EPSTEIN BECKER GREEN

Mental Health Parity: Managing Compliance Across Commercial, Medicaid, and Duals Products

Health Care Compliance Association
Managed Care Compliance Conference
February 12, 2018

Helaine I. Fingold, Esq.
Epstein Becker & Green
Baltimore, MD
www.ebglaw.com

Presented by

Helaine I. Fingold
Senior Counsel
Epstein Becker Green

hfingold@ebglaw.com
443.663.1354

EPSTEIN BECKER GREEN

Agenda

1. History and overview of Parity requirements
2. Parity compliance vs. general program compliance
3. Application of Parity to Medicaid and Dual Eligibles
4. Trends in compliance, enforcement, and litigation

Legislative and Regulatory History

- 1996: Mental Health Parity Act (MHPA)
  - Prohibits large group health plans from imposing annual/ lifetime dollar limits on mental health benefits that are less favorable than such limits imposed on med/surg benefits.
- 2008: Mental Health Parity and Addiction Equity Act (MHPAEA)
  - **Applies to plans sponsored by private and public sector employers with more than 50 employees, including self-insured as well as fully insured arrangements**
- 2009: Children's Health Insurance Program Reauthorization Act (CHIPRA)
  - Applies the parity requirements of MHPAEA to coverage under a CHIP state plan in the same manner MHPAEA applies to group health plans
- 2010: Affordable Care Act (ACA)
  - Mandates that MHPAEA compliance Mental Health/Substance Use Disorder (MH/SUD) treatment services be provided as part of an "Essential Health Benefits" (EHB) package under individual, small group, and Medicaid non-managed care Alternative Benefit plans (ABPs)
- 2013 & 2016: MHPAEA Final Rule
  - MHPAEA Commercial Market Final Rule issued on Friday, November 8th, 2013; effective January 13, 2014, MHPAEA Medicaid final rule issued March 30th 2016, states must demonstrate compliance by October 2nd, 2017

MHPAEA – Key Requirements

- **Financial requirements and quantitative treatment limitations (QTLs)** applied to MH/SUD benefits must be no more restrictive than the predominant (1/2) type of financial requirements applied to substantially all (2/3) medical/surgical benefits (med/surg)
- **No separate cost sharing requirements or treatment limits** applying only to mental health or substance use disorder benefits
- **Non-Quantitative Treatment Limits (NQTLs)** -- Processes, strategies, evidentiary standards or other factors used to apply MH/SUD and med/surg **NQTLs must be comparable and no more stringent**
- If **out-of-network coverage** is available for medical/surgical benefits, it must be made available for mental health or substance use disorder benefits
- Robust medical necessity **disclosure obligations**

Parity in Financial Requirements and QTLs

- **Substantially All Test**: Entity must demonstrate that any financial requirement or QTL for MH/SUD benefits in a classification of benefits (or sub-classification) applies to at least 2/3 of med/surg benefits in the classification (or sub-classification)
- **Predominant Test**: Entity must demonstrate that any financial requirement or QTL that passes the substantially all test and is in place for MH/SUD benefits in a classification (or sub-classification) is no more restrictive than the predominant (more than ½) level of financial requirement or QTL used for med/surg benefits in the classification
  - Ex: In the inpatient, in-network classification, a copay is in place for 85% of med/surg benefits, therefore a copay may be used for inpatient, in-network MH/SUD benefits. A copay of $100 is used for 60% of inpatient, in-network med/surg benefits to which a copay applies, therefore the copay for MH/SUD benefits in the inpatient, in-network classification must be $100 or less

Note: For any financial requirement or QTL for which there is no predominant level, the entity must demonstrate that it combined levels until it exceeded the ½ threshold and selected the least restrictive level of the combination

Parity in use and application of NQTLs

- **6-step process for demonstrating compliance:**
  1. Provide the specific plan language regarding the NQTL and describe all services to which it applies in each respective benefits classification for MH/SUD and med/surg
  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
  3. Identify and describe the evidentiary standard for each of the factors identified in Step 2 and any other evidence relied upon to design and apply the NQTL
  4. Identify and provide the methods used to analyze and conclude that the NQTLs are comparable and applied no more stringently, as written
  5. Identify and provide the methods used to analyze and conclude that the NQTLs are comparable and applied no more stringently, in operation
  6. Detailed summary explanation of how the analyses have led the plan to conclude compliance with MHPAEA

EPSTEIN BECKER GREEN

MHPAEA Compliance vs. Program Compliance

MHPAEA Compliance vs. Program Compliance

PROGRAM COMPLIANCE

- Ensure a compliance plan is in place that addresses key areas including:
  - health care fraud, waste and abuse;
  - financial record keeping and reporting;
  - outcome and process measure reporting;
  - compliance with employment, whistleblower;
  - utilization review and other insurance laws;
  - rules for appeals and grievances;
  - marketing and enrollment procedures
- Program compliance also requires procedural and staffing requirements including:
  - Compliance Officer, Compliance Committee and High Level Oversight;
  - training and Education;
  - lines of Communication;
  - Disciplinary Standards;
  - System for Routine Monitoring and Identification of Compliance Risks.

MHPAEA Compliance vs. Program Compliance

MHPAEA COMPLIANCE

- Comprehensive analysis of plan operations across an enormous range of benefit design and administration otherwise only subject to limited, if any, regulatory oversight
- Documentation of plan operations that is not generally produced in a manner conducive to performing the analytical steps of the MHPAEA process

The MHPAEA analysis process itself is complex and must be performed regularly if benefit design or administration policies are changed in a manner that may impact the MHPAEA analysis

MHPAEA Compliance vs. Program Compliance

MHPAEA COMPLIANCE, cont.

- Requires unique data collection and analysis for each step and type of limit:
  - **Benefit Classification**: Identify which classification or sub-classification of benefits each service procedure or medication is assigned for both MH/SUD and med/surg benefits
  - Financial Requirements and QTLs: Demonstrate that all financial requirements QTLs imposed on MH/SUD services satisfy the substantially all (2/3) and predominant (1/2) tests in each classification
  - NQTLs: Demonstrate that the processes, strategies, evidentiary standards, or other factors used in designing and operationalizing each NQTL for both MH/SUD and med/surg in each classification of benefits are comparable and no more stringently applied

EPSTEIN BECKER GREEN

Application of MHPAEA to Medicaid

Final MHPAEA Medicaid Rule

- Published on March 30, 2016
- States required to certify compliance and post documentation supporting such certification on their public website no later than October 2, 2017
- Provides guidance on the application of MHPAEA to:
  - Medicaid managed care organizations ("MCOs")
  - Medicaid benchmark or benchmark-equivalent plans ("Alternative Benefit Plans" or "ABPs") and
  - The Children's Health Insurance Program ("CHIP")
- DOES NOT apply to the Medicaid State Plan
- Largely the same approach as under commercial Parity rules regarding financial requirements, QTLs, and NQTLs but focus is on *State* compliance

Final MHPAEA Medicaid Rule

APPLICATION TO MEDICAID MH/SUD SERVICES

- States have flexibility in defining how they cover and deliver Medicaid MH/SUD services
- Some states provide MH/SUD services through MCOs or through entities offering more limited benefit packages, such as prepaid inpatient health plans ("PIHPs") or prepaid ambulatory health plans ("PAHPs"), or through a combination of these
- Final Rule aims to ensure that beneficiaries enrolled in MCOs have access to a set of benefits that meets parity requirements regardless of how services are provided
- If a state uses private health plans or MCOs to provide ***any*** of its state plan benefits under an MCO contract, then
  - the parity protections would apply *across* the delivery system, to the entire package of services MCO enrollees receive, whether from the MCO, PIHP, PAHP, or through traditional fee-for-service ("FFS")

Final MHPAEA Medicaid Rule

RESPONSIBILITY FOR PARITY ANALYSIS

- If MCO has responsibility for offering all medical/surgical and MH/SUD benefits, the MCO must conduct the parity analysis
  - Must also tell the state of changes required to bring the MCO contract into compliance with parity requirements
- If MCO does not offer all MH/SUD benefits, the state itself must conduct the parity analysis as follows:
  - Must complete the analysis across delivery systems and determine if the existing benefits and any financial or treatment limitations are consistent with parity
  - May rely on third parties (*including MCOs*) to collect relevant information and even complete a preliminary analysis, but the state itself must review and accept that analysis
  - Will be required to provide relevant documentation to CMS, answer related questions, and will be held accountable for the accuracy and completeness of the parity analysis

Final MHPAEA Medicaid Rule

MH/SUD PARITY AND ABPS

- All Medicaid ABPs (including benchmark equivalent and Secretary-approved benchmark plans) must meet the financial requirements and treatment limitations component of the mental health parity provisions
  - Regardless of whether services are delivered in managed care or non-managed care arrangements
  - ABPs were reviewed for financial and QTL compliance during the approval process
- ACA mandates that MH/SUD treatment services be provided as part of an "Essential Health Benefits" (EHB) package that individual, small group plans, and Medicaid non-managed care ABPs must provide
- All plans required to cover the EHB, including MH/SUD must do so in compliance with MHPAEA, effectively applying MHPAEA to the individual and small group market

Final MHPAEA Medicaid Rule

MH/SUD PARITY AND CHIP

- CHIP state plans are deemed to satisfy parity requirements related to financial requirements and treatment limitations if:
  - The plan elects to cover all required Early and Periodic Screening, Diagnostic and Treatment ("EPSDT") services (§1905(r) of SSA), and
  - The state informs individuals under 21 about the availability of the full range of EPSDT services available to them and provides/arranges for medically necessary screenings, diagnostic services, and treatments (§1902(a)(43) of SSA)
- States that apply NQTLs to EPSDT services must ensure that these limitations are applied in a manner that is consistent with the parity provisions
- CHIP programs that do not provide full EPSDT benefits and therefore do not meet the deeming requirements must:
  - Conduct a full analysis of the CHIP state plan and delivery system (including MCOs/PIHPs/PAHPs) to determine compliance with the parity standards

Final MHPAEA Medicaid Rule

MEDICAID SERVICE CLASSIFICATIONS

- CMS finalized the use of **four classifications** of benefits in assessing parity under the Final Rule: inpatient, outpatient, emergency care, and prescription drugs
  - Contrasts with six classifications included in the commercial Final Rule, which bifurcates inpatient and outpatient with in-network and out-of-network classifications
  - Outpatient may be sub-classified into office visits and all other outpatient services
- Final Rule does not define which services are in which classification
  - These terms are subject to the design of a state's managed care program and their meanings may differ depending on the benefit packages
  - May require guidance from State to perform classification
- CMS declined to create a new intermediate level services classification but allows for MCO/PIHP/PAHP/state to assign intermediate level services to any of the four benefit classifications
  - Must be reasonable and done using the same standards for both medical/surgical services and MH/SUD services

Final MHPAEA Medicaid Rule

MEDICAID CUMULATIVE LIMITATIONS

- ***Separate cumulative financial requirements*** for mental health, substance use or medical/surgical services are ***not allowed*** in connection with coverage provided to MCO enrollees, and in ABP and CHIP state plans
- ***Separate Quantitative treatment limitations are allowed*** for medical/surgical and MH/SUD services as long as they comply with the general parity requirement:
  - Any such limit for MH/SUD benefits is no more restrictive than the "predominant" limit applied to "substantially all" medical/surgical benefits in a given classification
  - In contrast quantitative treatment limitations may ***NOT*** accumulate separately under the commercial market MHPAEA final rule

Final MHPAEA Medicaid Rule

DISCLOSURE OF INFORMATION BY MCOs, PIHPs, AND PAHPs

- Affected MCOs, PIHPs, and PAHPs must make MH/SUD ***medical necessity criteria*** available to any enrollee, potential enrollee or contracting provider upon request
  - MCOs, PIHPs, and PAHPs found to be in compliance with existing practice guideline dissemination requirements will be deemed to meet this requirement
- Also, MCOs, PIHPs, or PAHPs must make available the ***reason for any denial*** of reimbursement or payment for services for MH/SUD benefits to the enrollee
  - MCOs, PIHPs, and PAHPs are already required to notify the requesting provider and give the enrollee written notice of whole or partial denials

Final MHPAEA Medicaid Rule

VARIANCE BETWEEN STATE CARVE-IN OR OUT FOR MH/SUD SERVICES

State Polices Regarding Medicaid MCO Coverage of Behavioral Health as of July, 2016				
	Specialty Outpatient Mental Health*	Inpatient Mental Health	Outpatient Substance Abuse Disorder	Inpatient Substance Abuse Disorder
Always carved in	20 States	24 States	24 States	26 States
Always carved out	12 States	10 States	9 States	8 States
Varies (by geography or other factor	7 States	5 States	6 States	5 States

* Includes services provided to adults with serious mental illness, and youth with serious mental disturbance

Source: Implementing Coverage and Payment Initiatives: 50-State Medicaid Budget Survey for Stat Fiscal years 2016-2017, Kaiser Family Foundation; available at http://files.kff.org/attachment/Report-Implementing-Coverage-and-Payment-Initiatives

Final MHPAEA Medicaid Rule

OVERSIGHT OF MH/SUD PARITY

- States must conduct oversight to ensure that enrollees in MCOs receive services in compliance with parity requirements
  - CMS oversight is focused on ABP and CHIP benefit documents and MCO contracts
  - States have discretion as to how they perform oversight of MCOs
  - CMS encourages states to include parity oversight and implementation terms in their MCO contracts
  - CMS has begun to provide technical assistance and tools to clarify the types of documentation it seeks to show compliance with parity requirements
  - The parity analysis does not be completed on an annual basis unless there is a change in operations by the state or the plans that would impact parity compliance
  - State documentation demonstrating compliance must be made available to the general public through the state's web site by October 2, 2017

MHPAEA and Medicare-Medicaid Dual Eligibles

PARITY APPLIES ONLY TO DUALS' MEDICAID BENEFITS

- MHPAEA does *not* apply to Medicare but does apply to Medicaid benefits for Medicare-Medicaid dual eligible beneficiaries, including demonstration plans.
- Demonstration plans (MMPs) are MCOs, and are therefore subject to MHPAEA. Duals are entitled to full Medicaid benefits under the MMP contract but Medicaid is the secondary payer. As such the MHPAEA analysis should look to the full set of covered Medicaid benefits, even if Medicare is the primary payer.
- If a plan has to do the quantitative parity test, the expenditure data will be unusual and may invalidate some QTLs that would pass muster in a Medicaid-only MCO.
- As to NQTLs, the analysis would be the same as for a straight Medicaid MCO with the caveat that it may be difficult to identify any "as applied" data for benefit classifications where Medicare is the primary payer.

MHPAEA and Medicare-Medicaid Dual Eligibles

MEDICAID COVERAGE OF MEDICARE COST-SHARING AND PREMIUMS

- Medicaid coverage of Medicare cost-sharing and premiums is an important Medicaid benefit for dual-eligible beneficiaries.
- CMS does not currently consider Medicaid's coverage of Medicare premiums and cost sharing as a benefit for purposes of MHPAEA.
- Even if this position changes, Medicaid coverage of Medicare premium/cost-share is not an issue for MMPs because the cost-sharing and premium coverage is in the state's capitation payment to the MMP, rather than as a covered service.
- The MMP is responsible for negotiating provider payment rates and ensuring that providers don't balance bill the beneficiary for cost-sharing not allowed under the Medicaid state plan.
- The cost-sharing issue would only generally come up for state coverage of Medicare cost-sharing for enrollees of an MLTSS-MCO. For partial "lesser of" states, this could be a really serious headache but it doesn't apply to MMPs.

MHPAEA and Medicare-Medicaid Dual Eligibles

PRESCRIPTION DRUG BENEFITS

- Full-dual eligible beneficiaries are *not entitled* to Medicaid coverage for drugs that are *coverable* under Medicare Part D (without regard to whether any particular drug is actually covered under a Part D formulary).
- As such, the only Medicaid prescription drug coverage for MMP enrollees is for certain prescription and non-prescription drugs covered by the state's Medicaid program that are not coverable under Medicare Part D. This generally includes over the counter medications and dietary supplements.
- This may present a challenge for classifying benefits as there may not be any Medicaid MH/SUD prescription drug benefits. MHPAEA requires coverage of MH/SUD benefits in all classifications if coverage is available in any classification.
- CMS has not provided clear guidance on how states and MMPs should address this area.

EPSTEIN BECKER GREEN

Trends in compliance, enforcement, and litigation

Parity Enforcement and Oversight

ERISA PLANS

- **DOL** generally has primary enforcement authority over private sector employment-based plans that are subject to ERISA but not over insurers and has only a limited CMP authority
- **IRS** enforces against ERISA plans and their sponsors, and Church Plans through excise taxes of $100/day/individual
- **ERISA plan participants and beneficiaries** may bring suit under ERISA § 502(a)(1) and/or (a)(3)

FULLY INSURED

- **State insurance commissioners** have primary authority over insurance issuers' compliance with federal parity rules, **HHS** has secondary enforcement authority to impose CMP $100/day/individual (HHS has no authority over ERISA plans)
- **HHS** has CMP authority over QHPs in the marketplace for MHPAEA
- MHPAEA does not preempt State laws and all 50 states, DC, Puerto Rico, and Guam have some sort of MH/SUD parity-type provisions

MEDICAID

- **State Medicaid agencies** have enforcement authority over MCOs, PIHPs and PAHPs
- **CMS** has enforcement authority over states in the delivery of Medicaid benchmark or benchmark-equivalent plans (ABPs), CHIP, and a state's performance of its obligations to oversee MCOs, PIHPs, and PAHPs

Parity Enforcement and Oversight

SELECT STATE PRACTICES IN COMMERCIAL MARKET REGULATION AND ENFORCEMENT

- Oregon – Issued regulations with small but meaningful differences from MHPAEA final rules, e.g., plans must use a "single definition of medical necessity" for MH/SUD and medical surgical benefits
- California – The Department of Managed Health Care (DMHC) requires plans to submit detailed NQTL information about MHPAEA compliance
- Massachusetts – The Division of Insurance requires plans to submit information about compliance with MHPAEA and state parity statutes, including denial rates, authorization rates, appeal overturn rates. There is disagreement as to whether this data accurately reflects actual compliance
- Illinois – IL statutes 215 ILCS 5/370c and 5/370c.1 require plans to use ASAM criteria and no other criteria when making SUD medical necessity determinations

Parity Enforcement and Oversight

DOL ENFORCEMENT AGAINST GROUP HEALTH PLANS

- Employee Benefits Security Administration (EBSA) enforces MHPAEA for 2.2 million private employment-based group health plans covering 130.8 million participants and beneficiaries
- In 2016, the EBSA reviewed 191 plans for MHPAEA compliance and cited 44 violations:
  - 54.5% NQTLs
  - 22.7% FLs or QTLs
  - 13.6% cumulative FRs or TLs
  - 6.8% coverage in all classifications
  - 2.3% annual dollar limits

SOURCE: EBSA enforcement fact sheet, available at https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2016.pdf

Parity Enforcement and Oversight

MEDICAID PARITY RULE ENFORCEMENT

- Most state Medicaid agencies were required to demonstrate compliance by October 2 with the Medicaid MHPAEA Final Rule
  - Several states were granted extensions for demonstrating compliance
- States were required to document MHPAEA compliance across entire delivery system for covered beneficiaries
- Each entity involved in the delivery system was required to cooperate in providing information to the state for provision to CMS and public
- Next steps for enforcement of Medicaid MHPAEA rule are unclear

Parity Enforcement and Oversight

LITIGATION – SUMMARY OF TRENDS

- Plaintiffs have mostly been beneficiaries bringing claims under ERISA/MHPAEA or state parity statutes
- Relatively limited state AG litigation to date
- Class action attempts are common
- Courts have allowed limited provider and provider association standing for assigned post-service claims
- Highest number of claims involve pediatric patients
- Settlements common following preliminary motions practice
- Third-party administrators frequently made party to suits

Parity Enforcement and Oversight

LITIGATION – COMMON CLAIMS

- Common subjects of claims:
- Experimental/investigational exclusion policies, especially for ABA services
- Age restrictions for medical necessity
- Categorical exclusions for residential MH/SUD treatment, especially for eating disorders (as either QTL or NQTL)
- Quantitative visit limits
- Disparate medical management in practice (more stringent review of MH/SUD prior authorization requests, etc.)

Parity Enforcement and Oversight

LITIGATION – KEY CASES

- Rea v. Blue Shield of California, 226 Cal. App. 4th 1209, 172 Cal. Rptr. 3d 823 (2014), as modified on denial of reh'g (July 9, 2014)
  - Extends Harlick v. Blue Shield of California, 686 F.3d 699, 713 (9th Cir. 2012) which came to similar ruling for ERISA plan
  - Court held that the CA Parity Act requires Knox-Keene Act health care service plans to provide residential treatment for eating disorders where medically necessary, even when not set forth in the plan
  - Knox-Keene applies coverage mandates for enumerated services while Parity Act requires coverage for enumerate severe conditions
  - Court found that the Parity Act expanded scope of coverage mandate to mental health benefits

Parity Enforcement and Oversight

LITIGATION – KEY CASES, cont.

- R.H. v. Premera Blue Cross, No. C13-97RAJ, 2014 WL 3867617 (W.D. Wash. Aug. 6, 2014).
  - ERISA class action suit alleging that defendant plan violated MHPAEA and WA state parity law in applying age and visit limits on neurodevelopmental therapy (NDT) and applied behavior analysis (ABA) services
  - Settlement resulted in an unprecedented expansion of coverage for NDT and ABA services for class members prospectively and allows all class members to seek damages for past claims denials on an individual basis

Parity Enforcement and Oversight

LITIGATION – KEY CASES, cont.

- New York State Psychiatric Association, Inc. v. UnitedHealth Group, 798 F.3d 125 (2d Cir.2015)
  - Provider association found to have standing to bring suit on behalf of patients for MHPAEA violations under ERISA (ERISA § 502(a)(1) and (a)(3); 29 U.S.C.A. § 1132(a)(1) and (a)(3))
  - Providers had accepted assignment and therefore had standing
  - TPA was appropriate defendant because it "exercised total control over the plan's claims process."
  - Court ruling aligns with TPA liability under ERISA § 502(a)(1) in six other circuits (5th, 6th, 7th, 8th, 9th and 11th)

Parity Enforcement and Oversight

LITIGATION – KEY CASES, cont.

- Am. Psychiatric Ass'n v. Anthem Health Plans, Inc., 821 F.3d 352, 357 (2d Cir. 2016)
  - Individual providers and provider associations allege MHPAEA violations in reimbursement practices (alleging lower rates)
  - Providers and provider associations do not have third-party standing to bring suit on behalf of patients for MHPAEA violations under ERISA (ERISA § 502(a)(1), 29 U.S.C.A. § 1132(a)(1))
  - Cites Griswold v. Connecticut, 381 U.S. 479 (1965) holding that providers have standing to raise constitutional, but not statutory claims on behalf of patients
  - Provider claims were not on their own behalf pursuant to assignment
  - Distinguishes AMA v. Anthem by stating that the providers here alleged third-party standing, not standing based on assigned claims
  - Also held that plan-wide reimbursement rate policies do not constitute fiduciary acts under ERISA

21st Century Cures Act (P.L. 114-255)

- Enacted and signed into law On December 13, 2016
- Requires the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury must:
  1. issue guidance to improve the compliance of group health plans and health insurance coverage with requirements for parity between mental health and substance use disorder benefits and medical and surgical benefits,
  2. publish feedback from the public on the disclosure request process for documents regarding parity requirements, and
  3. audit the plan documents of group health plans and health insurers that repeatedly violate parity requirements. Title XIII, Sections 13001-130.

Model parity disclosure form

- On June 16, 2017, the Departments of Labor, Health and Human Services and Treasury released ACA Implementation FAQs Part 38, a Paperwork Reduction Act Notice, and a Draft Model Form, and solicited comments.
- The model form could be used by participants, enrollees, or their authorized representatives, to request relevant MHPAEA disclosures.
- Payors asked the "tri agencies" to cut down on the amount of information the MHPAEA regulations and disclosure form require a plan to provide.
- The full list of commenters and comments can be downloaded at https://www.dol.gov/agencies/ebsa/laws-and-regulations/rules-and-regulations/public-comments/faq-38

President's Commission on Combating Drug Addiction and the Opioid Crisis

- Final report issued November 1, 2017
- Includes 56 recommendations that detail how the federal government can address the nation's ongoing opioid epidemic
- Relevant recommendations include:
  - Increased authority for the Department of Labor (DOL) to oversee insurers, levy monetary penalties and permit the DOL to launch investigations of health insurers independently for parity violations.
  - Federal and state regulators should use a standardized data collection tool for documenting and disclosing compliance strategies for non-quantitative treatment limitations (NQTL) parity.

Parity Accreditation and Non-Governmental Resources

- ClearHealth Quality Institute (CHQI) has begun a new accreditation program that seeks to facilitate compliance
  - The focus of the group is on four areas critical to mental health parity: medical management techniques, network adequacy, provider reimbursement rates, and the coverage of new technologies and treatments
- In addition, the Kennedy Forum has released a "Six-Step" Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements developed by consumer advocates to address a gap in regulatory guidance regarding an aspect of assessing whether non-quantitative treatment limitations (NQTLs) applied by health plans and health insurers comply with MHPAEA.
  - The publication describes steps for identifying NQTLs and their bases, and for conducting comparative analyses of NQTLs, as written and in operation. The Guide also lists types of documentation that may be helpful to review in conducting these analyses.

Questions?

Helaine I. Fingold
Senior Counsel
Epstein Becker Green

hfingold@ebglaw.com

443.663.1354

EPSTEIN BECKER GREEN