to any participant, beneficiary, or enrollee, and may do so in a form and manner consistent with the rules in 29 CFR 2560.503-1 (the DOL claims procedure rule) and 29 CFR 2590.715-2719 (internal claims and appeals and external review processes).

  - Pursuant to the internal claims and appeals and external review rules under the Affordable Care Act applicable to all non-grandfathered group health plans and to all non-grandfathered group and individual health insurance coverage, claims related to medical judgment (including MH/SUD) are eligible for external review. The **internal claims and appeals** rules include the right of claimants (or their authorized representatives) to be provided **upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits**. This includes documents with information about the **processes, strategies, evidentiary standards, and other factors used to apply an NQTL** with respect to medical/surgical benefits and MH/SUD benefits under the plan. *See 26 CFR 54.9812-1(d)(3), 29 CFR 2560.5301- 2590.712(d)(3), 45 CFR 146.136(d)(3), 147.136(b).*

- With respect to group health plans that are subject to ERISA, if coverage is denied based on medical necessity, **medical necessity criteria** for the MH/SUD benefits at issue and for medical/surgical benefits in the same classification must be provided **within 30 days of the request** to the participant, beneficiary, provider, or authorized representative of the beneficiary or participant. *See 29 CFR 2520.104b-1; 29 CFR 2590.712(d)(1).*

- If a plan or a plan administrator or health insurance issuer fails to provide these documents, a court may hold it liable for up to $110 a day from the date of failure to provide these documents. *See ERISA Sec. 502(c)(1).*

Compliance Tips

- The reasons for benefit denials include applicable medical necessity criteria as applied to that participant, beneficiary, or enrollee.
- Under ERISA, plans and issuers cannot refuse to disclose information necessary for the parity analysis on the basis that the information is proprietary or has commercial value.
- Under ERISA, plans and issuers can provide summary descriptions of the medical necessity criteria in a layperson's terms.

Make Showing Compliance Simple

Documents or Plan Instruments Participants and Beneficiaries or DOL may Request Include the following:

Under ERISA section 104(b), participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with MHPAEA, and copies must be furnished within 30 days of the request. These documents and plan instruments may include documentation that illustrates how the health plan has determined that any financial requirement, QTL, or NQTL complies with MHPAEA. For example, participants and beneficiaries may request the following:

- An analysis showing that the plan meets the predominant/substantially all tests. The plan may need to provide information regarding the amount of medical/surgical claims subject to a certain type of financial requirement, such as a co-payment, in the prior year for a classification or the plan's basis for calculating claims expected to be subject to a certain type of QTL in the current plan year for a classification, for purposes of determining the plan's compliance with the predominant/substantially all tests;
- A description of an applicable requirement or limitation, such as preauthorization or concurrent review, that the plan applies for MH/SUD benefits and medical/surgical benefits within the relevant classification (for example, in- or out-of-network, or in- or outpatient). These might include references to specific plan documents: for example provisions as stated on specified pages of the summary plan description (SPD), or other underlying guidelines or criteria not included in the SPD that the plan has consulted or relied upon;
- Information regarding factors, such as cost or recommended standards of care, that are relied upon by a plan for determining which medical/surgical or MH/SUD benefits are subject to a specific requirement or limitation. These might include references to specific related factors or guidelines, such as applicable utilization review criteria;
- A description of the applicable requirement or limitation that the plan believes has been used in any given MH/SUD service adverse benefit determination (ABD) within the relevant classification; and
- Medical necessity guidelines relied upon for in- and out-of-network medical/surgical and MH/SUD benefits.

Compliance Tips

- Find out how the plan administrator handles general information requests about coverage limitations as well as specific information or disclosure requests with respect to denied benefit claims.
- Review a sample of appeals files and examine what was disclosed to participants, including the criteria for medical necessity determinations and reasons for claim denials.
- Determine how long it took the plan or the plan administrator to furnish requested documents to participants.

As directed by the 21st Century Cures Act, and in response to comments received from the regulated community, the Departments continue to issue additional guidance regarding disclosures, in particular with respect to NQTLs. Based on requests from various stakeholders for model MHPAEA disclosure forms and for guidance on processes for requesting disclosures in a more uniform, streamlined, or otherwise simplified way, the Departments issued a model disclosure request form (available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/mhpaea-disclosure-template.pdf). For the most current version of the form please visit the DOL's dedicated MH/SUD parity webpage, available at https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

This form can, but is not required to, be used to request MHPAEA-related information from group plans and group and individual health insurance issuers, including general information about coverage limitations or specific information that may have resulted in denial of MH/SUD benefit claims.

Compliance Tips

- Participants, beneficiaries, enrollees, dependents, and contracting providers may request information to determine whether benefits under a plan are being provided in parity even in the absence of any specific ABD.
- Group health plans may need to work with insurance issuers providing coverage on behalf of an insured group health plan or with third party administrators administering the plan to ensure that such service providers either directly or in coordination with the plan are providing participants and beneficiaries any documents or information to which they are entitled.
- If a group health plan or group or individual health insurance issuer uses MH/SUD vendors and carve-out service providers, the plan must ensure that all combinations of benefits comport with MHPAEA. Therefore, vendors and carve-out providers should provide documentation of the necessary information to the plan to ensure that all combinations of benefits comport with parity.

NOTE: Compliance with the disclosure requirements of MHPAEA is not determinative of compliance with any other provision of other applicable federal or state law. Be sure that the plan or issuer, in addition to these disclosure requirements, is disclosing all information relevant to medical/surgical, mental health, and substance use disorder benefits as required pursuant to other applicable provisions of law. For example, if a plan document states it covers benefits consistent with generally accepted standards of care (for both medical/surgical and MH/SUD benefits), and the plan has developed internal guidelines that are more restrictive than the generally accepted standards of care for both medical/surgical and MH/SUD benefits, the plan might comply with MHPAEA but fail to comply with Part 4 of ERISA, which requires that the plan be administered in accordance with its plan documents. Plans should be prepared to disclose their medical necessity criteria and should ensure that, to the extent the plan document specifies a specific treatment guideline, it follows that as well.

Compliance Tip

- Under ERISA, ERISA-covered plans must provide an SPD that describes plan provisions related to the use of network providers and describe the composition of the provider network (*i.e.*, a provider directory). The provider directory may be distributed as a separate document from the SPD and, in many circumstances, may be provided electronically. However, the provider directory must be up-to-date, accurate, and complete (using reasonable efforts). *See e.g., 29 CFR 2520.102-3; FAQs About Mental Health And Substance Use Disorder Parity Implementation And the 21st Century Cures Act Part 39, Q10, available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf; ERISA Secs. 102, 104, and 404(a).*

SECTION H. ESTABLISHING AN INTERNAL MHPAEA COMPLIANCE PLAN

Although not required by MHPAEA, an internal compliance plan that promotes the prevention, detection, and resolution of potential MHPAEA violations can help plans and issuers improve compliance with the law. Compliance plans for group health plans or issuers may differ, but many successful compliance plans share the following characteristics:

1. **Conducting effective training and education**. Successful compliance programs provide ongoing training and education to all individuals responsible for ensuring MHPAEA compliance, including those who are responsible for making decisions related to medical/surgical and MH/SUD benefits on behalf of the plan or issuer (such as claims reviewers). EBSA provides many educational materials, webcasts, and in-person compliance assistance events that may assist in these trainings and can also be made available to participants and beneficiaries to inform them of their parity protections under MHPAEA.[2]

2. **Ensuring retention of records and information.** ERISA Section 107 requires the retention of certain documents. These documents should be retained for at least six years after the Form 5500 for the relevant plan year has been filed.

3. **Conducting internal monitoring and compliance reviews on a regular basis.** A plan or issuer may monitor compliance on an ongoing basis by conducting internal reviews for potential non-compliance and identification of problem areas related to MHPAEA and by auditing samples of adverse benefit determinations to assess the application of medical necessity criteria, the level of detail provided to claimants, and the correctness of determinations. Plans and issuers may wish to establish an internal consumer ombudsmen program to assist participants and beneficiaries in navigating their benefits and for elevating complaints of noncompliance. Plans and issuers that delegate management of MH/SUD benefits to another entity should have clear protocols to ensure that the service providers for both medical/surgical and MH/SUD benefits provide documentation of the necessary information to the plan or issuer (and to the entity that adjudicates MH/SUD benefit claims, if necessary) to ensure that all combinations of benefits that a participant or beneficiary can elect comport with MHPAEA and to ensure that plans and issuers are able to comply with disclosure requirements.

4. **Responding promptly to detected offenses and developing corrective action.** If a plan or issuer discovers a violation of MHPAEA, it should take steps to correct the violation promptly, including providing retroactive relief and notice to potentially affected participants and beneficiaries. EBSA Benefits Advisors may be able to assist plans and issuers in voluntarily complying with MHPAEA. They can be contacted at (866) 444-3272.

[2] See https://www.dol.gov/agencies/ebsa/laws-and-regulations/laws/mental-health-and-substance-use-disorder-parity.

If a group health plan is audited by DOL investigators for MHPAEA compliance, DOL may ask for at least the following, among other items:

1. Plan materials related to the plan's compliance with MHPAEA, including the following:

    a) Information regarding NQTLs that apply to MH/SUD and/or medical/surgical benefits offered under the plan or coverage.

    b) Records documenting NQTL processes and how the NQTLs are being applied to both medical/surgical and MH/SUD benefits to ensure the plan or issuer can demonstrate compliance with the law, including any materials that may have been prepared for compliance with any applicable reporting requirements under state law. Such records may also be helpful to plans and issuers in responding to inquiries from participants, beneficiaries, enrollees, and dependents regarding benefits under the plan or coverage.

    c) Any documentation, including any guidelines, claims processing policies and procedures, or other standards that the plan or issuer has relied upon as the basis for determining its compliance with the requirement that any NQTL applicable to MH/SUD benefits be comparable to and applied no more stringently than the NQTL as applied to medical/surgical benefits. Plans and issuers should include any available details as to how the standards were applied, and any internal testing, review, or analysis done by the plan or issuer to support the rationale that the NQTL is being applied comparably and no more stringently to MH/SUD benefits than medical/surgical benefits. If the standards that are applied to MH/SUD benefits are more stringent than those in nationally recognized medical guidelines, but the standards that are applied to medical/surgical benefits are not, plans and issuers should include any applicable explanation of the reason(s) for the application of the more stringent standard for MH/SUD benefits.

    d) Samples of covered and denied MH/SUD and medical/surgical benefit claims.

    e) Documents related to MHPAEA compliance with respect to service providers (if a plan delegates management of MH/SUD benefits to another entity).

    f) Any applicable MHPAEA testing completed by the plan or the issuer for financial requirements or QTLs applied to MH/SUD benefits.

In addition to this Self-Compliance Tool, the National Association of Insurance Commissioners (NAIC) has developed tools (such as a Data Collection Tool, which includes a Non-Quantitative Treatment Limitations Chart) to assist issuers in evaluating MHPAEA compliance. For more information regarding NAIC compliance assistance efforts, please visit its website at https://content.naic.org/.

APPENDIX I: ADDITIONAL ILLUSTRATIONS

ILLUSTRATION 1: A Plan covers neuropsychological testing but excludes such testing for certain conditions. In such situations, look to see whether the exclusion is based on evidence addressing, for example, clinical efficacy of such testing for different conditions and the degree to which such testing is used for educational purposes with regard to different conditions. Does the plan rely on criteria and evidence from comparable sources with respect to medical/surgical and mental health conditions? Does the plan have documentation indicating the criteria used and evidence supporting the plan's determination of the diagnoses for which the plan will cover this service and the rationale for excluding certain diagnoses? The result may be that the plan permissibly covers neuropsychological testing for some medical/surgical or mental health conditions, but not for all.

Conclusion: This outcome may be permissible to the extent the plan has based the exclusion of this testing for certain conditions on clinical efficacy and/or other factors if the factors are designed and applied in a comparable manner with respect to the conditions for which testing is covered and those for which it is excluded.

ILLUSTRATION 2: A Plan uses diagnosis related group (DRG) codes in their standard utilization review process to actively manage hospitalization utilization. For all non-DRG hospitalizations (whether due to an underlying medical/surgical condition or a MH/SUD condition), the plan requires precertification for hospital admission and incremental concurrent review. The precertification and concurrent review processes review unique clinical presentation, condition severity, expected course of recovery, quality, and efficiency. The evidentiary standards and other factors used in the development of the concurrent review process are comparable across medical/surgical benefits and MH/SUD benefits, and are well documented. These evidentiary standards and other factors are available to participants and beneficiaries free of charge upon request.

Conclusion: In this example, it appears that, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its precertification and concurrent review of hospitalizations are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

ILLUSTRATION 3: A Plan classifies care in skilled nursing facilities and rehabilitation hospitals for medical/surgical conditions as inpatient benefits and likewise treats any covered care in residential treatment facilities for MH/SUD as an inpatient benefit. In addition, the plan treats home health care as an outpatient benefit and treats intensive outpatient and partial hospitalization for MH/SUD services as outpatient benefits.

Conclusion: In this example, the plan assigns covered intermediate MH/SUD benefits to the six classifications in the same way that it assigns comparable intermediate medical/surgical benefits to the classifications.

ILLUSTRATION 4: Master's degree training and state licensing requirements often vary among provider types. The plan consistently applies its standard that any provider must meet the most

stringent licensing requirement standard in the applicable state related to supervised clinical experience requirements in order to participate in the network. Therefore, the plan requires master's-level therapists to have post-degree, supervised clinical experience in order to join its provider network. There is no parallel requirement for master's-level general medical providers because their licensing requires supervised clinical experience. In addition, the plan does not require post-degree, supervised clinical experience for psychiatrists or PhD level psychologists since their licensing already requires supervised training.

Conclusion: The requirement that master's-level therapists must have supervised clinical experience to join the network is permissible, as the plan consistently applies the same standard to all providers even though it may have a disparate impact on certain mental health providers whose state licensing does not require this experience.

ILLUSTRATION 5: A patient with chronic depression has not responded to five different anti-depressant medications and therefore was referred for outpatient treatment with repetitive transcranial magnetic stimulation (TMS). This specific treatment has been approved by the FDA and has been the subject of more than six randomized controlled trials published in peer reviewed journals. The plan denies the treatment as experimental. The plan states that it used the same criteria to deny TMS as it does to approve or deny any MH/SUD or medical/surgical benefits under the plan. The plan identifies its standard for both medical/surgical benefits and MH/SUD benefits as requiring that at least two randomized controlled trials showing efficacy of a treatment be published in peer reviewed journals for any new treatment. However, the plan indicates that while more than two randomized controlled trials regarding TMS have been published in peer reviewed journals, a committee of medical experts involved in plan utilization management reviews reviewed the journals and determined that only one of the articles provided sufficient evidence of efficacy. The plan did not identify what specific standards were used to assess whether a peer review had adequately evidenced efficacy and what the qualifications of the plan's experts are. Lastly, the plan does not impose this additional level of scrutiny with respect to reviewing medical/surgical treatments beyond the initial requirement that the treatment has been the subject of the requisite number and type of trials.

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 applies the NQTL more stringently to mental health benefits than to medical/surgical benefits without additional justification. To come into compliance, the plan could ensure that that any additional levels of scrutiny are imposed on both medical/surgical and MH/SUD benefits comparably, including by establishing standards for when a peer review has adequately evidenced efficacy, and that the qualifications of the plan's experts are similar for both MH/SUD and medical/surgical benefits.

ILLUSTRATION 6: A plan imposes prior authorization for certain MH/SUD and medical/surgical services. The medical/surgical outpatient services that require prior authorization include habilitative and rehabilitative services such as physical therapy. Physical therapy services were selected for prior authorization because of findings that physical therapists' documentation of medical necessity is often inadequate. In addition, there has been an increase in litigation regarding physical therapy claims. Prior authorization is conducted telephonically and authorization determinations are reviewed by a physician in consultation with

a licensed physical therapist for medical necessity. Authorization determinations are provided verbally and in writing consistent with federal and state timeliness requirements. The number of sessions authorized is tailored to the specific medical/surgical condition treated, consistent with generally accepted national clinical guidelines. Determinations to approve or deny coverage are made by physicians with consultation from a licensed physical therapist.

Psychological testing also requires prior authorization. Psychological testing was selected for prior authorization because of recent Medicare fraud schemes and consistent with the Medicare Improper Payment Reports, which found improper payments with respect to psychological testing claims because of inadequate documentation from psychologists. Prior authorization is conducted telephonically and reviewed by a licensed psychologist for medical necessity. Authorization determinations are provided verbally and in writing consistent with federal and state timeliness requirements. The number of hours authorized for psychological testing are tailored to the age of the client and type of evaluation requested and range from two to five hours for an average evaluation (on the basis of the average number of hours for evaluation as included in generally accepted national clinical guidelines). Determinations to approve or deny coverage are made by licensed psychologists with at least five years of experience in psychological testing.

Conclusion: In this example, under the terms of the plan as written and in practice, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its preauthorization requirements, particularly the use of prior authorization to detect fraud and abuse, are comparable and applied no more stringently with respect to MH/SUD benefits than those applied with respect to medical/surgical benefits.

APPENDIX II:

PROVIDER REIMBURSEMENT RATE WARNING SIGNS

The Departments have noted that, while outcomes are not determinative of a MHPAEA violation, they can often serve as red flags or warning signs to alert the plan or issuer that a particular provision may warrant further review. With respect to provider reimbursement, comparing a plan or issuer's average reimbursement rates for both medical/surgical and MH/SUD providers against an external benchmark of reimbursement rates, such as Medicare, may help identify whether the underlying methodology used to determine the plan's or issuer's reimbursement rates warrants additional review for compliance with MHPAEA. Furthermore, evaluating how medical/surgical and MH/SUD providers are reimbursed for the same or similar services may also help a plan or issuer determine if the plan's or issuer's underlying methodology for provider reimbursement warrants further review.

Accordingly, the following framework for comparison may assist plans and issuers in identifying information they might consider when comparing reimbursement rates for certain MH/SUD and medical/surgical services based on Current Procedural Terminology (CPT) codes. This is not the only framework for analyzing provider reimbursement rates, and it is not determinative of compliance. This framework utilizes Medicare reimbursement rates as its benchmark for comparison. If a plan's or issuer's comparison of reimbursement rates indicates that the reimbursement rate is lower for MH/SUD providers, either as compared to medical/surgical providers or as compared to an external benchmark, such as Medicare, the plan or issuer should consider further review to ensure that the processes, strategies, evidentiary standards, and other factors used with respect to provider reimbursement for MH/SUD benefits are comparable to, and applied no more stringently than, those used with respect to provider reimbursement for medical/surgical benefits. Please see Section F. Nonquantitative Treatment Limitations for information on how to further evaluate provider reimbursement rates for compliance with MHPAEA.

Specialty	CPT Code	Average Plan rate for [insert locality]	Medicare rate for [insert locality]	Plan rate as a percentage of Medicare
Orthopedic Surgery	99203 99213	$ xx.xx $	$ xx.xx $	xx.x%
Cardiologists	99203 99213	$ $	$ $	
Internists MD	99203 99213	$ $	$ $	
Endocrinologists	99203 99213	$ $	$ $	
Gastroenterologist	99203 99213	$ $	$ $	

Specialty	CPT Code	Average Plan rate for [insert locality]	Medicare rate for [insert locality]	Plan rate as a percentage of Medicare
Neurologists	99203 99213	$ $	$ $	
Pediatrician	99203 99213	$ $	$ $	
Dermatologists	99203 99213	$ $	$ $	
Psychiatrists	99203 99213	$ $	$ $	
Psychologists	90832 (based on 1 hr) 90791 (based on ½ hour)	$ $	$ $	
LCSW	90832 (based on 1 hr) 90791 (based on ½ hour)	$ $	$ $	
Podiatrists	99203 99213	$ $	$ $	
Chiropractor	99203 99213	$ $	$ $	
Occupational Therapy	97165 97166 97167 97168	$ $	$ $	
Physical Therapy	97161 97162 97163 97164	$ $	$ $	
Speech Therapy	Initial Office Visit Codes do not exist. Analysis of specific tests or follow- up may be useful to consider.			

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Prior Authorization Review Process

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies.

Prior authorization is a pre-service request for authorization of payment for an item or service under the terms of a member's plan of benefits. Health Plan members are referred first for non-emergency inpatient services to an in-network provider within Kaiser Permanente's delivery system. If a member requires covered services not available from a network provider, he or she will be referred to an out-of-network provider inside or outside the Health Plan's service area with review and approval by our Quality Resource Department. Members are advised to call 911 (when applicable) or go to the nearest hospital emergency department if they believe they are experiencing a medical emergency. No prior authorization is required for emergency services. When a member receives treatment for an emergency medical condition, Health Plan covers emergency services received from network providers or out-of-network providers. Once the emergency condition has been stabilized, coverage of further services requires authorization from Health Plan.

The Kaiser Permanente Pharmacy and Therapeutic Committee establishes and approves the specific prior authorization criteria based on FDA approved indications, peer-reviewed scientific evidence, clinical practice guidelines, industry standard of care and quality and safety concerns.

Drugs requiring prior authorization have specific clinical criteria based on FDA approved indications, peer-reviewed scientific evidence, clinical practice guidelines and standard of practices treatment protocols including but not limited to diagnosis of specified condition, laboratory requirements or prescriber specialty, that must be met for the prescription to be eligible for coverage. Kaiser Permanente medications requiring prior authorization is available upon request.

B. Identify the factors used in the development of the limitation(s);

Factors used to determine the need for prior authorization for both M/S and MH/SUD include:

- The severity or chronicity of an illness – Services that, in the professional judgment of the members of the Service Quality Resource Management Committee (SQRMC), Pharmacy and Therapeutics Committee, and the Regional Utilization Management Committee (RUMC) are specifically for the treatment of severe or chronic conditions. Examples are - Clinical indications and/or evidence, professional standards and protocols, comparative effectiveness studies and clinical trials.
- Clinical efficiency of treatment or service - Services which, in the professional judgment of members of the Utilization Management Committee are based on evidence as defined by nationally accepted best practices. Examples are adherence to clinical standards - over-utilization of services of overprescribing could lead to quality/safety concerns for the member. Efficacy demonstrated in rare conditions only - drugs that are approved for specific rare conditions and specific diagnostic testing is required.
- Appropriate level of care - Services which, in the professional judgment of members of the Regional Utilization Management Committee and or the Pharmacy and Therapeutics Committee are provided at the appropriate level of care for the member's condition. Examples are least restrictive appropriate level of care - lowest.

There were no factors that were considered but rejected.

Drugs requiring prior authorization have specific clinical criteria based on FDA approved indications, peer-reviewed scientific evidence, clinical practice guidelines and standard of practices treatment protocols including but not limited to diagnosis of specified condition, laboratory requirements or prescriber specialty, that must be met in order for the prescription to be eligible for coverage. These criteria are developed, reviewed and approved by Kaiser Permanente Pharmacy and Therapeutic Committee.

Prior authorizations are applied to outpatient prescription drugs:

- With multiple medical uses to ensure appropriate prescribing,
- Higher in cost,
- With significant safety concern
- At risk for waste, abuse and misuse.

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C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

UM adopts and utilizes nationally developed clinical criteria and regionally developed medical coverage policies that are approved by the RUMC to evaluate the necessity of medical/surgical and behavioral health services requiring approval. The RUMC membership includes a cross section of health care professionals from across the organization, among them senior level physicians from both medical-surgical and behavioral health who play a key role in the approval of UM criteria.

When reviewing medical/surgical and behavioral health referrals for prior authorization review, Health Plan uses nationally recognized, written criteria, i.e., MCG™ or ASAM, based on sound clinical evidence to make utilization decisions and specifies procedures for appropriately applying the criteria. Objective, evidence-based criteria are applied while taking individual circumstances into account when determining medical appropriateness of health care services. Utilization Management is a Health Plan accountability, and The Southeast Permanente Medical Group (TSMPG) participates substantively in the process, recommending the UM decision on Health Plan's behalf.

The Pharmacy and Therapeutics Committee follow national guidelines, peer reviews, and evidentiary standards in the development of the prior authorization criteria. Members of the Pharmacy and Therapeutics Committee reviews the available information, including the prescribing information, independent studies, and other recognized authoritative compendia and creates criteria for review with assistance of Specialty Departments. The physician specialist provides input regarding the appropriate use of a specific drug. Criteria are reviewed annually or when changes are made. The Kaiser Permanente Pharmacy and Therapeutic Committee establishes and approves the specific criteria for these drugs based on FDA approved indications, peer-reviewed scientific evidence, clinical practice guidelines, industry standard of care and quality and safety concerns. The Committee members are made up of trained and licensed clinical pharmacists, physicians, and other clinicians as appropriate. The process of adding prior authorization criteria for either behavioral health or medical/surgical drugs, follow the same evidentiary standards in the development of the criteria. The physician specialist provides input regarding the appropriate use of a specific drug. Criteria are reviewed annually or when changes are made. The prior authorization criteria are applied to medications with:

- Potential for significant safety concerns
- High potential for adverse effects
- High cost-to-benefit ratio in conjunction with other available therapies for the disease state
- High potential for abuse or misuse.

D. Identify the methods and analysis used in the development of the limitation(s); and

The scope of the Utilization Program includes RUMC oversight of the development, review, evaluation to consistently adopt criteria that are approved based on the active involvement of appropriate and actively credentialed practitioners. All UM criteria sets are reviewed and revised annually and updated as needed, then reviewed and approved by the RUMC as delegated by the Regional Quality Improvement Committee, RQIC. Medical Clinical Policies (MPC)s are reviewed against current clinical and medical evidence and are updated, when appropriate. Neither coverage policies nor criteria sets are designed to be the final determinate of the need for care but are used to provide guidance, along with consideration for the needs and health status of the individual patient. Licensed, board-certified practitioners or clinical subject matter experts in their area of specialty are given the opportunity to advise or comment on development or adoption of UM criteria, and on instructions for applying criteria. This process occurs in the same manner and is no more stringent for MH/SUD than for M/S.

This process is a team effort that includes behavioral and non-behavioral health practitioners from across the region, led by the TSPMG UM Physician Director in partnership with the UM physician reviewers, service chiefs, subject matter experts and the UM Compliance team.

Kaiser Permanente P&T approved prior authorization criteria development take into consideration:

- Potential for significant safety concerns
- High potential for adverse effects
- High cost-to-benefit ratio in conjunction with other clinical considerations (comparative cost of alternative equivalent therapy, availability of current formulary drugs to meet therapeutic need)
- High potential for abuse or misuse

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Annually, UM evaluates the consistency with which healthcare professionals involved in UM apply criteria for M/S and MH/SUD in decision making, and act on opportunities to improve consistency. Monitoring and Inter-Rater Reliability (IRR) assessment activities evaluate UM staff and physician reviewers to ensure consistency and appropriateness in the use of clinical criteria among our licensed health professionals conducting UM review for M/S and MH/SUD. Studies of consistency (e.g., inter-rater reliability), and actions to improve consistency are shared with UM physicians and staff and reported to RUMC and RQIC through the quarterly work plan. Staff members conducting the UM prior authorization reviews undergo an annual interrater reliability assessment test.

An inter-rater reliability assessment is used to measure the level of consistency among the staff and adherence to medical management criteria or standard. Its purpose is to:

- Minimize variation in the application of clinical guidelines and policies
- Evaluate staff ability to identify potential avoidable waste, fraud, and abuse
- Evaluate staff ability to identify quality of care issues
- Identify specific areas needing improvement including additional training needs

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Concurrent Review Process

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

When performing concurrent review for referrals classifications, Network Inpatient, Out of Network Inpatient, Network Outpatient-Office, Out of Network Outpatient- Office, In Network Outpatient-All Other, Out of Network Outpatient-All Other, all steps in the referral management process are documented and notified via the electronic medical record. The initial referral is reviewed by clinically licensed and qualified Utilization Management (UM) staff for availability of the benefits in their plan, adequacy of clinical information, and criteria. The member's benefit array, referral specific clinical information, history, and other medical records of care, are available to the UM reviewer directly within the same electronic platform. During this process, the clinical reviewer enters relevant member specific information directly into the referral notes. The applicable UM criteria is also entered in the referral for review.

B. Identify the factors used in the development of the limitation(s);

The following information is taken into consideration when conducting concurrent review:

- If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the organization does not meet the definition of "urgent care," the request may be handled as a new request and decided within the time frame appropriate for the type of decision (i.e., preservice or post-service)
- If the course of care ends prior to requesting an extension, then the request becomes a standard pre-service claim
- When determining whether a concurrent request meets the definition of "urgent," Health Plan considers the content of the request and whether making the decision is in accordance with the non-urgent preservice time frame which could lead to adverse health consequences
- The staff determines whether it is reasonable to handle the request as urgent if application of a non-urgent time frame could involve an unnecessary interruption in the member's treatment that may jeopardize the member's health or ability to recover.

Examples of Factors for determining that concurrent review is appropriate:

- Severity or chronicity of an illness
- Lack of Clinical efficiency of treatment or service

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

After reviewing the evidentiary standards for both benefit areas, Medical/Surgical (M/S) and mental health/substance abuse disorder (MH/SUD) services follow a similar concurrent review process that applies the following evidentiary standards:

- Evidence Based Medicine: Routine evaluation by a trained reviewer similarly credentialed for both M/S and MH/SUD in the application of evidence-based medicine as defined within each practice.
- Medical Necessity and Level of Care: Assessment of medical necessity and level of care placement follows MCG for mental health. Recommended level of care evaluation for SUD also includes ASAM. CMS guidelines are applied to skilled nursing to ensure the length of stay is appropriate to the patient's needs, while providing proper clinical care coordination.

D. Identify the methods and analysis used in the development of the limitation(s); and

The scope of the Utilization Program includes SQRMC oversight of the development, review, evaluation to consistently adopt criteria that are approved based on the active involvement of appropriate and actively credentialed practitioners. All Medical Clinical Policies (MCP) and UM criteria sets are reviewed and revised annually and updated as needed, then reviewed and approved by the RUMC as delegated by the Regional Quality Improvement Committee (RQIC). MCPs are reviewed against current clinical and medical evidence and are updated, when appropriate. Neither coverage policies nor criteria sets are designed to be the final determinate of the need for care but are used to provide guidance, along with consideration for the needs and health status of the individual patient. Licensed, board-certified practitioners or clinical subject matter experts on asks for in their area of specialty are given the opportunity to advise or comment on development or adoption of QRM criteria, and on instructions for applying criteria.

This process occurs in the same manner and is no more stringent for MH/SUD than for M/S.

This process is a team effort that includes behavioral and non-behavioral health practitioners from across the region, led by the GAPMG QRM Physician Director of Referrals in partnership with the QRM physician reviewers, APIC, service chiefs, subject matter experts and the UM Compliance team.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits

Annually, QRM evaluates the consistency with which its QRM reviewers apply criteria in decision making, and acts upon opportunities to improve consistency. Monitoring and Inter-Rater Reliability (IRR) assessment activities evaluate QRM staff and physician reviewers to ensure consistency and appropriateness in the use of clinical criteria among our licensed health professionals conducting QRM review. Studies of consistency (e.g., inter-rater reliability), and actions to improve and ensure consistency are shared with QRM physicians and staff and reported to SQRMC and the RQIC, through the quarterly work plan.

The annual IRR assessment measures the level of consistency among the staff and their adherence to medical management criteria or standards. Its purpose is to:

- Minimize variation in the application of clinical guidelines and policies
- Evaluate staff's ability to identify potential avoidable waste, fraud, and abuse
- Evaluate staff's ability to identify quality of care issues
- Identify specific areas needing improvement including additional training needs

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Standards for Provider Credentialing:

A. Provide the specific plan language for each NQTL and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies:

Credentialing policies are identified as an NQTL that requires a comparative analysis to ensure the processes are applied no more stringently to Mental Health and Substance Use Disorder (MH/SUD) providers than to Medical/ Surgical (M/S) providers. Medical/ Surgical practitioners and organizational providers that provide inpatient or outpatient, in-network services are credentialed, if credentialing is required based on their scope of practice and if they meet credentialing requirements in accordance with NCQA standards. The Credentialling process is conducted the same for M/S and MH/SUD providers. NCQA standards do not differentiate requirements based on specialties; therefore, standards are applied the same for any practitioner or organizational facility that is credentialed.

B. Identify the factors used in the development of the limitation(s);

Credentialing factors, such as practitioner and organization provider qualifications, are continuously reevaluated to ensure that network providers meet the minimum standards that are outlined by NCQA, our accrediting body, internal credentialing policies and state and federal regulations. Adhering to the standards eliminates possibility of biases in credentialing decisions for behavioral health providers versus medical/specialty providers.

Factors included in Credentialing:

- Governance
- Processes and Strategies
- Practitioner and Organizational Provider Qualifications

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above:

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The following are the sources that are used to guide the credentialing and recredentialing processes for Med/Surg practitioners and organizational providers. KFHPGA policies are in compliance with all regulatory standards and the standards are equivalent for both Med/Surg and Mental Health.

- NCQA Accreditation Standards
- Kaiser Foundation Health Plan of Georgia Credentialing and Fair Hearing Policies
- State and Federal Regulations

D. Identify the methods and analysis used in the development of the limitation(s):

An analysis of the Credentialing written processes, procedures, factors, and strategies were used in determining network inclusion for providers. This comprised of a review of Credentialing and Fair Hearing Policies, including but not limited to who makes the credentialing decisions (governance) and what those decisions are based on (provider qualifications and approval processes) and an analysis of the Credentialing application acceptance and denial rates and average application processing times. Based on the analysis, KFHPGA concludes that we did not find evidence that we are more restrictive in applying Credentialing processes for MH than for Med/Surg providers or facilities.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Based on the policy reviews and data analysis, Kaiser Permanente of Georgia's credentialing processes, strategies, evidentiary standards, and factors are comparable to and no more stringently applied to MH/SUD providers than to M/S providers. The approval/ denial percentages and average processing times were equivalent for the MH/SUD practitioners, concluding that the data shows no disparities between MH/SUD providers and M/S providers.

In accordance with NCQA standards, the same standards are applied to the credentialing of all practitioners that meet the credentialing requirements. NCQA standards do not differentiate requirements based on specialties. The credentialing criteria described are no more stringently applied to any one provider population than another as evidenced in the credentialing decision and processing data.

Kaiser Foundation Health Plan of the Georgia, Inc.
MHPAEA NQTL Analysis Report and Data Report Plan Year 2021
MHPAEA Summary Form
December 15, 2023

Reimbursement for INN Providers, OON Providers, INN Facilities, OON Facilities (separately)

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

The NQTL applied for Reimbursement for Medical and Surgical benefits is based on rate negotiation. Reimbursement rates for In Network (INN) providers and ancillary facilities are established based upon market conditions. Reimbursement rates for Out of Network (OON) providers and ancillary facilities are calculated according to the federal and state guidelines.

B. Identify the factors used in the development of the limitation(s);

The following factors are used in determining the appropriate reimbursement rates for both Medical/ Surgical (M/S) and Mental Health and Substance Use Disorder (MH/SUD) providers:

- The credential/provider type of the practitioner(s).
- Treatment protocols/type of service
- Inpatient/Outpatient practitioner/provider reimbursement
- Inpatient/Outpatient facility reimbursement
- Geographic area
- Reputation
- Market benchmarks
- Supply and demand conditions

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

The following are sources used to evaluate the above factors:

- Medicare reimbursement guidelines
- CPT codes as found in the AMA official CPT Codebook
- RBRVS Factors
- MS-DRGs
- Facility Location
- Provider's market position

- Geographic area
- Reputation
- Existing contract rates
- Market rates - market analysis conducted by external entities (e.g., independent 3rd party analysis)
- CMS Medicare reimbursement rates
- Claims Data
- Supply and demand conditions
- External competitive market analysis

D. Identify the methods and analysis used in the development of the limitation(s); and

An analysis of the written processes, procedures, factors and strategies used to set reimbursement rates for in-network inpatient, in-network outpatient office, and in-network outpatient/all other subclassification providers was conducted.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

An analysis of the processes, procedures, factors and strategies used to operationalize reimbursement rates and adjust reimbursement rates for MH/SUD and M/S providers was conducted including analyzing the outcome data, working sessions with contract managers who negotiate Reimbursement, and with leadership around decision making processes and contracting strategies on reimbursement and rate adjustments. By reviewing the approach, analysis of these factors, along with the analysis of processes and strategies used to determine reimbursement for MH/SUD providers, both written and in operation, we found that the approach and outcome were comparable and no more stringently applied to MH benefits, SUD benefits, and M/S benefits.