

Instructions for Reimbursement

General guidance applicable to all NQTL analyses: Every comparative analysis for each classification of benefits should be self-contained. In other words, it should not be necessary for the regulator to read through attachments or other separate policy documents to determine if the comparative analysis is sufficient. For any relevant document such as utilization management manuals, clinical policy bulletins, guidelines, criteria, etc., it is the responsibility of the plan/issuer to examine those documents and determine if there is comparability and no more stringent application between MH/SUD and medical/surgical. The is the fundamental expectation of comparative analysis: the plan/issuer examines all relevant materials and data, compares, contrasts, probes, and analyzes them and then explains what was revealed and how or why everything examined did or did not reveal compliance. Attachments and other documents may be submitted so that the regulator can corroborate the plan/issuer’s findings and conclusions, but the plan/issuer should avoid responding to any step with “see attachments X, Y, and Z for proof of compliance”. There will be select instances when the instructions for a particular step allow for the submission of attachments in lieu of analysis text.

Step 1: The specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all mental health or substance use disorder (MH/SUD) and medical or surgical benefits to which each such term applies in each respective benefits classification.

Guidance: This Step requires that the plan/issuer identify the different types of facilities and provider types that the plan/issuer reimburses for furnishing services, items, procedures, or medications in the classification of benefits in question. The plan/issuer should also identify the relevant payment structure or structures in place for reimbursement in the classification. For example, in the inpatient classification M/S reimbursement may be paid on a DRG basis in many instances, a per diem basis in some instances, or a DRG basis with supplemental payment in instances when a patient stay unexpectedly extends beyond the reimbursement provided under the typical DRG assumptions. However reimbursement is structured, this step should account for and briefly describe all of the different ways this occurs. Further, for each facility type and provider type that is listed there should be clear identification of which payment structure or structures apply to that facility type or provider type. This step should also identify any capitation arrangement or other alternative payment models that may be in play.

Step 2: The factors used to determine that the NQTL will apply to MH/SUD benefits and medical or surgical benefits.

Guidance: This Step requires that the plan/issuer list two types of factors:

One, factors that determine what base rates are for provider type and facility type.

Two, factors that establish when and how reimbursement may deviate from base rates for provider types and facility types.

Here is an illustrative and not exhaustive list of factors:

- Payment methodology, which could be MS-DRG, Per Diem, Per Case, Per Visit, Per Unit, Fee schedule
- Fee schedule/payment benchmarks such as Medicare PFS rates, FAIR Health data, Competitor fee schedules, Medicare DRGs, Medicare outpatient prospective payment system
- Regional/service area market dynamics such as Market studies which measure demand for services and/or supply of provider type and/or specialty

- Provider practice size or solo practice adjustments, multispecialty practice or group, hospital or facility based
- Bargaining power
- Network shortages of particular types or categories of providers (e.g. Spanish speaking mental health providers, for example)
- Type of provider, training, experience and licensure of providers, and/or specialty, adjustments for non-MD providers
- Contract factors such as length of contract, built in rate escalators (e.g.; annual CPI adjustments), frequency of rate review, provider ability to negotiate rates

Please avoid stating that “factors include” or “factors may include” in the response. The response should report only on factors that do in fact play a role in setting base rates and then deviations from base rates. Stating that factors include or may include makes it impossible to tell if the listed factors actually did play a role or not.

Step 3: The evidentiary standards used for the factors identified in step 2, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to MH/SUD benefits and medical or surgical benefits.

Guidance: For this step the plan/issuer should provide the definition and/or context for each of the factors listed in step 2 and explain how they were used. For example:

- If the payment methodology factor included fee schedules, specify which ones.
- If benchmarking was a factor, explain which unit or units were selected for benchmarking and describe how the benchmarking was determined, ie, 120-135% of Medicare PFS rates
- If market dynamics or market studies were factors used, identify which ones and how the results of those dynamics, studies, data, etc informed rate setting
- If practice size or type was a factor relied upon, how did it inform rate setting
- If bargaining power was a factor relied upon, how is this power ascertained and how does that then inform rate setting
- If network provider type or provider category shortages are a factor, how does that inform rate setting
- If provider training, experience, licensure, etc was a factor relied upon, how did it inform rate setting
- Define how various contract factors relied upon or what their parameters were (eg frequency of rate review, value of rate escalators, variability in negotiating rates)

As noted in the above examples the key question to answer is how the factor informed rate setting. Answering that question invariably involves explaining to what extent it informs rates setting. Please address if certain factors have greater influence on the ultimate rate setting or adjustments to base rates.

Step 4: The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to medical or surgical benefits in the benefits classification.

As written: The as written component of this step should focus on any written materials delivered, provided, or exchanged with potential network providers, any internal written documents developed and circulated to staff regarding rate setting/adjusting and negotiating with providers, minutes from staff

meetings regarding rate setting, etc. It is not necessary to produce the materials describe above but demonstrate how the plan/issuer has examined them and determined that they are in fact comparable to and applied no more stringently than for MH/SUD versus M/S. If all written materials relied upon during the rate setting/adjusting process are the same for MH/SUD and M/S, a simple explanation as such will suffice.

In operation: To meet the in operation requirements, the plan/issuer should provide the comparative analysis demonstrating that the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used in operationalizing reimbursement rates and adjusting reimbursement rates for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies (as well as the factors and evidentiary standards identified in steps 2 and 3) used in operationalizing preliminary reimbursement rates and negotiating final reimbursement rates for medical surgical benefits. This shall include a comparison of the negotiation processes between the plan/issuer and providers as well as any processes in place for adjusting rates for MH/SUD providers and the negotiation processes between the plan/issuer and providers as well as any processes in place for adjusting rates for M/S providers.

Step 5: The specific findings and conclusions reached by the group health plan or health insurance issuer with respect to the health insurance coverage, including any results of the analyses described in this step that indicate that the plan or issuer is or is not in compliance with this section.

Guidance: The plan/issuer should provide a reasoned discussion of its findings and conclusions identified in Steps 1, 3, and 4 within the affected classification, including any citations to specific evidence considered and results of analyses which demonstrate that the plan/issuer is or is not in compliance with MHPAEA.

The required information in Step 5 is inclusive of a summary and conclusion. The summary should be a concise statement or account of the principal information and results of the analyses offered to demonstrate compliance. It should not introduce new information or analyses not presented in the foregoing Steps. The conclusion provided should not merely be a summary of the principal supporting information or a re-statement of the plan/issuer's analysis; it should be a synthesis of the basis from the above required information and analyses which definitively demonstrates compliance as written and in operation.

If the plan/issuer has decided that it is not in compliance, it should describe any plan it has for corrective action.