



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

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## About the Publishers



The American Psychiatric Association is an organization of psychiatrists working together to ensure humane care and effective treatment for all persons with mental illness, including substance use disorders. It is the voice and conscience of modern psychiatry. Its vision is a society that has available, accessible quality psychiatric diagnosis and treatment. See <https://www.psychiatry.org/>



The Kennedy Forum convenes cutting-edge thought leaders who are united by the potential for reform in behavioral health service delivery made possible by new and existing laws, revolutionary technologies and enhanced understanding of effective services and treatments. The Kennedy Forum is organized to drive real, lasting, policy change in order to achieve true health equity. See <https://thekennedyforum.org/>



The Parity Implementation Coalition members have advanced parity legislation for over fifteen years in an effort to end discrimination against individuals and families who seek services for mental health and substance use disorders. PIC remains committed to full implementation and enforcement of parity. See <https://parityispersonal.org/>

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For more information about the Compliance Guide or for permission to use multiple copies, please contact Tim Clement, MPH, Senior Policy Advisor, The Kennedy Forum (email: [tim@thekennedyforum.org](mailto:tim@thekennedyforum.org)) or Irvin L. “Sam” Muszynski, JD, Senior Policy Advisor and Director, Parity Implementation and Enforcement for the American Psychiatric Association (email: [imuszynski@psych.org](mailto:imuszynski@psych.org)).

## The Purpose of this Guide

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The purpose of this guide and its accompanying spreadsheet is to provide regulators, health plans, and issuers with a tool that enables them to perform the comparative analyses necessary to determine if a plan or issuer is in compliance with the non-quantitative treatment limitation (NQTL) requirements specified in the final regulations of the Mental Health Parity and Addiction Equity Act (MHPAEA).

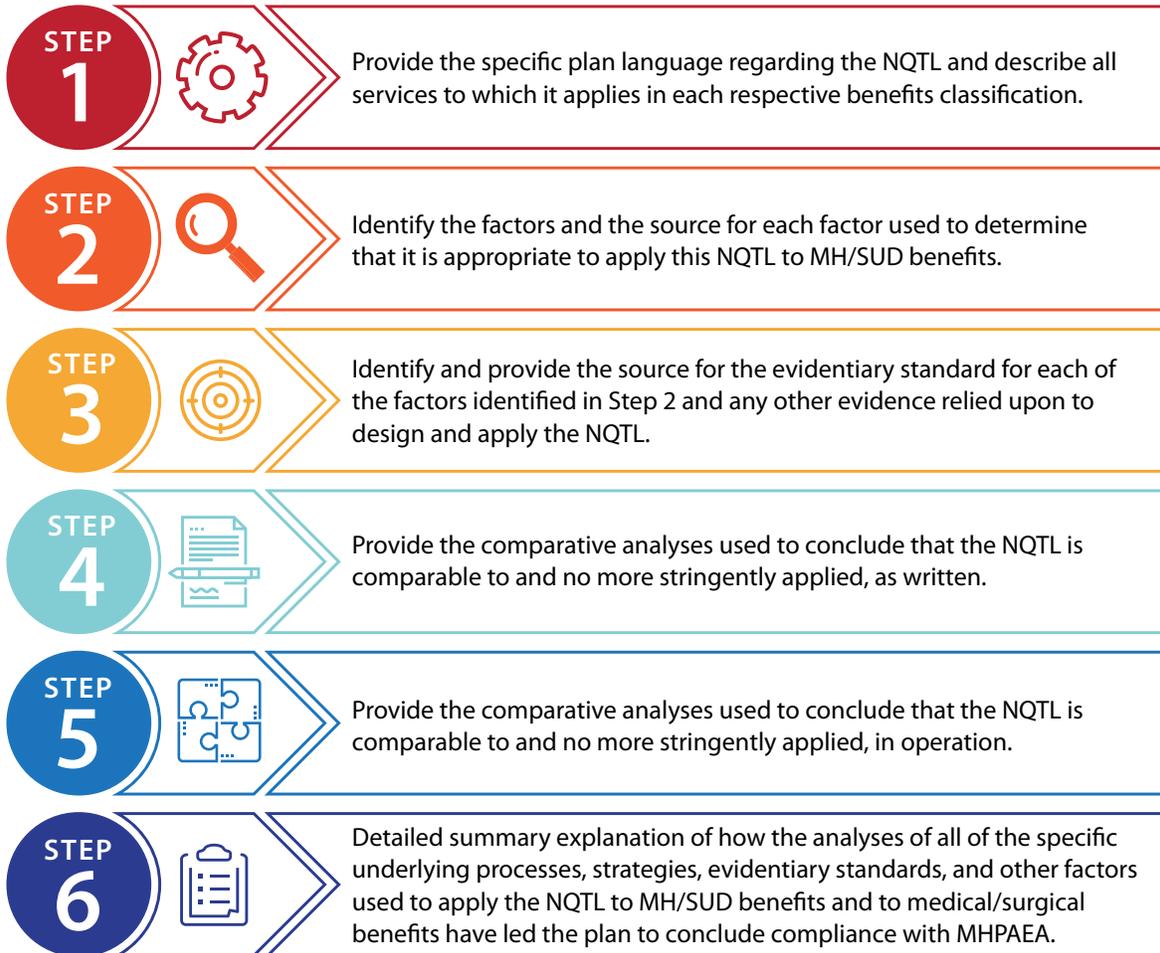
Specifically, this guide and spreadsheet establish a cohesive structure for performing these analyses in the context of the key terms within the final regulations found at 26 CFR 54.9812-1(c)(4)(i), 29 CFR 2590.712(c)(4)(i), and 45 CFR 146.136(c)(4)(i).<sup>1</sup>

It should be noted that the plan or issuer response protocol required by this six-step approach reflects and operationalizes the NQTL guidance the Federal Departments of Health and Human Services, Labor, and Treasury are to produce as stipulated by the 21st Century Cures Act at Section 13001(b), contained within 42 U.S.C. 300gg-26(a)(7)(C). It also provides a defined approach to addressing the model forms for determining plan/issuer NQTL compliance identified in Affordable Care Act Implementation FAQs Part 34 issued on October 27, 2016 and restated in FAQs About Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part 38 issued on June 16, 2017.

The first group of terms is processes, strategies, evidentiary standards, and factors used in applying an NQTL to mental health or substance use disorder (MH/SUD) benefits and medical surgical benefits. The second group of terms is comparable and no more stringently applied. The third group of terms is as written and in operation. The guide and spreadsheet create a six-step approach for unpacking those groups of key terms in a way that facilitates a logical and structured set of comparative analyses.

The purpose of this guide and its accompanying spreadsheet is to provide regulators, health plans, and issuers with a tool that enables them to perform the comparative analyses necessary to determine if a plan or issuer is in compliance with the non-quantitative treatment limitation (NQTL) requirements specified in the final regulations of the Mental Health Parity and Addiction Equity Act (MHPAEA).

These six steps are described below and embedded within the spreadsheet for 19 different NQTLs ranging from prior authorization, to provider credentialing, to formulary design, among others. There certainly are other NQTLs that may be used by a plan or issuer and should be analyzed for compliance through this six-step approach. The six steps, which are described in further detail below, are comprised of:



The description below explains the requirements of each step and provides examples of things that fall within each of the terms of processes, strategies, evidentiary standards, and factors. In the spreadsheet, the steps have been adapted for each specific NQTL. The steps are identical for some NQTLs, very similar for others, and for some, certain steps are omitted or significantly reduced.

## The Six-Step Approach

**STEP 1**  Provide the specific plan language regarding the NQTL and describe all services to which it applies in each respective benefits classification.

Identify and provide the specific language of the NQTL as provided in the plan documents. This shall include each step, associated triggers, timelines, forms and requirements.

**STEP 2**  Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.

Provide the comparative analysis demonstrating that comparable factors were used to determine the applicability of the NQTL for the identified MH/SUD benefits as were used for medical/surgical benefits, including the sources for ascertaining each of these factors. List factors that were relied upon but subsequently rejected and the rationale for rejecting those factors.

*Examples of factors for medical management and utilization review include (these examples are merely illustrative and not exhaustive):*

- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

*Examples of sources for medical management and utilization review factors include:*

- Internal claims analyses
- Internal quality standard studies
- Expert medical review

*Examples of factors for provider network adequacy include:*

- Service type
- Geographic market
- Current demand for services
- Projected demand for services
- Practitioner supply and provider-to-enrollee ratios
- Wait times
- Geographic access standards
- Out-of-network utilization rates

*Examples of sources for provider network adequacy factors include:*

- State and federal regulatory requirements
- National accreditation standards
- Internal plan market analyses
- CAHPS data

*Examples of factors for provider reimbursement include:*

- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
- Provider type (i.e., hospital, clinic, and practitioner) and/or specialty
- Supply of provider type and/or specialty
- Network need and/or demand for provider type and/or specialty
- Medicare reimbursement rates
- Training, experience, and licensure of provider

*Examples of sources for provider reimbursement factors include:*

- External healthcare claims database (e.g., Fair Health)
- Current Medicare Physician Fee Schedule
- Internal market and competitive analysis
- Medicare RVUs for CPT codes.

As noted above, these are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.



**STEP**  
**3**

Identify and provide the source for the evidentiary standard for each of the factors identified in Step 2 and any other evidence relied upon to design and apply the NQTL.

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified in Step 2 and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term “evidentiary standards” is not limited to a means for defining “factors”. Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

*Examples of evidentiary standards to define the factors identified in Step 2, their sources, and other evidence considered include:*

- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
- Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).

- Two published RCTs required to establish a treatment or service is not experimental or investigational.
- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

As noted above, these are illustrations of evidentiary standards and are not an exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.



**STEP 4**

Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written.

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

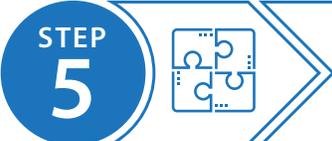
*Examples of comparative analyses include:*

- Results from analyses of the health plan’s paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key

factor(s) was present with similar frequency and magnitude for specific categories of the health plan’s MH/SUD and medical/surgical services.

- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had “high cost variability” (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan’s panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

As noted above, these are illustrations of comparative analyses and are not an exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.



**Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation.**

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits.

Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.

*Illustrative analyses includes:*

*Medical Management*

- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category.
- Audit/review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan’s criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

*Network Adequacy*

- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

As noted above, these are illustrations of comparative analyses and are not an exhaustive list of comparative analyses. While not illustrated, additional analyses would apply to different types of NQLs.



Detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.

Based on the responses provided in the steps above, clearly summarize the basis for the plan or issuer’s conclusion that both as written and in operation, the processes, strategies, evidentiary standards, and factors used to impose the NQL on MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used to impose the NQL on medical/surgical benefits in each classification of benefits in which the NQL is imposed.

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## Endnote

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- <sup>1</sup> (4) *Nonquantitative treatment limitations—(i) General rule.* A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

