STATE OF WEST VIRGINIA
Offices *of the* Insurance Commissioner

Allan L. McVey
Insurance Commissioner

To: **Health Carriers Subject to Mental Health Parity in West Virginia**

From: **Joylynn Fix, Director of Health Policy,**
Offices of the Insurance Commissioner (OIC)

Date: **March 20, 2023**

Re: **West Virginia 2023 Mental Health Parity Data Call**

The West Virginia Legislature, through W.Va. Code §§33-15-4u, 33-16-3ff, 33-24-7u, 33-25-8r, 33-25A-8u, and W.Va. Rule 114-64-7.3 and 8. charges the West Virginia Offices of the Insurance Commissioner (OIC) to annually issue a mandatory data call and provide a detailed report to the Joint Committee on Government and Finance on the status of mental health and substance use disorder (MH/SUD) parity. That detailed report must address adverse benefit determinations, quantitative treatment limitations (QTLs), financial requirements (FRs), and comparative analyses of all nonquantitative treatment limitations (NQTLs). This data call and information and reporting request (Data Call) is designed to collect the information necessary to complete the annual report, and to provide the OIC with information necessary to determine the state of compliance with State and Federal mental health parity laws.

The Instructions for the Carrier's response to the Data Call are set forth in Attachment A. For purposes of the Data Call, the period of review (Reporting Period) is January 1, 2022, through December 31, 2022, or the 2022 plan year for plan benefit requested information.

The Carrier's completed response is due to the OIC no later than 5:00 p.m. EDT on April 20, 2023. Responses should be uploaded to the secure ShareFile location established for this project. Copies of the requests may be found here: WV MHPAEA>for Carrier Uploads>(Company Name) >2022>Request Document. Completed responses should be uploaded to ShareFile here: WV MHPAEA> for Carrier Uploads>(Company Name) >2022.

If you are uncertain where to locate your folder or need more guidance about uploading documents, please contact WVMHPAEA@theinscompanies.com.

The Carrier's response to the Data Call will be collected as provided in the Instructions at Attachment A on the forms and worksheets provided for the Reporting Period. The Carrier must provide responses that are clearly labeled and address each and every element of the request with either a comprehensive response, or a statement and explanation that the requested item is not available and/or applicable and why it is not available and/or applicable. The responses provided must contain all necessary information and should not be limited to the items enumerated in the Instructions. Additional information should be provided, if information is necessary to understand all aspects and components of the related matter. Include with your response, any applicable definitions, illustrative examples, and copies of supporting documentation. Ensure any attached documents is explained and referenced in the comparative analyses, forms or workbooks,

including the title of the document and the page number. The specific relevance to a comparative analysis of any supporting documentation or additional information provided must be indicated in the textual analysis. The face page of any documents provided should be annotated with the response identifier (Ex. A.1.) and the page, paragraph, and sentence containing the actual text, which supports the explanatory response provided.

Based on a review of the Carrier's response to the Data Call, the OIC may determine that the Carrier is not in compliance with federal or State laws and regulations. If the OIC makes a determination that the Carrier is out of compliance, they will notify you of the determination and any intended enforcement action and/or any corrective action for non-compliance.

Please direct any questions to me at the email address or phone number listed below.

Sincerely,

Joylynn Fix, PIR, FHIAS
Director, Health Policy

ATTACHMENT A
INSTRUCTIONS FOR DATA CALL

As part of the Data Call, the Carrier must (1) complete the Carrier Information Worksheet, (2) provide comparative analyses for its NQTLs on the submission form provided by the OIC and attached hereto, (3) provide information regarding the Carrier's FRs and QTLs on the worksheets found at the link provided, and (4) complete the Carrier Attestation. The instructions for each of the Data Call requirements is set forth below.

(1) CARRIER INFORMATION WORKSHEET

The OIC provided the Carrier with a Carrier Information Worksheet, which is included for your ease of use. In addition, this Carrier Information Worksheet has been loaded to the ShareFile location and is downloadable from there. This worksheet is for the collection of information about the Carrier and its plans sold in the State. The Carrier must complete the Sections in the Worksheet as described in Sections A – F below.

Section A: Carrier Information Worksheet

Section A requests information related to the Carrier, the individuals and/or experts completing the submission related to NQTL comparative analyses and their contact information. Under the Staff Information section of the Carrier Information Worksheet, in regard to staff members responsible for developing plan policies and benefit designs, qualifications means the degree or other educational and/or work experience the plan requires for individuals with the title identified. For example, the Director of Plan Development is required to be a board-certified medical doctor.

Section B: Plans and Claim Expense Data for Medical/Surgical Benefits

This Section B requests data related to the plans marketed and sold during the Reporting Period, the number of policies in force as of December 31, 2022, the total number of members, including policyholders, primary insureds, and covered dependents as of December 31, 2022, and the claims experience for the period of review of January 1, 2022, through December 31, 2022.

Dollar Amount of Claims should be the amount actually paid out by the Carrier. Any amounts applied to the member's cost-sharing, coordination of benefits bank, or penalties should not be included.

Total # of Claims Received:

Although each claim may contain multiple lines, each unique claim number (regardless of the number of claim lines for the unique claim number), would only be counted as a single claim. The number of claims should correspond with the number of claim numbers assigned during the Reporting Period.

If a claim was processed more than once, it should be counted only once within the population based upon the final determination. For example, if a prescription is denied, but then reprocesses to pay, this claim would be listed once within the approved population.

If a claim is approved, but the entire amount applies to the members deductible, include the claim within the approved population.

Denied claims are those claims where every line was denied, regardless of reason, including administrative denials.

Section C: Vendor/Delegate Information

Section C requires the Carrier to identify any vendors or delegates, whether internal or external to the Carrier, who provide any administrative or utilization management services to the medical/surgical, MH/SUD, or pharmacy benefits. Moreover, Section A requires the Carrier to describe how it monitors and coordinates with the vendor/delegate compliance with MHPAEA.

Section D: Adverse Benefit Determinations.

Section D requires the Carrier to provide certain information related to the number of prior authorization requests and the number of requests that are approved, denied or modified. Section D.1. requires the Carrier to provide the information with respect to the medical/surgical benefit, Section D.2. requires the Carrier to provide the information with respect to the MH benefit, and Section D.3. requires the Carrier to provide the information with respect to the SUD benefit. The data provided should be plan specific and not include data from other plans. If necessary, the Carrier should provide additional data for each plan identified as being sold in the state as set forth in the Carrier's Section B response.

Section E: Identification of NQTLs

This Section requests a listing of all NQTLs that are applied to MH/SUD benefits or medical and surgical benefits within each classification or permitted sub-classification of benefits. Add additional rows as necessary.

It is important for the Carriers' plans to identify all NQTLs and be able to demonstrate that the Carrier meets the Required Steps.

For purposes of this Data Call, the OIC expects to receive evaluations for the below listed NQTLs at a minimum, and additional NQTLs as needed. If a Carrier believes an NQTL in the list below to not be applicable, provide an explanation that the NQTL is not imposed by the Plan.

- Utilization Management Protocols (prior authorization, concurrent review, and post-claim payment retrospective review[1]);
- Exclusions for failure to complete a course of treatment
- Experimental/investigational
- Medical necessity standards
- Reimbursement rates (in-network and out-of-network professional provider and facility);
- Provider reimbursement
- Restrictions based on geographic region, facility type, or provider specialty;
- Standards for provider admission to a network;
- Any NQTL imposed on the pharmacy benefit (e.g., prior authorization, step therapy or fail first protocols, quantity limits, formulary tiering, medical necessity criteria, etc.); and
- Any other NQTL that limits the scope or duration of a benefit.

Section F: Medical Necessity Criteria and Definitions

[1] Post claim payment retrospective review is….

Section asks for the plan's definitions for pertinent terms and responses to discussion questions related to the plans selection of medical necessity criteria used to determine plan benefits for medical/surgical and mental health and substance use disorder benefits.

(2) NQTL Comparative Analyses

MHPAEA requires health plans and health insurance issuers that impose NQTLs on mental health or substance use disorder (MH/SUD) benefits to perform and document comparative analyses of the design and application of NQTLs that demonstrate compliance with the law and its regulations. The Consolidated Appropriations Act of 2021 (the "CAA") was enacted on December 27, 2020, and amended MHPAEA by requiring that group health plans and health insurance issuers offering group or individual health insurance coverage that offer both medical/surgical and MH/SUD benefits to perform and document comparative analyses of the design and application of all NQTLs. Under the CAA, plans must "perform and document comparative analyses of the design and application of NQTLs." The comparative analyses must *demonstrate:*

> "that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs 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 NQTLs to medical or surgical benefits in the benefits classification."[2]

The terms of the statute require that issuers perform the comparative analyses in a manner which demonstrates compliance with MHPAEA's NQTL rule via five required information elements (the "Required Steps") as follows:

1. The specific plan or coverage terms or other relevant terms regarding the NQTLs and a description of all MH/SUD and med/surg benefits to which each such term applies in each benefits classification;
2. The factors used to determine that the NQTLs will apply to MH/SUD benefits and med/surg benefits;
3. The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTLs to MH/SUD benefits and med/surg benefits;
4. The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs 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 NQTLs to med/surg benefits in the benefits classification; and
5. The specific findings and conclusions reached by the plan or issuer, including any results of the analyses that indicate that the plan or coverage is or is not in compliance with the MHPAEA requirements.[3]

[2] 42 U.S.C. 300gg-26(a)(8)(A)(iv)

[3] 42 U.S.C. section 300gg-26(a)(8)(A)(i) - (v).

The Required Steps are "Compliance Requirements," as reflected in the title of 42 U.S.C. section 300gg-26(a)(8), the section of the law which sets forth the Required Steps. Each step is a requirement that is necessary for establishing compliance. If a plan fails to meet any Required Step, it is a failure to provide the required information and demonstrate a conclusive comparative analysis.

We will review the comparative analyses and related documentation you provide in response to this request to ensure that the submitted information is sufficient to demonstrate compliance with MHPAEA. The comparative analyses submitted must comply with the requirements of the statutory text above and will be evaluated for compliance with subsection (a)(8)(A) in addition to being evaluated for compliance with the underlying NQTL requirements of 45 CFR 146.136(c)(4) that are implicated by subsection (a)(8)(A).

With respect to the Data Call related to NQTLs, the Carrier must provide responses in the forms provided for in Attachment B. Attachment B requires the following information:

The comparative analyses for the NQTLs requested below must include the requirements set forth in 42 U.S.C. 300gg-26(a)(8)(A). The submission form includes relevant guidance from The FAQs About Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021, Part 45[4] (FAQ 45) for each Required Step. The stipulations provided in FAQ 45 are governing principles respecting the Required Steps which define whether the elements of a comparative analysis can be deemed sufficient or insufficient regarding NQTL comparative analyses and must be adhered to.

The following are important instructional information that should be closely followed when preparing the NQTL comparative analyses:

1) The Carrier must provide comparative analyses using the required NQTL submission form provided in Section E of Attachment B. If the Carrier does not provide a comparative analysis in the submission form provided, this alone may render the comparative analysis unacceptable for assessment by the OIC. The form explicitly requires a textual analysis and not a presentation of side by side plan terms.
2) Any supporting documentation provided should be explained and referenced in the comparative analyses and the appropriate page numbers and identifying information provided.
3) Responses that merely identify or describe processes, strategies, evidentiary standards, or factors without clear explanations of how they were defined and applied in practice do not meet the requirements of subsection (a)(8)(A).
4) Responses that are merely conclusory or generalized statements, or recitations of the legal standard of 45 CFR 146.136 without supporting evidence and explanation are insufficient.
5) Responses that merely identify or describe processes, strategies, evidentiary standards, or factors without a clear and detailed comparative analysis do not meet the requirements of subsection (a)(8)(A).
6) Note that the statutory requirements of subsection (a)(8)(A)(iv) stipulate that the NQTL comparative analyses must succeed in "…**demonstrating** that the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to mental health or substance use disorder benefits, **as written and *in***

[4] See FAQs-Part-45 (cms.gov).

operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply the NQTLs to medical or surgical benefits in the benefits classification." If a response does not clearly demonstrate or clearly show through proof or evidence, via the Required Step set forth above, that the tests of comparability and no more stringent application have been met, both as written and in operation, the analysis will have failed to meet the statutory requirements of clause iv., and thus, the overall requirements of subsection (a)(8)(A). It is the responsibility of the issuer to meet these requirements in an unambiguous manner.

(3) Financial Requirements and Quantitative Treatment Limitations

A worksheet for QTL calculations has also been attached for your use in submitting QTL test results. A copy is also found in ShareFile. This Workbook contains multiple formulas to complete required substantially all and predominant testing and determine the allowable limits that may be applied to behavioral health, mental health, and substance use disorder benefits for the plan. Below are illustrations of the various Worksheets and how best to complete them. As an initial step, identification of all covered services, both medical/surgical and MH/SUD, as well as Reporting Period plan payment data for West Virginia members only is critical for complete QTL and NQTL analyses. Classification of covered services must remain consistent across both types of analysis and across both Tools, thus must be established at the outset.

- While QTL testing is not completed for the Pharmacy classification, or for MH/SUD benefits, those benefits and claims dollars are still required to be listed in the FR and QTL Workbook.
- The total claims dollars provided in the NQTL Workbook for a plan should reconcile to the claims' dollars in the FR and QTL Workbook for that plan. Both documents request claims information for the same period.
- The number of FR and QTL Workbooks completed should reconcile to the total number of plans listed in the NQTL Workbook.
- Please note that a separate FR and QTL Workbook will need to be created for every plan. The only exception to this requirement is if the plans have identical cost-share and quantitative treatment limitations, it is permissible to combine those plans in one FR and QTL Workbook. However, if there is any variation in limitations, then each plan must have a separate FR QTL Workbook. For example, if two plans have the same co-pay, co-insurance, and deductible application for all benefits in all classifications, except one plan limits chiropractic visits to 20 and another to 30, then two separate FR and QTL Workbooks must be completed. If a Carrier does combine plans in FR and QTL Workbooks, then this relationship needs to be clearly identified in both Workbooks.

Covered Services Worksheet

Step 1. Provide the Carrier Name, Plan Name/ID, Plan Year, and Coverage Type (i.e., HMO, PPO, EPO, POS, etc.), and select the appropriate dropdown box (large group, small group, or individual) for the Plan Market information.

Cell	Notes on Response
C2	Provide Carrier Name

C3	Plan Name/ID (e.g., HIOS #)
C4	Plan Year
E4	Select from Dropdown (Small, Large, Individual)
F4	Provide Coverage type

Step 2. Answer the following questions by selecting either Yes or No in the appropriate dropdown box:

- "Are outpatient services sub-classified into "office visit" and "other"?"
  - This question must be answered in order to populate the classification cells in column E.
- "Is there a tiered network?" If Yes, continue to the next question. If no, move to Step 3.
  - Tiered network refers to multiple levels of tiering with respect to contracted providers. Out-of-network is not considered a tier.
- "If yes, please select the number of tiers:" Select the appropriate number of tiers from the dropdown box.

NOTE: This template does not automatically separate multiple networks for purposes of analysis. If the Carrier chooses to subclassify based on networks (pursuant to 45 C.F.R. §146.136(c)(3)(iii)(B)), the analysis will have to be completed manually utilizing additional Workbooks if necessary.

Cell	Notes on Response
E6	Select from Dropdown: Yes or No regarding outpatient sub-classification
E7	Select from Dropdown: Yes or No regarding tiering

E8	If Yes above, select number of tiers (excluding out-of-network)

Step 3. List all Covered Services in Column B

Cell	Notes on Response
Beginning with B10	List all Covered Services

- All services included in the Certificates of Coverage and Schedules of Benefits should be identifiable in the list of covered services.
- Covered services should have their own line based on network (in and out, as well as tiering if applicable), cost-sharing type, applicable visit or day limits, FR or QTL level, and classification.

Network: Include a separate covered service line for services that are covered in-network and out-of-network, e.g., one line for primary care physician (PCP) office visit-in network, and a separate line for PCP office visit-out of network.

Covered Services Worksheet Illustration I

Covered Services	Medical/Surgical or MH/SUD	Expected Claim Dollar Amount	Classification
PCP Office Visit, In-network	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
Specialist Office Visit, In-network	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
PCP Office Visit, Out-of-network	Med/Surg	$XX,XXX,XXX	OutPt, OON-Office
Specialist Office Visit, Out-of-network	Med/Surg	$XX,XXX,XXX	OutPt, OON-Office

Services should be separated by tier when there is more than one network tier, e.g., preferred specialist on one line, non-preferred specialist on a separate line.

Covered Services Worksheet Illustration II

Covered Services	Medical/Surgical or MH/SUD	Expected Claim Dollar Amount	Classification
PCP Office Visit, Preferred Tier	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
PCP Office Visit, Non-preferred Tier	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
PCP Office Visit, Out-of-network	Med/Surg	$XX,XXX,XXX	OutPt, OON-Office

Cost-Sharing: Include a separate covered service line for services that have different cost sharing that is dependent upon site of service or diagnostic vs. preventive. For example, CDC - recommended immunizations are $0 cost-sharing but may be provided in a PCP's office or at a pharmacy, while other immunizations (e.g., for travel) may be provided by a PCP but may have cost-sharing applied. Each instance would need to have its own line for reporting on covered services.

Covered Services Worksheet Illustration III

Covered Services	Medical/Surgical or MH/SUD	List the Expected Claim Dollar Amount for Each Medical/Surgical Benefit	Classification
Immunizations - ACA preventive - PCP office	Med/Surg	$xx,xxx,xxx	OutPt, IN-Office
Immunizations - non-ACA preventive - PCP office	Med/Surg	$xx,xxx,xxx	OutPt, IN-Office
Immunizations - ACA preventive - non-PCP	Med/Surg	$xx,xxx,xxx	OutPt, IN-Other

Classification: For purposes of MHPAEA analysis, classification of benefits, and any corresponding limitations, should be based on the underlying diagnosis, regardless of site of service or the system through which claims are processed. For example, occupational therapy may be appropriate for both medical/surgical and MH/SUD diagnoses and processed through a medical claims system. For purposes of the analysis, however, the occupational therapy claims processed for underlying medical/surgical diagnoses should be classified as medical/surgical and occupational therapy processed for underlying MH/SUD (e.g., ADHD, Autism, as defined in product information) should be classified as MH/SUD.

Covered Services Worksheet Illustration IV

Covered Services	Medical/Surgical or MH/SUD	List the Expected Claim Dollar Amount for Each Medical/Surgical Benefit	Classification
Occupational Therapy - office	Med/Surg	$xxx,xxx,xxx	OutPt, IN-Office
Occupational Therapy - ADHD office	MH/SUD		OutPt, IN-Office
Occupational Therapy - ASD office	MH/SUD		OutPt, IN-Office
Occupational Therapy - ASD community	MH/SUD		OutPt, IN-Other

And

Covered Services Worksheet Illustration V

Covered Services	Medical/Surgical or MH/SUD	Expected Claim Dollar Amount	Classification
Speech therapy, ASD	MH/SUD		OutPt, IN-Office
Speech therapy, Medical/Surgical	Med/Surg	$XX,XXX,XXX	OutPt, IN-Office
Speech therapy, ASD	MH/SUD		OutPt, OON-Office
Speech therapy, Medical/Surgical	Med/Surg	$XX,XXX,XXX	OutPt, OON-Office

Step 4. Designate whether each covered service is Medical/Surgical or MH/SUD in Column C, taking the following into consideration:

- Services must be identified as medical/surgical or MH/SUD as defined under the terms of the plan and in accordance with applicable state and federal law. Any condition defined by the plan as being medical/surgical or MH/SUD must be consistent with generally recognized independent standards of current medical practice (e.g., the most current version of the ICD or State guidelines). For example, state law defines bipolar disorder, major depressive disorder, and anorexia nervosa as a mental illness, thus covered services used in the treatment of those diagnoses must be identified as MH/SUD in the MHPAEA analysis.
- Once defined as medical/surgical or MH/SUD, the Carrier's definition must remain consistent for all MHPAEA analyses within the product being analyzed, i.e., QTL and NQTL analyses.

NOTE: Every medical/surgical service classification should have corresponding MH/SUD covered services

Cell	Notes on Response
Beginning with C10	Select from Dropdown: Medical/surgical or MH/SUD for each Covered Service listed in Column B

Step 5. Enter Expected Claim Dollar Amounts in Column D for each listed covered service that is identified as medical/surgical.

- All covered medical/surgical services, including those services with zero-dollar cost sharing for members, must have an associated expected plan claim dollar amount listed. Also, expected claim dollar amounts must be based on the dollar amount of all plan payments for medical/surgical benefits in the classification expected to be paid under the

plan for the plan year; expected claim dollar amounts are not cost sharing amounts paid by members.

Cell	Notes on Response
Beginning with D10	List expected claim dollar amount for each Covered Service listed in Column B

Step 6. Choose the appropriate Classification or Sub-Classification in Column E by selecting the appropriate responses in the dropdown boxes.

- Services should be classified consistently regardless of ACA requirements, e.g., Mammography (preventive/screening) and Mammography (non-screening) should be included in the same classification since the service is the same regardless of whether it is an ACA covered preventive mammogram or a diagnostic mammogram.
- Location of service may be a permissible distinction, e.g., immunizations in PCP's office may be placed in the outpatient, office visit subclassification while immunizations in a pharmacy may be placed in the outpatient, all other subclassification.
- Similar services should be classified together unless the location or other distinction can be identified, e.g., breastfeeding supplies and diabetic supplies may be in the same classification unless diabetic supplies are covered under pharmacy benefits and breastfeeding supplies are considered DME.

Cell	Notes on Response
Beginning with E10	Select classification or sub-classification from dropdown for each Covered Service listed in Column B

Step 7. In Column F and Column G, provide citations in the form of page numbers and sections in both the Certificate of Coverage and Schedule of Benefits where the services included in each line of the listed Covered Services can be found.

- This information will allow reviewers to determine the specific services from Certificates of Coverage and Schedules of Benefits that are included in each line of Covered Services.

Cell	Notes on Response
Beginning with F10	List COC page number related to each Covered Service listed in Column B
Beginning with G10	List SOB page number related to each Covered Service listed in Column B

Covered Services Worksheet Illustration VI

COC Cites:	SOB Cites:
pg. 14, Section III	pg. 3, Section II
pg. 25, Section V	pg. 4, Section III

Analysis Worksheets

Data entered in columns B through G in the Covered Services Worksheet will auto-populate the corresponding classification Worksheets for purposes of reporting QTLs and Financial Requirements, e.g. All benefits listed under the Outpatient, In-network classification on the Covered Services Worksheet will automatically populate on the Outpatient-INN Worksheet.

For each Worksheet, enter the corresponding cost-sharing and/or visit limit information in the lines with covered services. Where limits are not applied or the cost-sharing is $0, enter "N." **Do not enter information in any other areas. Formulas in place will complete the calculations.**

Note: Only medical/surgical services carry over to the calculation Worksheets.

SubC-Outpatient-Office INN Worksheet Illustration

Service Categories within the Sub-Classification of: OPTION-OUTPATIENT, IN, OFFICE	COLUMN 1 EXPECTED CLAIM DOLLAR AMOUNT	COLUMN 2 COPAY APPLICATION	COLUMN 3 COINSURANCE APPLICATION	COLUMN 4 DEDUCTIBLE APPLICATION	COLUMN 5 SESSION LIMITS APPLICATION
INSTRUCTIONS: All MEDICAL/SURGICAL service categories provided within this sub-classification are listed below.	INSTRUCTIONS: List Claim Expected Allowed Dollar Amounts (Annual) for each service category listed.	INSTRUCTIONS: Is a copay applied to this service category? If yes, list the copay dollar amount applied to the Service Category. If no, put a "N" for every Service Category where there is no copay application.	INSTRUCTIONS: Is a coinsurance applied to this service category? If yes, list coinsurance Percentage Amount Applied to the Service Category. If no, put a "N" for every Service Category where there is no coinsurance application.	INSTRUCTIONS: Is a deductible applied to this service category? If yes, put a "Y" for every Service Category with a deductible application. If no, put a "N" for every Service Category where there is no deductible application.	INSTRUCTIONS: Is a session limit applied to this service category? If yes, put the session limit for every Service Category. If no, put a "N" for every Service Category where there is no session limit application.
Occupational Therapy - office	$45,545,522.00	$40.00	N	N	N
Speech Therapy - office	$48,552,679.00	$40.00	N	N	N
Immunization- ACA - PCP office	$1,525,588.00	N	N	N	N
Immunization - Travel - PCP office	$544,899.00	$25.00	N	N	N

When Columns 2-6 (D-H) are filled out, formulas will auto-calculate the substantially all and predominant level tests. The user will be prompted if the substantially all threshold is not met and which level is the predominant level, if applicable.

MHPAEA FR and QTL Workbook (Add Link)

(4) Attestation of Truth, Accuracy and Completeness

Once the responses described in Sections (1), (2), and (3) above are fully complete and all supporting documents are completed, prior to returning the response to the OIC, an officer of the Carrier must complete and sign attesting to the completeness and accuracy of the response.

ATTACHMENT B
MHPAEA NQTL Required Response Forms

Instructions: This NQTL reporting submission form includes the required five elements as specified by 42 USC Section 300gg-26(a)(8)(A); 29 USC Section 1185a(a)(8)(A); and 26 USC Section 9812(a)(8)(A). A separate reporting form should be prepared and completed for each NQTL within each benefits classification/subclassification (e.g., the comparative analysis for prior authorization for the inpatient, in-network benefits classification should be provided on its own reporting submission form).

[Insert NQTL Name and Benefits Classification/Subclassification]

Step 1:

Specify the specific Plan or coverage terms or other relevant terms regarding the NQTL, that apply to such Plan or coverage, and provide a description of all mental health or substance use disorder (MH/SUD) and medical or surgical benefits to which the NQTL applies or for which it does not apply.

FAQ 45 Guidance: The FAQ 45 (Q2, #'s 1 and 2) guidance stipulate that a sufficient analysis should include:

A clear description of the specific NQTL, plan terms, and policies at issue; and

Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Plan Response: [Insert Here]

Step 2:

Identify all the factors (quantitative and qualitative and label as appropriate) used to determine that the NQTL will apply to MH/SUD benefits and medical or surgical benefits.

FAQ 45 Guidance: The FAQ 45 (Q2, #3) guidance stipulates that a sufficient analysis includes:

Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

Plan Response: [Insert here]

Step 3:

Provide 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.

FAQ 45 Guidance: The FAQ 45 (Q 2, # 4) guidance stipulates that a sufficient response includes:

To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

The FAQ 45 guidance (Q 3, # 5) states that the following is insufficient:

Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Plan Response: [Insert here]

Step 4:

Provide 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 NQTLs to medical or surgical benefits.

FAQ 45 Guidance: The FAQ 45 guidance states that the following is necessary for a sufficient response:

(Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.

(Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).

(Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.

(Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

(Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.

(Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Plan Response – As Written: [Insert here]

Plan Response – In Operation: [Insert here]

Step 5:

The specific findings and conclusions reached by the Plan or issuer with respect to the health insurance coverage, including any results of the analyses described in the previous steps that indicate that the Plan or issuer is or is not in compliance with the MHPAEA NQTL requirements.

FAQ 45 Guidance: The FAQ 45 guidance states that a sufficient response should include:

(Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

The FAQ 45 guidance states that the following constitutes an insufficient response:

(Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Plan Conclusion: [Insert here]

ATTACHMENT C
Attestation of Truth, Accuracy and Completeness

Carrier Name:
HIOS#:

Responsible Officer

Name: (Last) _____ (First) _____
(MI) _____

Title:

_____

Street or P.O. Box:

_____

City/State/Zip Code:

_____

I certify under penalty of law, based upon the information and belief formed after reasonable inquiry and review, that the completed data call response, including both the NQTL Workbook and the FR and QTL Workbook and any attachments, and statements and information contained in these documents are true, accurate and complete to the best of my knowledge and belief.

Name: (Signed) _____

Name: (Typed) _____

Date: _____