



Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) Report for the Centers of Medicare and Medicaid Services

Submitted by the Maryland Department of Health

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Executive Summary

This report presents the Maryland Department of Health (MDH) 2022 analysis of the State's Medicaid and Children's Health Insurance Program's (CHIP) compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and the Affordable Care Act. MDH has updated this report annually since 2018. MHPAEA requires parity in the treatment limitations and financial requirements for mental health and substance use disorder (MH/SUD) benefits, as compared to medical/surgical (M/S) benefits, provided to enrollees of Medicaid managed care organizations (MCOs) and coverage provided by Medicaid alternative benefit plans (ABPs) and Children's Health Insurance Programs (CHIP).

Pursuant to applicable MHPAEA implementing regulations promulgated by the federal Centers for Medicare and Medicaid Services (CMS), States must analyze parity compliance based on the following domains:

1. **Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)**—Dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis are not applied to MH/SUD benefits unless a limit is applied to at least one-third of M/S benefits.
2. **Financial Requirements (FRs)**—Payment obligations imposed on participants for services received including copayments, coinsurance, and deductibles applied to MH/SUD benefits may be no more restrictive than the financial requirements applied to M/S benefits in the same classification.
3. **Quantitative Treatment Limitations (QTLs)**—Limits on the scope or duration of a benefit that are expressed numerically such as day or visit limits applied to a classification of MH/SUD benefits may not be more restrictive than the QTLs applied to M/S benefits in the same classification.
4. **Non-Quantitative Treatment Limitations (NQTLs)**—Limits on the scope or duration of benefits that cannot be expressed numerically such as prior authorization or data collection requirements, which otherwise limit the scope or duration of benefits applied to MH/SUD benefits, must be applied in a manner that is comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to apply the NQTL to M/S benefits in the same classification.

MDH found that in nearly all areas addressed by this analysis, MH/SUD benefits are being delivered and managed in a comparable and no more stringent manner to the way M/S benefits are managed. In particular, there are no AL/ADL in place for any benefits. There are no QTLs on any MH or SUD benefits. In addition, all NQTL types analyzed are being implemented in a comparable and no more stringent manner for MH/SUD and M/S services in the emergency, inpatient, and prescription drug classifications.

In its 2020 analysis, MDH determined that the FR in the form of drug co-pays apply to MH, SUD, and M/S benefits in a manner that satisfied the substantially all and predominant tests. MDH addressed the decision by certain MCOs to waive drug co-pays as a supplemental benefit in order to enhance marketability. MDH concluded that as this supplemental benefit is paid for by the MCOs from their own profits, is not included for purposes of rate setting, and is not

considered a covered benefit that waiver of co-pays as a supplemental benefit is not a limit for the purposes of MHPAEA. Further, neither the FFS Program nor the MCOs may deny pharmacy services to an individual who is eligible for services because of the individual's inability to pay the cost-sharing; therefore, payment of copays is not a firm enforceable limit for any drug, regardless of its classification as MH, SUD, or M/S or the delivery system used by the participant to access the medication (FFS Program or MCO). CMS disagreed with this conclusion and determined that “Despite copays not being enforced if a participant cannot afford them per Maryland state regulation, the fact remains that some Medicaid managed care beneficiaries have greater cost-sharing imposed on them for MH/SUD versus M/S prescription drug benefits.” As a result of this determination by CMS, MDH is committed to working with MCOs in the next rate period (CY 2022) to eliminate the option to voluntarily waive drug co-pays for M/S drugs in accordance with CMS guidance. This will be implemented within 60 days of the end of the COVID-19 Public Health Emergency (PHE).

The 2021 analysis raised two areas of concern highlighted in previous analyses with respect to the application of NQTLs to outpatient benefits: Data Collection (DC) and Service Limitations (SL). With respect to DC, all issues have been resolved as of the time of this report and MDH is pursuing alternative means to incentivize data collection efforts. The SL concerns are more complex and MDH has sought CMS guidance on the best means of resolving them. In effect, CMS guidance regarding exclusion of National Correct Coding Initiative (NCCI) edits from MHPAEA analysis results in the creation of a per se parity violation that likely would not exist if the NCCI were included within the analysis of SLs as an NQTL. Additionally, MDH has identified the provider reimbursement rate methodology as an NQTL that will require further analysis in future reports following completion of two studies required by *HB1329/SB967—Heroin & Opioid Prevention Effort (HOPE) & Treatment Act of 2017 (Chs. 571 and 572 of the Acts of 2017)*. The Request for Proposals (RFPs) for the first of these studies was released on July 1, 2022.¹ MDH will take steps to ensure that the rate setting methodology developed pursuant to HB1329/SB967 complies with the parity requirements of the Final Rule. As of September 2022, CMS has not shared any concerns regarding MDH’s compliance with parity for the 2021 Parity report.

For this analysis, MDH worked on two separate initiatives to improve the quality of parity reporting. First, MDH developed a guide to the factors considered and relied upon for the application of NQTLs (Appendix A2). Secondly, MDH, in collaboration with the MCOs, ASO, and FFS teams, is working to implement a data collection tool to examine claims, denials, and prior authorization data. This initiative will strengthen the alignment between the in-operation comparability and stringency for the different benefits classifications. The template and data reporting are still in progress; updates will be given in future reports.

Updates to this report will be issued on an annual basis to determine whether MH and SUD benefits continue to meet parity requirements. Any changes to the state plan or waivers that impact MH and SUD benefits will be reviewed for compliance. MDH will also conduct reviews on an ad hoc basis as needed in response to concerns raised by stakeholders and complaints filed by participants.

¹ See Public Solicitations on eMMA, MDH/OCMP-22-19518 Behavioral Health Rate Setting, <https://emma.maryland.gov/>.

I. Introduction

On March 30, 2016, the Center for Medicare and Medicaid Services (CMS) issued the final rule explaining the application of MHPAEA to Medicaid (Final Rule). The Final Rule requires states to analyze financial requirements and treatment limitations applied to MH/SUD services, in order to ensure that those limitations are no more restrictive than those under M/S benefits. States must also ensure that certain availability of information requirements are met. The report is an update on prior analyses submitted to CMS, with the most recent report submitted on October 1, 2021.²

The parity analysis was a joint effort between the MDH Office of Health Care Financing (Maryland Medicaid), the Behavioral Health Administration (BHA) and MDH's behavioral health Administrative Service Organization (ASO), Optum Maryland. The structure and content of this report are based on feedback from CMS regarding the 2018, 2019, and 2020 reports, numerous meetings with BHA and Medicaid staff, and meetings with representatives of all nine HealthChoice Managed Care Organizations (MCOs). MDH also worked closely with URAC to deploy the ParityManager™ software solution for use in collecting the information used for this report and for future parity compliance activities.

The report covers requirements of the Final Rule and an overview of the Maryland Medicaid system, including:

1. The benefit packages subject to MHPAEA and a description of the process used to determine them.
2. A mapping of all benefits within each package into the classifications described in the Final Rule and a description of the process used.
3. An analysis of financial requirements, quantitative treatment limitations, aggregate lifetime and annual dollar limits and their compliance with the Final Rule.
4. A list of NQTLs used in the Maryland Medicaid program and their uniform definitions.
5. An analysis of the comparability and stringency of all NQTLs in accordance with the Final Rule.
6. A plan for community outreach and education.
7. A description of how MDH will meet availability of information requirements.

II. Methodology

MDH adopted an approach to parity analysis consistent with CMS sub-regulatory guidance as outlined in the CMS parity toolkit, "Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs" and included the following steps:³

² For historical reports, please see MDH's Medicaid Parity website: <https://health.maryland.gov/mmcp/Pages/Mental-Health-Parity.aspx>.

³ Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs, <https://www.medicaid.gov/medicaid/benefits/downloads/bhs/paritytoolkit.pdf>.

1. Identifying all benefit packages to which parity applies and the covered populations.
2. For each benefit package, determining whether MDH, an MCO, or the behavioral health ASO is responsible for delivery of services.
3. Determining which covered benefits are MH/SUD benefits and which are M/S benefits.
4. Defining the four benefit classifications (inpatient, outpatient, prescription drugs, and emergency care) and determining into which benefit classification MH/SUD and M/S benefits fall.
5. Determining whether AL/ADL apply to MH/SUD benefits, and if they do, whether assessing for compliance with applicable parity requirements.
6. Determining whether any FRs or QTLs apply to MH/SUD benefits and testing the applicable FRs or QTLs for compliance with parity.
7. Identifying and analyzing NQTLs that apply to MH/SUD benefits, and testing the applicable NQTLs for compliance with parity.
8. Identifying the work that will need to be completed to bring the Department into full compliance with parity requirements.

New for the 2022 analysis, MDH developed a “best practices” guide for the development of factors and their definitions. MDH developed this guide in order to ensure that the MCOs, ASO, and FFS teams both had an adequate understanding of what a factor is and how it should be defined. MDH, in collaboration with the MCOs, ASO, and FFS teams, is also working to implement a data collection tool to examine claims, denials, and prior authorization data. This initiative will strengthen the alignment between the in-operation comparability and stringency for the different benefits classifications. The template and data reporting are still in progress; updates will be given in future reports.

III. Parity Compliance Process

A. Medicaid/CHIP Delivery System, Covered Populations, and Benefits Package

1. Medicaid/CHIP Delivery System

MDH is responsible for all Medicaid funded services in the state. The vast majority of participants receive services through the HealthChoice Program. HealthChoice—Maryland’s statewide mandatory Medicaid managed care program—was implemented in 1997 under authority of Section 1115 of the Social Security Act. As of July 2022, 1,725,099 Marylanders are enrolled in Medicaid.⁴ Approximately 86 percent of the State’s Medicaid population is enrolled in the HealthChoice Program. Participants in the HealthChoice Program include children enrolled in the Maryland Children’s Health Program (MCHP), Maryland’s Children’s Health Insurance Program (CHIP). Maryland elected to expand services to adults under the age of 65 up to 138%.of the federal poverty level under the Affordable Care Act in 2014. These individuals are also covered under HealthChoice. HealthChoice participants choose one of the nine (9)

⁴ Please note that enrollment in Maryland Medicaid is trending upward due the Coronavirus Public Health Emergency Maintenance of Effort requirements.

participating managed care organizations (MCOs)--Aetna Better Health (Aetna), Amerigroup Community Care (Amerigroup), CareFirst Blue Cross Blue Shield (CF), Jai Medical Systems (Jai), Kaiser Permanente (KP), Maryland Physicians Care (MPC), MedStar Family Choice (MedStar), Priority Partners (Priority), and UnitedHealthcare (UHC).

Maryland currently operates a bifurcated care delivery system for M/S and MH/SUD benefits. MCOs are responsible for delivering the majority of Medicaid covered services. Inpatient, emergency, and specialty outpatient MH/SUD services are delivered on a fee-for-services (FFS) basis through an Administrative Services Organization (ASO) model.⁵ Optum currently operates the ASO. MH/SUD prescription services are managed by MDH on a FFS basis. Dental services are delivered by the FFS Program through a dental benefits administrator (DBA), SKYGEN. Long-term services and supports (LTSS), including services for individuals with intellectual and developmental disabilities, are also carved out from the MCO contracts. As such, MDH has the responsibility under the Final Rule of performing the parity analysis and to identify and address any areas of non-compliance across all delivery systems.

2. Covered Populations

For purposes of the parity analysis, participants have been grouped into three broad categories: children, adults, and pregnant women. The sub-groups of Medicaid-eligible individuals who enroll in HealthChoice MCOs include the following:

- Families with low income that have children;
- Families that receive Temporary Assistance for Needy Families (TANF);
- Children younger than 19 years who are eligible for MCHP;
- Children in foster care and individuals up to age 26 who were previously enrolled in foster care;
- Adults under age 65 with income up to 138 percent of the federal poverty level (FPL);
- Women with income up to 264 percent of the FPL who are pregnant or less than 12 months postpartum (effective April 1, 2022); and
- Individuals receiving Supplemental Security Income (SSI) who are under 65 and not eligible for Medicare.

Not all Maryland Medicaid beneficiaries are enrolled in HealthChoice MCOs. These participants receive care on a FFS basis. Groups that are not eligible for MCO enrollment, and thus not subject to parity analysis, include the following:

- Medicare beneficiaries;
- Individuals aged 65 years and older;⁶
- Individuals in a “spend-down” eligibility group who are only eligible for Medicaid for a limited period of time;
- Individuals who require more than 90 days of long-term care services and are subsequently disenrolled from HealthChoice;
- Individuals who continuously reside in an Institution for Mental Disease (IMD) for more

⁵ Please note that MH/SUD services delivered by the participant’s primary care provider are the responsibility of the MCO.

⁶ Individuals aged 65 and older can be enrolled in a HealthChoice MCO if covered as a parent or caretaker.

than 30 days;

- Individuals who reside in an intermediate care facility for intellectual disabilities; and
- Individuals enrolled in the Model Waiver or the Employed Individuals with Disabilities program.
- Additional populations covered under the HealthChoice waiver—but not enrolled in HealthChoice MCOs and therefore not covered by MHPAEA pursuant to the Final Rule—include individuals in the REM programs.

3. Benefit Mapping and Classifications

For purposes of the parity analysis and administration of MH/SUD services, MDH defines behavioral health conditions as those conditions listed in ICD-10CM, Chapter 5, “Mental, Behavioral Health, and Neurodevelopmental Disorders.” The conditions listed in Chapter 5: subchapter 1, “Mental disorders due to known physiological conditions” (F01 to F09), subchapter 8, “Intellectual disabilities” (F70 to F79), and subchapter 9, “Pervasive and specific developmental disorders” (F80 to F89) are excluded. Details regarding specialty behavioral health services administered by the ASO can be found in COMAR 10.67.08.02.⁷

M/S conditions are defined to include those listed in ICD-10-CM, Chapters 1-4, Chapters 5-subchapter 1, 8, and 9, and Chapters 6-20.

MDH adopted the following definitions for each classification of benefits called for under the Final Rule:

- **Inpatient:** Any non-emergency service that involves the individual staying overnight at a facility. This includes inpatient overnight MH and SUD treatment and crisis stabilization services occurring in a facility. This classification includes all covered services or items provided to a beneficiary when a physician has written an order for admission to a facility.
- **Outpatient:** Services (primary care or specialist) that are provided to a beneficiary in a setting that does not require a physician’s order for admission and do not meet the definition of emergency care.⁸
- **Prescription Drugs:** Covered medications, drugs and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a free-standing pharmacy.
- **Emergency:** All covered services or items delivered in an emergency department (ED) setting or to stabilize an emergency/crisis, other than in an inpatient setting.

Federal parity regulations permit states latitude with respect to the placement of benefits in each of these classifications. MDH developed a preliminary list of benefits in each classification, broken out by M/S, MH, and SUD, based on current state plan services and state regulations. This list was augmented to include both dental benefits and LTSS services, which were not addressed in Maryland’s prior reports. MDH then consulted with MCOs, the ASO, and MDH

⁷ COMAR 10.67.08.02: <http://www.dsd.state.md.us/comar/comarhtml/10/10.67.08.02.htm>

⁸ The URAC ParityManager™ tool separates between Outpatient - Office services and Outpatient - Other services. For the purposes of this report, those two categories have been merged to create a single Outpatient classification.

staff to confirm the accuracy of the list and alignment with policy and practice across all participants in the delivery system. The final benefits map is incorporated in this report as Appendix B. MDH also developed a list of definitions for common NQTLs known to be in use by the MCOs, ASO, and FFS benefits (Appendix A). This helped ensure consistency between the MCOs, ASO, and FFS Program when answering questions about each benefit classification.

For the 2022 report, two new services were added to the benefit package. MDH began reimbursing for doula services in February 2022 for both prenatal and postpartum services. MDH also expanded its Home Visiting Services (HVS) pilot program statewide effective January 2022. HVS is an evidence-based home visiting services program for high-risk pregnant women and children up to age 2.

Additionally, MDH expanded its IMD program to include those diagnosed with a Serious Mental Illness or Serious Emotional Disorder (SMI/SED) beginning January 1, 2022. These services are outside the scope of the MHPAEA analysis.

B. Information Gathering Process

MDH gathered information to inform its parity analysis from key respondents within the MCOs, the ASO, the DBA, and FFS Program staff responsible for oversight of dental benefits, LTSS, and pharmacy benefits. Beginning with the 2020 report and continuing for this year's report, Maryland required all respondents to report parity information using URAC's ParityManager™ software tool. ParityManager™ includes a framework for the initial collection of information and for the ongoing monitoring of parity compliance, including information regarding AL/ADLs, QTLs, and NQTLs. The tool also includes a document management system. This information was then reviewed by MDH and used to create consolidated reports for each MCO to analyze the compliance of Medicaid benefits for all applicable state populations (see Appendix H).

Maryland's service delivery system creates unique challenges with respect to aligning data reported by each component of the delivery system. To educate MCOs, the ASO, and other MDH staff, the Medicaid staff has held multiple parity sessions designed to orient the respective teams to the requirements of parity and reporting expectations under the Maryland service delivery system. MDH Medicaid staff has coordinated the responses from each of the teams and served as a resource for any team with questions.

Final Parity Analysis

A. Aggregate Lifetime/Annual Dollar Limits (AL/ADL)

MDH does not have any AL/ADLs in place for its MH/SUD benefits.

B. Financial Requirements (FRs)

Maryland's Medicaid program only applies FRs to the prescription drug benefit classification.

Because of their limited applicability, MDH assessed FRs outside the formal ParityManager™ reports (Appendix H).

Copays are the only FRs for medications under Maryland Medicaid. These are as follows: \$1 for generic/preferred drugs and \$3 for brand-name/nonpreferred drugs for both drugs delivered by the MCOs and through the FFS prescription drug program. Copays are automatically waived for (i) Family planning services and supplies; (ii) Individuals younger than 21 years old; (iii) Pregnant women; (iv) Institutionalized individuals who are inpatients in long-term care facilities or other institutions; and (v) Emergency services.⁹ Neither the FFS Program nor the MCOs may deny pharmacy services to an individual who is eligible for services because of the individual's inability to pay the cost-sharing.¹⁰

Historically, certain MCOs elected to waive some or all copays as a supplemental benefit paid for from their own profits. CMS determined that

“Despite copays not being enforced if a participant cannot afford them per Maryland state regulation, the fact remains that some Medicaid managed care beneficiaries have greater cost-sharing imposed on them for MH/SUD versus M/S prescription drug benefits.” As a result of this determination by CMS, MDH committed to working with MCOs to eliminate the option to voluntarily waive drug co-pays in order to bring the MDH into compliance with MHPAEA. Reestablishing co-pays will require operational and system changes on the part of the MCOs. These changes will be implemented within 60 days of the end of the COVID-19 PHE. Once implemented, copays will apply to 100% of the M/S prescription drugs in each tier and therefore pass the substantially all test. Further, the copay level applied to MH/SUD drugs in each tier is no higher than the predominant level applied to each classification. See below for the comparability and stringency analysis of the use of the tiered drug formulary (TDF) as an NQTL.

C. Quantitative Treatment Limits (QTLs)

Maryland does not impose any QTLs for either MH or SUD services subject to parity under the Final Rule.

CMS has approved Maryland to cover certain SMI and SUD residential treatment services for adults ages 21 to 64, which are considered IMD under federal law, for a limited number of days annually.

Specifically, the Maryland Medicaid Program covers services at ASAM levels 3.1, 3.3, 3.5, 3.7, and 3.7D, which are no longer subject to a per stay cap, although MDH must maintain a statewide average length of stay of 30 days pursuant to the requirements in MDH's §1115 waiver approved by CMS. CMS also authorized MDH to cover IMD services for adults with a serious mental illness (SMI) for up to 60 days per stay and MDH must maintain a statewide average length of stay of no more than 30 days . If the statewide average length of stay exceed 30 days, CMS can impose a hard limit of 45 days on stays.

⁹ 10.09.03.05(C)(5), 10.67.06.01(F)(1)

¹⁰ COMAR 10.09.03.03(O); COMAR 10.67.06.01(F)(2).

However, under Maryland's integrated behavioral health care delivery system, where the ASO is responsible for delivery of not only Medicaid benefits but also state-only funded benefits, if such services are medically necessary beyond the Medicaid covered days, the participant can continue to receive treatment. Due to the federal restriction placed by CMS on the number of days covered by Medicaid, these additional days are covered using state-only funds.

The Medicaid MHPAEA Final Rule at 81 FR 18423 provides that the payment exclusion for Medicaid services provided to beneficiaries in IMDs is a statutory eligibility requirement established by the Congress in 1965 and is therefore not a limit within the scope of MHPAEA.

D. Non-Quantitative Treatment Limits (NQTLs)

Under the Final Rule, a state or MCO may not impose an NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the benefit as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits 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 M/S benefits in the classification. The Final Rule generally defines an NQTL as any limit on benefits that is not expressed in a firm number (i.e. AL/ADL, FR, or QTL), but which otherwise limits the scope or duration of benefits for treatment under a plan or coverage.

MDH conducted its review of NQTL information across the delivery system based on information reported through ParityManager™. As such, MDH was forced to rely on the attestations made by staff within each of the MCOs, the ASO, and FFS Program staff responsible for oversight of dental benefits, LTSS, and pharmacy benefits. MDH performed a detailed analysis of the data provided through ParityManager™ and reviewed for gaps, facial errors, logical consistency, and credibility. MDH engaged with the source of any questionable information to obtain clarification and/or corrections. In future years, MDH intends to repeat this process of validation and include source document validation to ensure accuracy and completeness of information submitted for review.

To facilitate consistency of reporting between the ASO, MCOs, and FFS Program, MDH established a "core set" of nine NQTLs. (Appendix A)

Note that although Provider Rates (i.e. network provider reimbursement rate methodologies) is an NQTL defined in the core set and which apply to benefits in all classifications, it is not addressed directly in the analysis below. Please see the Next Steps section for discussion of this NQTL.

MDH analyzed the comparability and stringency of the application of NQTLs to MH/SUD benefits through the use of a uniform five step process that aligns with the process called for under the Final Rule, the MHPAEA Self-Compliance Tool promulgated by the U.S. Department of Labor, the "Six-Step" Parity Compliance Guide for NQTLs developed by the Kennedy Forum, and the NQTL analysis required by URAC's MH/SUD Parity Accreditation Program. The five steps include: (1) definition of the NQTL type, (2) identification of the benefits in the

classification subject to the NQTL type, (3) in-writing comparability and stringency analysis based on the identification and definition (including the source and any applicable evidentiary standards) of the factors considered in the decision whether or not and how to apply the NQTL type, (4) an identification of the operations measures used by each participant in the delivery system for each NQTL type for each classification, and (5) a summary analysis of the comparability and stringency of the NQTL type for each classification. The report proceeds through each classification and documents the detailed analysis of each NQTL type within that classification.

Because the operations measures in use by the ASO, MCOs, and FFS Programs are not uniform for each NQTL type in each classification, and those that are uniform did not report identical technical specifications, steps 4 and 5 of the analysis do not include a comparability and stringency analysis based on specific operations measure data. However, the report does describe the measures being used by the ASO, MCOs, and FFS Program for each NQTL type in each classification. As noted in the Next Steps section, MDH intends to use this baseline of information about which operations measures are being used across the delivery system to move towards alignment in operations measures and technical specifications for each NQTL type in each classification in the coming years to support a cross-delivery system comparability and stringency analysis.

Please see the MCO-specific reports for the underlying information supporting the summary provided in this report (Appendices B2 and H).

1. Emergency Benefits

MDH reviewed the MH and SUD services delivered through the ASO in the Emergency classification. All benefits covered by MDH with an associated MH or SUD diagnosis are covered and not subject to further review. In addition, the ASO does not identify any NQTLs in use for the Emergency Benefits classification. As such, the Emergency classification is being delivered in compliance with the Final Rule.

2. Inpatient Benefits

MDH reviewed the MH and SUD services delivered through the ASO. The ASO identifies four NQTLs as in use for MH and/or SUD services in the Inpatient classification: Concurrent Review (CR), Medical Necessity Criteria (MNC), Outlier Management (OM), and Prior Authorization (PA). These NQTLs are also reported as being in use for M/S IP benefits delivered by all nine MCOs and LTSS benefits delivered by the FFS Program. An in-depth discussion of each of these NQTLs as it relates to the IP Classification is included below.

a. Inpatient Benefits--Concurrent Review

1. **Definition of IP-Concurrent Review (CR) NQTL**

“Concurrent review” means a periodic reauthorization of continued medical eligibility for the level of services provided which allows for close monitoring of the participant’s progress, treatment goals, and objectives.

2. Benefits Subject to IP-Concurrent Review (CR) NQTL

The ASO reports applying the CR NQTL to some, but not all benefits in the MH IP Benefits Classification and to some, but not all benefits in the SUD IP Benefits Classification.

The 9 MCOs report applying CR to some, but not all, of the M/S benefits they administer in the IP classification.

The FFS Program/LTSS applies CR to all M/S IP benefits. Please refer to the report for each benefit administered to participants for each MCO to review the specific IP benefits subject to CR (Appendix H).

3. In-writing comparability and stringency--IP-Concurrent Review (CR) NQTL

Factors the ASO relies upon in deciding to apply and designing this NQTL include *high levels of variation in length of stay, least restrictive appropriate level of care, service type severity/chronicity of illness, and variability in quality*. The ASO defines these factors identically for both MH and SUD benefits. These factors are all defined as intended to ensure the medical necessity of a service while accounting for potential variation in length of stay and for a condition to persist over time. *High levels of variation in length of stay* is defined as “Individuals with the same illness having different courses of improvement.” *Service type* is defined as “services with various levels of intensity, including frequency and expected duration.” *Variability in quality* is defined as assessing whether an individual is improving, or if there is a need for a change in the treatment plan, monitoring appropriateness and efficacy of treatment. These factors are all related to professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.

The factors the MCOs rely upon in the design of this NQTL are comparable to and at least as stringent as those used by the ASO. All MCOs report one or more factors considered in the design of the NQTL that can be categorized as focused on establishing medical necessity in compliance with evidentiary standards related to recognized treatment guidelines in a manner that is comparable to and at least as stringent as the factors upon which the ASO/BHA relies. Most factors the MCOs identify that fall under this type of categorization are directly named and/or defined in relation to the review of clinical treatment criteria (e.g., *clinical guidelines MCG, clinical guidelines - InterQual, clinical indications and/or evidence, high levels of variation in length of stay, industry standards, lack of clinical efficiency of treatment or service, least restrictive appropriate level of care, medical necessity* (Aetna-based on Milliman Criteria/Aetna Policy Bulletins), and *patient safety*). KP identifies *severity/chronicity of illness* as a factor for this NQTL and defines it comparably to the ASO as “degree to which an illness is a long term health condition for which there may be no cure and require ongoing services to treat.”

In addition to factors directly associated with clinical criteria, five of the MCOs (Amerigroup, Jai, MedStar, Priority, and UHC), rely on one or more additional factors more closely aligned with controlling costs and utilization, including *appropriateness of utilization* (Jai-based on patient history and internal claims cost increases of 10%+ over two years; Priority-based on medical necessity and efficient service use); , and *fiscal responsibility* (Jai- assessing whether medically

equivalent, lower cost options are available). Therefore, the MCOs are relying on some factors that are potentially more stringent than the factors used by the ASO in the same classification.

Certain MCOs define factors in a way that encompasses both validating medical necessity and cost/utilization management. Amerigroup's definition of the factor *excessive utilization* indicates that the MCO "facilitates the delivery of appropriate care and monitors the impact of its utilization management program to detect and correct potential under-and over-utilization based on Level of Care (LOC) and Service Types (Outpatient)" through "monitoring and comparing use of service aggregated data or non-identifiable utilization reports quarterly", physician review, and use of reports "looking for patterns of over-utilization and/or underutilization of services" in comparison to benchmark and comparative data sources. In addition to being defined according to whether a service met Interqual Criteria, Jai's definition of *medical necessity* as a factor in deciding whether or not to use concurrent review also encompasses considerations for costs "Is this the safest, cheapest option of covered services available for this situation?" KP defines the factor *lack of clinical efficiency of treatment or service* as "Failure to provide the necessary services or treatments in a manner that avoids ineffective use of available resources and/or creates or causes unnecessary delay from the expected course of treatment goal based on clinical guidelines." Similarly, MedStar's definition of the factor *lack of clinical efficiency of treatment or service* embraces both a medical necessity component and consideration of costs/utilization management ("review may be required to ensure that procedure/service is performed at most appropriate level of care or that the least costly (dollars or clinical impact) medication has been prescribed and/or that more conservative treatment has been tried and failed.")

The factors the FFS Program relies upon in the design of this NQTL as applied to M/S IP benefits are also comparable to and at least as stringent as those used by the ASO. The FFS Program relies upon the factors *service type* and *excessive utilization* in design of the CR NQTL. Both factors are defined as ensuring medical necessity of the service in accordance with compliance with professionally recognized treatment guidelines based on the evidentiary standard of review of medical literature and professional standards (including comparative effectiveness studies and clinical trials), and published research studies.

4. In-operation comparability and stringency--IP-Concurrent Review (CR) NQTL

The ASO reports use of three measures for monitoring in-process operations for the IP MNC NQTL--*Authorization Denial Rates for MH and SUD services, internal audits, and inter-rater reliability surveys.*

Five MCOs (Aetna, CF, Jai, MPC, and MedStar) report use of claims reporting of some variety to monitor this NQTL. Examples include *utilization trends, authorization denial rates, frequency with which reviews are conducted, and average length of stay authorized.* Seven MCOs (CF, Jai, KP, MPC, MedStar, Priority, and UHC) also identify use of *inter-rater reliability surveys.* Amerigroup reports monitoring *internal audit findings related to coverage determination consistency with the plan's medical necessity criteria.* Only one MCO, CF, did not report reliance on any type of internal audit process.

The FFS Program/LTSS also reports review of some types of claims monitoring including *reports addressing frequency that authorization requirements are waived and number of days or visits authorized per review*. Although the FFS Program/LTSS does not monitor this NQTL using a formal inter-rater reliability survey, it does monitor *the frequency with which reviews are conducted and the degree of discretion exercised by utilization review staff*.

5. Summary/Parity Assessment--IP-Concurrent Review (CR) NQTL

MDH determined that parity exists for the IP CR NQTL, as applied to MH, SUD, and M/S benefits. The definitions of the factors used by the ASO for both MH and SUD benefits are comparable to and no more stringent to those used by the MCOs/FFS Program for M/S benefits. The processes, strategies, and evidentiary standards used to apply CR to both MH and SUD services are comparable to, and no more stringently applied than, the processes, strategies, and evidentiary standards used to apply CR requirements to M/S services.

b. Inpatient Benefits--Medical Necessity

1. Definition of IP-Medical Necessity Criteria (MNC) NQTL

All Medicaid benefits, irrespective of delivery system, are universally subject to medical necessity requirements pursuant to state regulation.

| MH/SUD Definition | MCO M/S Definition¹¹ |
|--|---|
| COMAR 10.09.36.01B | COMAR 10.67.01.01B |
| <p>(11) "Medically necessary" means that the service or benefit is:</p> <p>(a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;</p> <p>(b) Consistent with currently accepted standards of good medical practice;</p> | <p>(112) "Medically necessary" means that the service or benefit is:</p> <p>(a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;</p> <p>(b) Consistent with current accepted standards of good medical practice;</p> |

¹¹ See also e.g., COMAR 10.09.05.01B (delivery of FFS dental benefits).

| MH/SUD Definition | MCO M/S Definition ¹¹ |
|---|--|
| <p>(c) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and</p> <p>(d) Not primarily for the convenience of the consumer, family, or provider.</p> | <p>(c) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and</p> <p>(d) Not primarily for the convenience of the consumer, the consumer's family, or the provider.</p> |

2. Benefits Subject to IP-Medical Necessity Criteria (MNC) NQTL

The ASO reports applying the MNC NQTL all MH and SUD benefits in the inpatient benefits classification. Medical Necessity is also in use by all 9 MCOs and the FFS Program for all benefits they administer in the IP classification.

3. In-writing comparability and stringency--IP-Medical Necessity Criteria (MNC) NQTL

Factors the ASO relies upon in deciding to apply and designing this NQTL include *high levels of variation in length of stay, least restrictive appropriate level of care, service type severity/chronicity of illness, and variability in quality*. The ASO defines these factors identically for both MH and SUD benefits. These factors are all defined as intended to ensure the medical necessity of a service while accounting for potential variation in length of stay and for a condition to persist over time. *Service type* is defined as “services with various levels of intensity, including frequency and expected duration.” *Variability in quality* is defined as assessing whether an individual is improving, or if there is a need for a change in the treatment plan, monitoring appropriateness and efficacy of treatment. These factors are all related to professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.

The factors the MCOs rely upon in the design of this NQTL are comparable to and at least as stringent as those used by the ASO in definition. All MCOs report one or more factors considered in the design of the NQTL that can be categorized as focused on establishing medical necessity in compliance with evidentiary standards related to recognized treatment guidelines in a manner that is comparable to and at least as stringent as the factors upon which by the ASO/BHA relies. Most factors the MCOs identify that the fall under this type of categorization are directly named and defined in relation to the review of clinical treatment criteria (e.g., *clinical guidelines MCG, high levels of variation in length of stay, industry standards, internally developed guidelines, lack of clinical efficiency of treatment or service, least restrictive appropriate level of care, medical necessity* (Aetna-based on Milliman Criteria/Aetna Policy Bulletins), *professional standards and protocols, and recognized medical literature*). KP identifies *severity/chronicity of illness* as a factor for this NQTL and defines it comparably to the ASO as “degree to which an illness is a long term health condition for which there may be no cure and require ongoing services to treat.”

In addition to factors directly associated with clinical criteria, six MCOs (Amerigroup, CF, Jai,

KP, MedStar, and Priority) rely on additional factors more closely aligned with controlling costs and utilization. Jai reported the factor *fiscal responsibility* (assessing whether medically equivalent, lower cost options are available) based on internal claims analysis). Therefore, the MCOs are relying on some factors that are potentially more stringent than the factors used by the ASO in the same classification.

Certain MCOs define factors in a way that encompasses both validating medical necessity and cost/utilization management. Priority defines the factor *appropriateness of utilization* as “Utilization based on medical necessity, and efficient use of healthcare services and facilities as directed by the Plan benefits.” KP defines the factor *lack of clinical efficiency of treatment or service* as “Failure to provide the necessary services or treatments in a manner that avoids ineffective use of available resources and/or creates or causes unnecessary delay from the expected course of treatment goal based on clinical guidelines.” Amerigroup’s definition of the *excessive utilization* factor indicates that the MCO “facilitates the delivery of appropriate care and monitors the impact of its utilization management program to detect and correct potential under-and over-utilization based on Level of Care (LOC) and Service Types (Outpatient)” through “monitoring and comparing use of service aggregated data or non-identifiable utilization reports quarterly”, physician review, and use of reports “looking for patterns of over-utilization and/or underutilization of services” in comparison to benchmark and comparative data sources. MedStar defines *excessive utilization* as “the potential to be used for cosmetic purposes that are not medically necessary...the potential for off-label use that is not medically necessary (ex. Viagra) or a potential for abuse (ex. controlled substances greater than 90 MMEs” and identifies use of FWA software to identify outliers. Similarly, CF defines the *excessive utilization* factor for this NQTL as “the identification of specific services and/or CPT codes that lead to circumstances where the potential for harm for fraud, waste, and abuse exceeds the potential for benefit” and identifies use of compliance with recognized industry standards. The factors the FFS Program relies upon in the design of this NQTL as applied to M/S IP benefits are also comparable to and at least as stringent as those used by the ASO. The FFS Program defines both factors, *excessive utilization* and *service type*, as ensuring medical necessity of the service in accordance with compliance with professionally recognized treatment guidelines based on the evidentiary standard of review of medical literature and professional standards (including comparative effectiveness studies and clinical trials), and published research studies.

4. In-operation comparability and stringency--IP-Medical Necessity Criteria (MNC) NQTL

The ASO reports use of three measures for monitoring in-process operations for the Medical Necessity NQTL--*authorization denial rates for MH and SUD services, internal audits, and inter-rater reliability surveys.*

All but two MCOs (KP, and Priority) report use of claims reporting of some variety to monitor this NQTL. Examples include *utilization trends, authorization denial rates, and average length of stay authorized.* Eight MCOs (Amerigroup, CF, Jai, KP, MPC, MedStar, UHC, and Priority) also identify use of *inter-rater reliability surveys* and some also report monitoring *average denial rates for medical necessity, and use of internal audit findings related to coverage determination*

consistency with the plan's medical necessity criteria.

The FFS Program/LTSS also reports review of some types of claims monitoring including *reports addressing frequency that authorization requirements are waived and number of days or visits authorized per review*. Although the FFS Program/LTSS does not monitor this NQTL using a formal inter-rater reliability survey, it does monitor the *frequency with which reviews are conducted* and the *degree of discretion exercised by utilization review staff*.

5. Summary/Parity Assessment--IP-Medical Necessity Criteria (MNC) NQTL

MDH determined that parity exists for the IP MNC NQTL, as applied to MH, SUD, and M/S benefits. The definitions of the factors used by the ASO for both MH and SUD benefits are comparable to and no more stringent to those used by the MCOs/FFS Program for M/S benefits. The processes, strategies, and evidentiary standards used to apply CR to both MH and SUD services are comparable to, and no more stringently applied than, the processes, strategies, and evidentiary standards used to apply MNC requirements to M/S services.

c. Inpatient Benefits--Outlier Management

1. Definition of IP-Outlier Management (OM) NQTL

Procedures that are designed to review services after they have been delivered to assess medical necessity and detect and/or¹² prevent fraud, waste, and abuse through investigation of unusual patterns in service utilization, billing, prescribing, and denials.

2. Benefits Subject to IP-Outlier Management (OM) NQTL

The ASO reports applying the Outlier Management NQTL to some, but not all, MH benefits and some, but not all, SUD benefits in the inpatient benefits classification.

All nine MCOs report using this NQTL for IP M/S benefits. Six report using the NQTL with all M/S benefits—CF, Jai, KP, MPC, and UHC.

The FFS Program/LTSS applies OM to some, but not all, M/S IP benefits.

Please refer to the report for each benefit administered to participants for each MCO to review the specific IP benefits subject to OM (Appendices B2 and H).

3. In-writing comparability and stringency--IP-Outlier Management (OM) NQTL

The ASO relies on several factors in deciding to apply and designing this NQTL include *excessive utilization, high levels in variation in length of stay, least restrictive appropriate level of care, service type, severity or chronicity of illness, and variability in quality*. The ASO defines these factors identically for both MH and SUD benefits. These factors are all defined as intended to ensure the medical necessity of a service while accounting for potential variation in length of stay and for a condition to persist over time. *Excessive utilization* is defined as

¹² This was changed from 'and' to 'and/or' in 2022.

significantly higher use of a service than average by a participant, two standard deviations above average utilization per episode of care and also based on the evidentiary standard of compliance with professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines. *Service type* is defined as “services with various levels of intensity, including frequency and expected duration.” *Variability in quality* is defined as assessing whether an individual is improving, or if there is a need for a change in the treatment plan, monitoring appropriateness and efficacy of treatment. These factors are all related to professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.

The factors the MCOs rely upon in the design of this NQTL are comparable to and at least as stringent as those used by the ASO. All MCOs, with the exception of Jai, report one or more factors considered in the design of the NQTL that can be categorized as focused on establishing medical necessity in compliance with evidentiary standards related to recognized treatment guidelines in a manner that is comparable to and at least as stringent as the factors upon which the ASO/BHA relies. Most factors the MCOs identify that fall under this type of categorization are directly named and defined in relation to the review of clinical treatment criteria (e.g., *clinical indications and/or evidence, high levels of variation in length of stay, industry standards, lack of clinical efficiency of treatment or service, least restrictive appropriate level of care, medical necessity* (Aetna-Milliman Criteria and Aetna Policy Bulletins by Aetna, KP--was the service medically indicated and/or were there medical factors contributing to lack of prior authorization), *Par facilities Medical Necessity Review Post Payment*, and *safety risks*. Additional factors related to validating medical necessity are defined by the MCOs as follows. KP identifies *severity/chronicity of illness* as a factor for this NQTL and defines it comparably to the ASO as “degree to which an illness is a long term health condition for which there may be no cure and require ongoing services to treat.” UHC defines *service type* as the health plan applying limits based on the type of service performed within the benefit classification in compliance with professionally recognized treatment guidelines, medical literature and professional standards, and committee developed standards. MedStar’s definition of this factor is driven by this tenet: “Severity or chronicity of an illness could require a higher level of care than would be expected in those without such conditions.” MPC identifies *excessive utilization* as a factor, which it defines as “Utilization of services greater than industry standards based on CPT codes per InterQual guidelines.” UHC identifies use of *utilization patterns* as a factor for this NQTL, which it defines as “Utilization pattern reviews suggest evidence-based national clinical guidelines are not being followed consistently” based on evidence of increased medical costs year over year.

In addition to factors directly associated with clinical criteria, seven MCOs (Amerigroup, CF, Jai, KP, MPC, MedStar, Priority, and UHC) rely on additional factors more closely aligned as defined with controlling costs and utilization. Factors the MCOs cite include *administrative burden/cost; claim types with high percentage of fraud; claims evaluation, reporting, and analytics; fiscal responsibility; provider discretion - diagnosis; provider discretion - type or length of treatment; and recent medical cost escalation*. Therefore, the MCOs are relying on some factors that are potentially more stringent than the factors used by the ASO in the same classification.

Certain MCOs define a factor in a way that encompasses both validating medical necessity and cost/utilization management. MedStar defines *service type* in part as “Authorization requirements may be applied by service type due to potential overutilization or safety issues” while also referencing medical necessity criteria. Additionally, Priority defines *appropriateness of utilization* as “Utilization based on medical necessity, and efficient use of healthcare services and facilities as directed by the Plan benefits.” *Excessive utilization*, as defined by Amerigroup, CF, and MedStar, also aligns with both medical necessity and costs/utilization management. Amerigroup’s definition of the factor *excessive utilization* indicates that the MCO “facilitates the delivery of appropriate care and monitors the impact of its utilization management program to detect and correct potential under-and over-utilization based on Level of Care (LOC) and Service Types (Outpatient)” through “monitoring and comparing use of service aggregated data or non-identifiable utilization reports quarterly”, physician review, and use of reports “looking for patterns of over-utilization and/or underutilization of services” in comparison to benchmark and comparative data sources. MedStar defines *excessive utilization* as “the potential to be used for cosmetic purposes that are not medically necessary...the potential for off-label use that is not medically necessary (ex. Viagra) or a potential for abuse (ex. controlled substances greater than 90 MMEs)” and identifies use of FWA software to identify outliers. Similarly, CF defines the *excessive utilization* factor for this NQTL as “the identification of specific services and/or CPT codes that lead to circumstances where the potential for harm for fraud, waste, and abuse exceeds the potential for benefit” and identifies use of compliance with recognized industry standards. KP defines the factor *lack of clinical efficiency of service* as “Failure to provide the necessary services or treatments in a manner that avoids ineffective use of available resources and/or creates or causes unnecessary delay from the expected course of treatment goal based on clinical guidelines.” Similarly, MedStar defines this factor as “Pre authorization, concurrent review, or retrospective review may be required to ensure that procedure/service is performed at most appropriate level of care or that the least costly (dollars or clinical impact) medication has been prescribed and/or that more conservative treatment has been tried and failed, or medication is medically appropriate for the condition.”

Finally, one MCO (UHC) identifies two factors more closely aligned with provider qualifications--*accreditation and training, experience, and licensure of the providers.*

The factors the FFS Program/LTSS relies upon in the design of this NQTL are comparable to and at least as stringent as those used by the ASO in definition. The FFS Program identifies two factors considered in the design of the NQTL that can be categorized as focused on establishing medical necessity in compliance with evidentiary standards related to recognized treatment guidelines. Specifically, the FFS Program relies upon the following factors: *excessive utilization beyond medical necessity criteria and safety risks.*

4. In-operation comparability and stringency--IP-Outlier Management (OM) NQTL

The ASO reports use of four measures for monitoring in-process operations for the IP OM NQTL--*Authorization Denial Rates for MH and SUD services, Outlier Management Data, internal audits, and inter-rater reliability surveys.*

All but two MCOs (Amerigroup, and KP) report use of claims reporting of some variety to

monitor this NQTL. Examples include *utilization trends* and *FWA Reports*. Three MCOs (KP, MedStar, and Priority) identify use of *inter-rater reliability surveys*, one (Aetna) identifies use of *internal audit findings related to coverage determination consistency with the plan's medical necessity criteria*, and UHC monitors *Medical claim review accuracy*.

The FFS Program/LTSS also reports review of some types of claims monitoring including *provider financial analysis reports* and *duplicate records*. Although the FFS Program/LTSS does not monitor this NQTL using a formal inter-rater reliability survey, it does monitor *the frequency with which reviews are conducted* and a *monthly audit tracker*.

5. Summary/Parity Assessment--IP-Outlier Management (OM) NQTL

MDH determined that parity exists for the IP OM NQTL, as applied to MH, SUD, and M/S benefits. The definitions of the factors used by the ASO for both MH and SUD benefits are comparable to and no more stringent to those used by the MCOs/FFS Program for M/S benefits. The processes, strategies, and evidentiary standards used to apply CR to both MH and SUD services are comparable to, and no more stringently applied than, the processes, strategies, and evidentiary standards used to apply MNC requirements to M/S services.

d. Inpatient Benefits--Prior Authorization

1. Definition of IP-Prior Authorization (PA) NQTL

The approval required from the Department or its designee (including the MCO) before a service can be rendered by the provider and reimbursed.

2. Benefits Subject to IP-Prior Authorization (PA) NQTL

The ASO reports applying the Prior Authorization NQTL to some, but not all, MH benefits and some, but not all, SUD benefits in the inpatient benefits classification.

All nine MCOs report using this NQTL for some, but not all, IP M/S benefits.

The FFS Program/LTSS applies PA to some, but not all, IP M/S benefits.

Please refer to the report for each benefit administered to participants for each MCO to review the specific IP benefits subject to PA (Appendix H).

3. In-writing comparability and stringency--IP-Prior Authorization (PA) NQTL

The two factors the ASO relies upon in deciding to apply and designing this NQTL to both MH and SUD IP benefits are *least restrictive appropriate level of care* and *severity/chronicity of illness*. The ASO defines these factors identically for both MH and SUD benefits. These factors are both defined as intended to ensure the medical necessity of a service while ensuring the person accounting for the potential for a condition to persist over time.

The factors the MCOs rely upon in the design of this NQTL are comparable to and at least as

stringent as those used by the ASO. All MCOs report one or more factors considered in the design of the NQTL that can be categorized as focused on establishing medical necessity in compliance with evidentiary standards related to recognized treatment guidelines in a manner that is comparable to and at least as stringent as the factors upon which the ASO/BHA relies. Most factors the MCOs identify that fall under this type of categorization are directly named and defined in relation to review of clinical treatment criteria (e.g., *appropriate care setting* (CF-based on MCG clinical guidelines), *clinical guidelines MCG*, *clinical indications and/or evidence based on clinical guidelines*, *industry standards*, *lack of clinical efficiency of treatment/service*, *lack of adherence to quality standards*, *nationally recognized guidelines*, and *patient safety*). Aetna and MPC each identify *excessive utilization* as a factor. Aetna defines it in part as “Utilization that exceeds the threshold outlined in Milliman Care Guidelines...the purpose of database analysis is to confirm the reasonability and clinical appropriateness of care guideline utilization goals and objectives.” MPC defines *excessive utilization* as “Utilization of services greater than industry standards based on CPT codes per InterQual guidelines.” Aetna and KP both identify *severity/chronicity of illness* as a factor for this NQTL. Both define it comparably to the ASO. Aetna defines the factor as whether the treatment matched the severity and chronicity of the illness based on compliance with professionally recognized treatment guidelines. KP uses this definition: “degree to which an illness is a long term health condition for which there may be no cure and require ongoing services to treat.”

In addition to factors directly associated with clinical criteria, seven MCOs (Amerigroup, CF, Jai, KP, MPC, Priority, and UHC) rely on additional factors more closely aligned as defined with controlling costs and utilization. Factors cited include *administrative burden/cost*; *claim types with high percentage of fraud*; *value*; *current and projected demand for services*, *fiscal responsibility*; *high utilization with variable cost per episode*; and *quality and performance measures* (MedStar-Reduction of pre-auth requirements to reduce barriers to care based on customer feedback).

Certain MCOs define a factor in a way that encompasses both validating medical necessity and cost/utilization management. Priority defines *appropriateness of utilization* as based on medical necessity and efficient service use. Amerigroup’s definition of the factor *excessive utilization* indicates that the MCO “facilitates the delivery of appropriate care and monitors the impact of its utilization management program to detect and correct potential under-and over-utilization based on Level of Care (LOC) and Service Types (Outpatient)” through “monitoring and comparing use of service aggregated data or non-identifiable utilization reports quarterly”, physician review, and use of reports “looking for patterns of over-utilization and/or underutilization of services” in comparison to benchmark and comparative data sources. In addition to being defined according to whether a service met Interqual Criteria, Jai’s definition of *medical necessity* also encompasses considerations for costs “Is this the safest, cheapest option of covered services available for this situation?” KP defines the factor *lack of clinical efficiency of service* as “Failure to provide the necessary services or treatments in a manner that avoids ineffective use of available resources and/or creates or causes unnecessary delay from the expected course of treatment goal based on clinical guidelines.” Amerigroup defines *service type* as “All inpatient admissions require preauthorization and/or ongoing authorization using approved clinical criteria to assess medical necessity and level of care appropriateness” in cases where utilization is two standard deviations above average utilization per episode of care and internal claims data

showing that medical cost for certain services increased 10 percent or more per year for two years. The plan also identifies *accreditation standards for quality assurance* as a factor.

The factors the FFS Program/LTSS relies upon in the design of this NQTL are comparable to and at least as stringent as those used by the ASO in definition. The FFS Program/LTSS relies upon *service type* and *excessive utilization* in design of the IP PA NQTL for M/S services. The FFS Program defines both factors as ensuring medical necessity of the service in accordance with compliance with professionally recognized treatment guidelines based on the evidentiary standard of review of medical literature and professional standards (including comparative effectiveness studies and clinical trials), and published research studies. In addition, the FFS Program identifies one factor more closely aligned with provider qualifications, *Medicare/Medicaid Program participation eligibility* (“Federal and State requirements for participation in the Medicare/Medicaid program, including those pertaining to medical, technical and financial eligibility and accreditation”).

4. In-operation comparability and stringency--IP-Prior Authorization (PA) NQTL

The ASO reports use of three measures for monitoring in-process operations for the IP PA NQTL--*authorization denial rates for MH and SUD services, internal audits, and inter-rater reliability surveys.*

All but one MCO (KP) report use of claims reporting of some variety to monitor this NQTL. Examples include *utilization trends* and *average denial rates*. Eight MCOs (Amerigroup, CF, Jai, KP, MedStar, MPC, Priority, and UHC) identify use of *inter-rater reliability surveys.*

The FFS Program/LTSS also reports review of some types of claims monitoring including *number of days or visits authorized per review.* Although the FFS Program/LTSS does not monitor this NQTL using a formal inter-rater reliability survey, it does monitor *the frequency with which reviews are conducted, the degree of discretion exercised by utilization review staff, and the frequency that authorization requirements are waived.*

5. Summary/Parity Assessment--IP-Prior Authorization (PA) NQTL

MDH determined that parity exists for the IP PA NQTL, as applied to MH, SUD, and M/S benefits. The definitions of the factors used by the ASO for both MH and SUD benefits are comparable to and no more stringent to those used by the MCOs/FFS Program for M/S benefits. The processes, strategies, and evidentiary standards used to apply CR to both MH and SUD services are comparable to, and no more stringently applied than, the processes, strategies, and evidentiary standards used to apply MNC requirements to M/S services.

3. Outpatient Benefits

MDH reviewed the MH and SUD outpatient services delivered through the ASO. The ASO identifies six NQTLs as in use for both MH and SUD services: Concurrent Review, Data Collection, Medical Necessity, Outlier Management, Prior Authorization, and Service Limitations. Each of these NQTLs with the exception of Data Collection and Service Limits, is

also reported as being in use for M/S benefits delivered by all nine MCOs and LTSS benefits delivered by the FFS Program.

Outpatient Benefits--Concurrent Review

1. Definition of OP-Concurrent Review (CR) NQTL

“Concurrent review” means a periodic reauthorization of continued medical eligibility for the level of services provided which allows for close monitoring of the participant’s progress, treatment goals, and objectives.

2. Benefits Subject to OP-Concurrent Review (CR) NQTL

The ASO reports applying the CR NQTL to some, but not all benefits in the MH OP Benefits Classification and to some but not all benefits in the SUD OP Benefits Classification.

The 9 MCOs report applying CR to some, but not all, of their OP benefits.

The FFS Program/LTSS applies CR to all M/S OP benefits.

Please refer to the report for each benefit administered to participants for each MCO to review the specific OP benefits subject to CR (Appendices B2 and H).

3. In-writing comparability and stringency--OP-Concurrent Review (CR) NQTL

The factors the ASO relies upon in deciding to apply and designing this NQTL include *clinical indications and/or evidence, high levels in variation in length of stay, least restrictive appropriate level of care, service type, severity or chronicity of illness, and variability in quality* (applied to MH benefit only). The ASO defines these factors identically for both MH and SUD benefits. These factors are all defined as intended to ensure the medical necessity of a service while accounting for potential variation in length of stay and for a condition to persist over time. *Service type* is defined as “services with various levels of intensity, including frequency and expected duration.” *Variability in quality* is defined as assessing whether an individual is improving, or if there is a need for a change in the treatment plan, monitoring appropriateness and efficacy of treatment. These factors are all related to professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.

The factors the MCOs rely upon in the design of this NQTL are comparable to and at least as stringent as those used by the ASO. All MCOs report one or more factors considered in the design of the NQTL that can be categorized as focused on establishing medical necessity in compliance with evidentiary standards related to recognized treatment guidelines. Most factors the MCOs identify that fall under this type of categorization are directly named and defined in relation to the review of clinical treatment criteria, e.g., *appropriate care setting, clinical guidelines MCG, clinical guidelines - InterQual, clinical indicators and/or evidence, high levels of variation in length of stay, industry standards, least restrictive appropriate level of care, medical necessity, patient safety, and safety*. KP identifies *severity/chronicity of illness* as a

factor for this NQTL and defines it comparably to the ASO as “degree to which an illness is a long term health condition for which there may be no cure and require ongoing services to treat.”

In addition to factors directly associated with clinical criteria, all of the MCOs with the exception of Aetna, rely on additional factors more closely aligned with controlling costs and utilization, including value (UHC)*claims with a high percentage of fraud* (MPC), *demand for services* (MPC), *fiscal responsibility* (Jai-assessing whether medically equivalent, lower cost options are available). Therefore, the MCOs are relying on some factors that are potentially more stringent than the factors used by the ASO in the same classification.

Some MCOs define a factor in a way that encompasses both validating medical necessity and cost/utilization management. Both Jai and Priority define the factor *appropriateness of utilization* similarly, Jai as based on patient history and internal claims cost increases of 10%+ over two years and Priority as “Utilization based on medical necessity, and efficient use of healthcare services and facilities as directed by the Plan benefits.” Amerigroup’s definition of the factor *excessive utilization* indicates that the MCO “facilitates the delivery of appropriate care and monitors the impact of its utilization management program to detect and correct potential under- and over-utilization based on Level of Care (LOC) and Service Types (Outpatient)” through “monitoring and comparing use of service aggregated data or non-identifiable utilization reports quarterly”, physician review, and use of reports “looking for patterns of over-utilization and/or underutilization of services” in comparison to benchmark and comparative data sources. MedStar defines *excessive utilization* as “the potential to be used for cosmetic purposes that are not medically necessary....the potential for off-label use that is not medically necessary (ex. Viagra) or a potential for abuse (ex. controlled substances greater than 90 MMEs” and identifies use of FWA software to identify outliers. KP defines the factor *lack of clinical efficiency of treatment or Service-UM* as “failure to provide the necessary services or treatments in a manner that avoids ineffective use of available resources and/or creates or causes unnecessary delay from the expected course of treatment goal based on clinical guidelines.” In addition to being defined according to whether a service met Interqual Criteria, Jai’s definition of *medical necessity* also encompasses considerations for costs “Is this the safest, cheapest option of covered services available for this situation?”

One MCO (Aetna) also identifies several factors related to provider qualifications, e.g., *Par Status*, which it defines as the provider contracted with the plan.

The factors the FFS Program/LTSS relies upon in the design of this NQTL are comparable to and at least as stringent as those used by the ASO in definition. The FFS Program identifies three factors considered in the design of the NQTL that can be categorized as focused on establishing medical necessity in compliance with evidentiary standards related to recognized treatment guidelines in a manner that is comparable to and at least as stringent as the factors upon which the ASO/BHA relies. Specifically, the FFS Program relies upon the following factors: *excessive utilization beyond medical necessity criteria*, *safety risks*, and *service type*.

In addition, the FFS Program identifies several factors more closely aligned with provider qualifications. These include *health plan accreditation standards for quality assurance* (“State

and/or Federal standards that must be met by the health plan in order to obtain accreditation, including those pertaining to medical, technical and financial eligibility.”), and *Medicare/Medicaid Program participation eligibility* (“Federal and State requirements for participation in the Medicare/Medicaid program”), *Quality and Performance Measures* (“Measures intended to evaluate and improve the quality of services, including, but not limited to: performance measures associated with waiver assurances, State regulations, national quality standards and pay for performance efforts”), and *Separate payments for managing a patient’s care outside of face-to-face contact* (“Reimbursement to providers to ensure case management activities are completed in accordance with State and Federal requirements.”)

4. In-operation comparability and stringency--OP-Concurrent Review (CR) NQTL

The ASO reports use of three measures for monitoring in-process operations for the OP CR NQTL--*Authorization Denial Rates for MH and SUD services, Inter-rater reliability surveys, and internal audits.*

Seven MCOs (Aetna, CF, Amerigroup, Jai, MPC, MedStar, and UHC) report use of claims reporting of some variety to monitor this NQTL. Examples include *utilization trends* and *dollar spend trends*. Seven MCOs (Aetna, Amerigroup, Jai, KP, MPC, MedStar, and Priority) also identify use of *inter-rater reliability surveys*. UHC identifies monitoring *average denial rates*. Only one MCO (CF) did not report reliance on any type of internal audit process.

The FFS Program/LTSS also reports review of some types of claims monitoring including reports addressing *frequency that reviews are conducted*. Although the FFS Program/LTSS does not monitor this NQTL using a formal inter-rater reliability survey, it does monitor the *frequency with which reviews are conducted, the degree of discretion exercised by utilization review staff, and evaluation of annual concurrent reviews and prior authorization reviews completed on a quarterly basis.*

5. Summary/Parity Assessment--OP-Concurrent Review (CR) NQTL

MDH determined that parity exists for the OP CR NQTL, as applied to MH, SUD, and M/S benefits. The definitions of the factors used by the ASO for both MH and SUD benefits are comparable to and no more stringent to those used by the MCOs/FFS Program for M/S benefits. The processes, strategies, and evidentiary standards used to apply CR to both MH and SUD services are comparable to, and no more stringently applied than, the processes, strategies, and evidentiary standards used to apply CR requirements to M/S services.

b. Outpatient Benefits--Data Collection

1. Definition of OP-Data Collection (DC) NQTL

Mandating that when an individual presents for services that the provider must submit supplementary data, such as Social Determinants of Health (SDOH) information, not necessary for clinical medical necessity determinations as a condition of the authorization of services for the individual and payment to the provider. This includes mandating data collection

requirements at various intervals as a condition of continued treatment for and payment of services. This requirement does not include requiring the provider to submit information necessary to identify the individual as a Medicaid participant or a participant of the managed care organization.

2. Benefits Subject to OP-Data Collection (DC) NQTL

The ASO reported applying the DC NQTL to all MH and SUD benefits in the outpatient benefits classification. The DC NQTL is not used for the M/S benefits administered by the MCOs or the FFS Program.

3. Summary/Parity Assessment--OP-Data Collection (DC) NQTL

As Data Collection is not used for any M/S benefits, this NQTL represents a per se parity violation. In order to remedy this issue, MDH required the ASO to eliminate data collection requirements. This process will be described further in the Next Steps section.

c. Outpatient Benefits--Medical Necessity

1. Definition of OP-Medical Necessity Criteria (MNC) NQTL

All Medicaid benefits, irrespective of delivery system, are universally subject to medical necessity requirements pursuant to state regulation. "Medically necessary" means that the service or benefit is:

- (a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
- (b) Consistent with current accepted standards of good medical practice;
- (c) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and
- (d) Not primarily for the convenience of the consumer, the consumer's family, or the provider.

2. Benefits Subject to OP-Medical Necessity Criteria (MNC) NQTL

The ASO reports applying the MNC NQTL all MH and SUD benefits in the outpatient benefits classification. Medical Necessity is also in use by all 9 MCOs and the FFS Program for all M/S benefits.

3. In-writing comparability and stringency--OP-Medical Necessity Criteria (MNC) NQTL

The factors the ASO relies upon in deciding to apply and designing this NQTL to MH benefits include *high levels of variation in length of stay, least restrictive appropriate level of care, service type severity/chronicity of illness, and variability in quality*. These factors are all defined

as intended to ensure the medical necessity of a service while accounting for potential variation in length of stay and for a condition to persist over time. *Service type* is defined as “services with various levels of intensity, including frequency and expected duration” based on compliance with professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines. *Variability in quality* is defined as assessing whether an individual is improving, or if there is a need for a change in the treatment plan, monitoring appropriateness and efficacy of treatment. These factors are all related to professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.

The ASO identifies a single factor for use of this NQTL with respect to SUD services, *service type*. This factor is defined as intended to ensure the medical necessity of a service while accounting for potential variation in length of duration. *Service type* is defined as “services with various levels of intensity, including frequency and expected duration” based on compliance with professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.

The factors the MCOs rely upon in the design of this NQTL are comparable to and at least as stringent as those used by the ASO. All MCOs report one or more factors considered in the design of the NQTL that can be categorized as focused on compliance with evidentiary standards related to recognized treatment guidelines. Factors the MCOs identify that fall under this type of categorization include *clinical guidelines MCG; industry standards; internally developed guidelines based upon rigorous review of scientific evidence or clinical registry data from professional specialty societies; lack of adherence to clinical standards could lead to safety concerns; lack of clinical efficiency of treatment or service; least restrictive appropriate level of care; medical necessity (Aetna-based on Milliman Criteria and Aetna Policy Bulletins); patient safety; professional standards and protocols; and recognized medical literature*. MPC identifies *excessive utilization* as a factor, which it defines as “Utilization of services greater than industry standards based on CPT codes per InterQual guidelines.” KP and MedStar both identify *severity/chronicity of illness* as a factor for this NQTL. Both define it comparably to the ASO. KP uses this definition: “degree to which an illness is a long term health condition for which there may be no cure and require ongoing services to treat.” MedStar’s definition is driven by this tenet: “Severity or chronicity of an illness could require a higher level of care than would be expected in those without such conditions.”

In addition to factors directly associated with clinical criteria, seven of the MCOs (Amerigroup, CF, Jai, KP, MPC, MedStar, and Priority) rely on additional factors more closely aligned with controlling costs and utilization. Factors cited include *appropriateness of utilization, claim types with high percentage of fraud, current and projected demand for services, elasticity of demand, fiscal responsibility, high variability in cost per episode of care, provider discretion - diagnosis, and provider discretion - type or length of treatment*.

Certain MCOs define a factor in a way that encompasses both medical necessity and cost/utilization management. Both Jai and Priority define the *factor appropriateness of utilization* similarly, Jai as based on patient history and internal claims cost increases of 10%+ over two years and Priority “Utilization based on medical necessity, and efficient use of healthcare

services and facilities as directed by the Plan benefits.” Amerigroup’s definition of the factor *excessive utilization* indicates that the MCO “facilitates the delivery of appropriate care and monitors the impact of its utilization management program to detect and correct potential under- and over-utilization based on Level of Care (LOC) and Service Types (Outpatient)” through “monitoring and comparing use of service aggregated data or non-identifiable utilization reports quarterly”, physician review, and use of reports “looking for patterns of over-utilization and/or underutilization of services” in comparison to benchmark and comparative data sources. MedStar defines the factor *excessive utilization* as “the potential to be used for cosmetic purposes that are not medically necessary....the potential for off-label use that is not medically necessary (ex. Viagra) or a potential for abuse (ex. controlled substances greater than 90 MMEs” and identifies use of FWA software to identify outliers. KP defines the factor *lack of clinical efficiency of treatment or service* as “Failure to provide the necessary services or treatments in a manner that avoids ineffective use of available resources and/or creates or causes unnecessary delay from the expected course of treatment goal based on clinical guidelines.” In addition to being defined according to whether a service met Interqual Criteria, Jai’s definition of the factor *medical necessity* also encompasses considerations for costs “Is this the safest, cheapest option of covered services available for this situation?” MedStar defines the factor *service type* in part as “Authorization requirements may be applied by service type due to potential overutilization or safety issues” while also referencing medical necessity criteria.

The factors the FFS Program/LTSS relies upon in the design of this NQTL are comparable to and at least as stringent as those used by the ASO in definition. The FFS Program for LTSS and Dental M/S benefits relies upon several factors for the OP-MNC NQTL. These factors include *current and projected demand for services, excessive utilization, lack of adherence to clinical standards, lack of clinical efficiency of treatment of service, and service type*. In addition to factors directly associated with clinical criteria, the FFS Program reports several factors more closely aligned as defined with controlling costs and utilization. These factors include *high variability in cost per episode of care, and relative reimbursement rates*. Finally, the FFS Program identifies one factor more closely aligned with provider qualifications. This factor is *Medicare/Medicaid Program participation eligibility* (“Federal and State requirements for participation in the Medicare/Medicaid program, including those pertaining to medical, technical and financial eligibility accreditation”).

4. In-operation comparability and stringency--OP-Medical Necessity Criteria (MNC) NQTL

The ASO reports use of four measures for monitoring in-process operations for the MNC NQTL--*Authorization Denial Rates for MH/SUD, authorization statistics, internal audits, and inter-rater reliability surveys for mental health and substance use disorder reviewers*.

All but two MCOs (KP and Priority) report use of claims reporting of some variety to monitor this NQTL. Examples include *utilization trends* and *authorization denial rates*. Eight MCOs identify use of *inter-rater reliability surveys* and one (Aetna) identifies use of *internal audit findings related to coverage determination consistency with the plan’s medical necessity criteria*. Only one MCO, CF, did not report reliance on any type of inter-rater reliability survey or internal audit

process.

The FFS Program (M/S LTSS and Dental Benefits) also reports review of some types of claims monitoring including reports addressing frequency with which services are denied. Although the FFS Program does not monitor this NQTL using a formal inter-rater reliability survey, LTSS does monitor *internal audit findings related to coverage determination consistency with the plan's medical necessity criteria and the degree of discretion exercised by utilization review staff*.

5. Summary/Parity Assessment--OP-Medical Necessity Criteria (MNC) NQTL

MDH determined that parity exists for the OP MNC NQTL, as applied to all MH, all SUD, and all M/S benefits. The definitions of the factors used by the ASO for both MH and SUD benefits are comparable to and no more stringent to those used by the MCOs/FFS Program for M/S benefits. The processes, strategies, and evidentiary standards used to apply MNC to both MH and SUD services are comparable to, and no more stringently applied than, the processes, strategies, and evidentiary standards used to apply MNC requirements to M/S services.

Stakeholders have requested a specific analysis of the application of parity to Maryland's MNC and clinical coverage guidelines for case management. As a threshold matter, under the Final Rule, NQTLs are analyzed at the classification level, not at the benefit level. However, in order to be responsive to stakeholder requests, this report includes a supplemental analysis of the MNC for case management. All Maryland Medicaid beneficiaries are eligible for case management through their MCO, ASO, and/or FFS programs. Case management programs assist beneficiaries with gaining access to the full range of other available services, as well as to any needed medical, social, financial, counseling, educational, housing, and other supportive services needed in order to maintain stability in the community. Maryland's Medicaid State Plan provides that case management is medically necessary and provides coverage guidelines for beneficiaries with qualifying diagnoses. Qualifying diagnoses include some but not all M/S, MH, and SUD diagnoses. Individuals with qualifying SUD conditions are eligible for case management through the Maryland Chronic Health Homes Program. The MNC for case management were developed according to the same factors described and analyzed above. In particular, case management is covered for conditions where professionally recognized treatment guidelines recognize the necessity and efficacy of case management as a service. Across the delivery system, the MNC for case management for all services are reviewed and updated at consistent intervals and for the same reasons. Therefore, case management MNC criteria are developed and applied in a comparable and no more stringent manner.

e. Outpatient Benefits--Outlier Management

1. Definition of OP-Outlier Management (OM) NQTL

Procedures that are designed to review services after they have been delivered to assess medical necessity and detect and/or¹³ prevent fraud, waste, and abuse through investigation of unusual patterns in service utilization, billing, prescribing, and denials.

¹³ This definition was changed in 2022.

2. Benefits Subject to OP-Outlier Management (OM) NQTL

The ASO reports applying the OM NQTL to some but not all MH or SUD benefits in the OP benefits classification.

All nine MCOs reported using this NQTL for OP M/S benefits.

The FFS Program/LTSS applies OM to some, but not all, M/S OP benefits.

Please refer to the report for each benefit administered to participants for each MCO to review the specific OP benefits subject to OM (Appendix H).

3. In-writing comparability and stringency--OP-Outlier Management (OM) NQTL

Factors the ASO relies upon in deciding to apply and designing this NQTL include *excessive utilization, high levels in variation in length of stay, least restrictive appropriate level of care, service type, severity or chronicity of illness, and variability in quality*. The ASO defines these factors identically for both MH and SUD benefits. These factors are all defined as intended to ensure the medical necessity of a service while accounting for potential variation in length of stay and for a condition to persist over time. *Service type* is defined as “services with various levels of intensity, including frequency and expected duration.” *Variability in quality* is defined as assessing whether an individual is improving, or if there is a need for a change in the treatment plan, monitoring appropriateness and efficacy of treatment. These factors are all related to professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.

The factors the MCOs rely upon in the design of this NQTL are comparable to and at least as stringent as those used by the ASO. All MCOs report one or more factors considered in the design of the NQTL that can be categorized as focused on establishing medical necessity in compliance with evidentiary standards related to recognized treatment guidelines. Most factors the MCOs identify that fall under this type of categorization are directly named and defined in relation to review of clinical treatment criteria (e.g., *clinical indications and/or evidence, industry standards, medical necessity* (KP--based on compliance with professionally recognized treatment guidelines), *Par facilities Medical Necessity Review Post Payment*, and *safety risks*. KP identifies *severity/chronicity of illness* as a factor for this NQTL and defines it comparably to the ASO as “degree to which an illness is a long term health condition for which there may be no cure and require ongoing services to treat.” MedStar’s definition of this factor is driven by this tenet: “Severity or chronicity of an illness could require a higher level of care than would be expected in those without such conditions.” Priority defines the factor *severity/chronicity of illness* as “The extent of organ system derangement or physiologic decompensation for a patient. It gives a medical classification into minor, moderate, major, and extreme” in accordance with medical expert review and related evidentiary standards. MPC defines the factor *excessive utilization* as “Utilization of services greater than industry standards based on CPT codes per InterQual guidelines.” UHC defines the factor *service type* as the health plan applying limits based on the type of service performed within the benefit classification in compliance with professionally recognized treatment guidelines, medical literature and

professional standards, and committee developed standards. UHC identifies use of *utilization patterns* as a factor for this NQTL, which it defines as “Utilization pattern reviews suggest evidence-based national clinical guidelines are not being followed consistently” based on evidence of increased medical costs year over year.

In addition to factors directly associated with clinical criteria, all but one (Aetna) rely on additional factors more closely aligned as defined with controlling costs and utilization. Factors cited include *administrative burden/cost*; *appropriateness of utilization* (Priority-based on medical necessity and efficient service use); *claim types with high percentage of fraud*; *claims evaluation, reporting, and analytics* (UHC-where there is statistically significant variation in the costs of services and it is sufficiently high that potential for savings exceeds the cost of monitoring requirements); *fiscal responsibility*; *high variability in cost per episode of care*; *prior authorization requirements imposed by the Department* (KP); *provider discretion - diagnosis*; *provider discretion - type or length of treatment*; and *recent medical cost escalation*. Therefore, the MCOs are relying on some factors that are potentially more stringent than the factors used by the ASO in the same classification.

Certain MCOs define a factor in a way that encompasses both validating medical necessity and cost/utilization management. MedStar defines the factor *service type* in part as “Authorization requirements may be applied by service type due to potential overutilization or safety issues” while also referencing medical necessity criteria. Amerigroup’s definition of the factor *excessive utilization* indicates that the MCO “facilitates the delivery of appropriate care and monitors the impact of its utilization management program to detect and correct potential under-and over-utilization based on Level of Care (LOC) and Service Types (Outpatient)” through “monitoring and comparing use of service aggregated data or non-identifiable utilization reports quarterly,” physician review, and use of reports “looking for patterns of over-utilization and/or underutilization of services” in comparison to benchmark and comparative data sources. MedStar defines the factor *excessive utilization* as “the potential to be used for cosmetic purposes that are not medically necessary....the potential for off-label use that is not medically necessary (ex. Viagra) or a potential for abuse (ex. controlled substances greater than 90 MMEs” and identifies use of FWA software to identify outliers. KP defines the factor *lack of clinical efficiency of treatment or service* as “Failure to provide the necessary services or treatments in a manner that avoids ineffective use of available resources and/or creates or causes unnecessary delay from the expected course of treatment goal based on clinical guidelines.”

Finally, one MCO (UHC) identifies two factors more closely aligned with provider qualifications--*accreditation and training, experience, and licensure of the providers*.

The factors the FFS Program/LTSS and Dental relies upon in the design of this NQTL are comparable to and as stringent as those used by the ASO. The FFS Program for LTSS and Dental M/S benefits relies upon several factors for the OP-OM NQTL. The FFS Program identifies three factors considered in the design of the NQTL that can be categorized as focused on establishing medical necessity in compliance with evidentiary standards related to recognized treatment guidelines: *excessive utilization, safety risks, and service type*. The FFS Program also relies on two additional factors more closely aligned as defined with controlling

costs and utilization, *high variability in cost of care per episode and relative reimbursement rates.*

4. In-operation comparability and stringency--OP-Outlier Management (OM) NQTL

The ASO reports use of four measures for monitoring in-process operations for the OP OM NQTL--*Authorization Denial Rates for MH, Outlier Management Data, internal audits, and Inter-rater reliability surveys.* For purposes of monitoring in-process operations for SUD services, *Outlier Management Data, internal audits, and Inter-rater reliability surveys* are used.

All but one MCOs (KP) report use of claims reporting of some variety to monitor this NQTL. Examples include *utilization trends and FWA Reports.* Three MCOs (KP, MedStar, Priority) identify use of *inter-rater reliability surveys,* one (Amerigroup) identifies use of *internal audit findings related to coverage determination consistency with the plan's medical necessity criteria,* and UHC monitors *medical claim review accuracy.*

The FFS Program/LTSS also reports review of some types of claims monitoring including reports addressing *frequency that authorization requirements are waived and number of days or visits authorized per review.* Although the FFS Program/LTSS does not monitor this NQTL using a formal inter-rater reliability survey, it does monitor the *frequency with which reviews are conducted* and the *degree of discretion exercised by utilization review staff.*

5. Summary/Parity Assessment--OP-Outlier Management (OM) NQTL

MDH determined that parity exists for the OP OM NQTL, as applied to MH, SUD, and M/S benefits. The definitions of the factors used by the ASO for both MH and SUD benefits are comparable to and no more stringent to those used by the MCOs/FFS Program for M/S benefits. The processes, strategies, and evidentiary standards used to apply OM to both MH and SUD services are comparable to, and no more stringently applied than, the processes, strategies, and evidentiary standards used to apply OM requirements to M/S services.

f. Outpatient Benefits--Prior Authorization

1. Definition of OP-Prior Authorization (PA) NQTL

The approval required from the Department or its designee (including the MCO) before a service can be rendered by the provider and reimbursed.

2. Benefits Subject to OP-Prior Authorization (PA) NQTL

The ASO reports applying the Prior Authorization NQTL to some but not all MH or SUD benefits in the OP benefits classification.

All nine MCOs report using this NQTL for some, but not all OP M/S benefits.

The FFS Program/LTSS and Dental also applies PA to certain M/S OP benefits.

Please refer to the report for each benefit administered to participants for each MCO to review the specific OP benefits subject to PA (Appendices B2 and H).

3. In-writing comparability and stringency--OP-Prior Authorization (PA) NQTL

The factors the ASO relies upon in deciding to apply and designing this NQTL to MH benefits include *high levels of variation in length of stay, least restrictive appropriate level of care, service type, severity/chronicity of illness, and variability in quality*. The ASO defines these factors identically for both MH and SUD benefits. These factors are all defined as intended to ensure the medical necessity of a service while accounting for potential variation in length of stay and for a condition to persist over time. *Service type* is defined as “services with various levels of intensity, including frequency and expected duration” based on compliance with professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines. *Variability in quality* is defined as assessing whether an individual is improving, or if there is a need for a change in the treatment plan, monitoring appropriateness and efficacy of treatment. These factors are all related to professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.

The ASO identifies a single factor for use of this NQTL with respect to SUD services, *service type*. This factor is defined as intended to ensure the medical necessity of a service while accounting for potential variation in length of duration. *Service type* is defined as “services with various levels of intensity, including frequency and expected duration” based on compliance with professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.

The factors the MCOs rely upon in the design of this NQTL are comparable to and at least as stringent as those used by the ASO. All MCOs report one or more factors considered in the design of the NQTL that can be categorized as focused on establishing medical necessity in compliance with evidentiary standards related to recognized treatment guidelines in a manner that is comparable to and at least as stringent as the factors upon which the ASO/BHA relies. Most factors the MCOs identify that fall under this type of categorization are directly named and defined in relation to the review of clinical treatment criteria (e.g., *appropriate care setting; clinical guidelines MCG; clinical indications and/or evidence based on clinical guidelines; industry standards; lack of clinical efficiency of treatment/service; medical necessity* (Aetna-based on Milliman Criteria and Aetna Policy Bulletins); nationally recognized guidelines; *patient safety; and safety risk*). CF identifies *benefit limitation* as a factor in applying prior authorization, which it defines in relation to medical necessity as “Benefits, services, drugs, procedures, and supplies considered experimental or investigational are not covered pursuant to Medicaid regulations (e.g. lack of approval by Food and Drug Administration (FDA), American Medical Association (AMA), or other body; determination of a medical policy committee and the standards they follow; or other means). Aetna and MPC each identify *excessive utilization* as a factor. Aetna defines it in part as “Utilization that exceeds the threshold outlined in Milliman Care Guidelines...the purpose of database analysis is to confirm the reasonability and clinical appropriateness of care guideline utilization goals and objectives.” MPC defines *excessive utilization* as “Utilization of services greater than industry standards based on CPT codes per InterQual guidelines.”

KP and MedStar both identify *severity/chronicity of illness* as a factor for this NQTL. Both define it comparably to the ASO. KP uses this definition: “degree to which an illness is a long term health condition for which there may be no cure and require ongoing services to treat.” MedStar definition of this factor is driven by this tenet: “Severity or chronicity of an illness could require a higher level of care than would be expected in those without such conditions.” UHC identifies use of *utilization patterns* as a factor for this NQTL, which it defines as “Utilization pattern reviews suggest evidence-based national clinical guidelines are not being followed consistently” based on evidence of increased medical costs year over year.

In addition to factors directly associated with clinical criteria, seven MCOs (Amerigroup, CF, Jai, MPC, Priority, and UHC) rely on additional factors more closely aligned as defined with controlling costs and utilization. Factors cited include *administrative burden/cost*; *appropriateness of utilization* (Priority-based on medical necessity and efficient service use); *claim types with high percentage of fraud*; *value*; *current and projected demand for services*; *elasticity of demand*; *fiscal responsibility*; *high variability in cost per episode of care*; *recent medical cost escalation*; and *relative reimbursement rates*.

Certain MCOs define a factor in a way that encompasses both medical necessity and cost/utilization management. Amerigroup and MedStar each identify *excessive utilization* as a factor. Amerigroup’s definition of the factor *excessive utilization* indicates that the MCO “facilitates the delivery of appropriate care and monitors the impact of its utilization management program to detect and correct potential under-and over-utilization based on Level of Care (LOC) and Service Types (Outpatient)” through “monitoring and comparing use of service aggregated data or non-identifiable utilization reports quarterly”, physician review, and use of reports “looking for patterns of over-utilization and/or underutilization of services” in comparison to benchmark and comparative data sources. MedStar defines the factor *excessive utilization* as “the potential to be used for cosmetic purposes that are not medically necessary....the potential for off-label use that is not medically necessary (ex. Viagra) or a potential for abuse (ex. controlled substances greater than 90 MMEs” and identifies use of FWA software to identify outliers. KP defines the factor *lack of clinical efficiency of service* as “Failure to provide the necessary services or treatments in a manner that avoids ineffective use of available resources and/or creates or causes unnecessary delay from the expected course of treatment goal based on clinical guidelines.” Similarly, MedStar defines this factor as “Pre authorization, concurrent review, or retrospective review may be required to ensure that procedure/service is performed at most appropriate level of care or that the least costly (dollars or clinical impact) medication has been prescribed and/or that more conservative treatment has been tried and failed, or medication is medically appropriate for the condition.” In addition to being defined according to whether a service met Interqual Criteria, Jai’s definition of the factor *medical necessity* also encompasses considerations for costs “Is this the safest, cheapest option of covered services available for this situation?” Amerigroup defines the factor *service type* as all services that “require preauthorization and/or ongoing authorization using approved clinical criteria to assess medical necessity and level of care appropriateness” in cases where utilization is two standard deviations above average utilization per episode of care and that it monitors aggregated data or non-identifiable utilization reports to detect and correct potential under-and over-utilization in comparison to benchmark and comparative data sources based on medical expert review in tandem with internal claims and internal market and competitive analysis. The plan also

identifies *accreditation standards for quality assurance*. Additionally, MedStar defines the factor *service type* in part as “Authorization requirements may be applied by service type due to potential overutilization or safety issues” while also referencing medical necessity criteria. Similarly, MedStar’s definition of the factor *lack of clinical efficiency of treatment or service* embraces both a medical necessity component and consideration of costs/utilization management (“review may be required to ensure that procedure/service is performed at most appropriate level of care or that the least costly (dollars or clinical impact) medication has been prescribed and/or that more conservative treatment has been tried and failed.”)

One MCO (Aetna) also identifies several factors related to provider qualifications, e.g., *Par Status*, which it defines as the provider contracted w/plan.

The factors the FFS Program/LTSS and Dental relies upon in the design of this NQTL are comparable to and at least as stringent as those used by the ASO in definition. The FFS Program identifies two factors considered in the design of the NQTL that can be categorized as focused on establishing medical necessity in compliance with evidentiary standards related to recognized treatment guidelines *excessive utilization beyond medical necessity criteria* and *safety risks*. Factors the FFS Program identifies designed to control costs and utilization include *elasticity of demand*, *high variability in cost per episode of care*, and *relative reimbursement rates*.

In addition, the FFS Program identifies a factor more closely aligned with provider qualifications, *Medicare/Medicaid Program participation eligibility* (“Federal and State requirements for participation in the Medicare/Medicaid program, including those pertaining to medical, technical and financial eligibility and accreditation”) and *Quality and Performance Measures* (“Measures intended to evaluate and improve the quality of services, including, but not limited to: performance measures associated with waiver assurances, State regulations, national quality standards and pay for performance efforts”).

4. In-operation comparability and stringency--OP-Prior Authorization (PA) NQTL

The ASO reports use of three measures for monitoring in-process operations for the OP PA NQTL for both MH and SUD services--*Authorization Denial Rates for MH and SUD services*, *internal audits*, and *inter-rater reliability surveys*.

All but two MCOs (KP, Priority) report use of claims reporting of some variety to monitor this NQTL. Examples include *utilization trends* and *average denial rates*. All nine MCOs identify use of *inter-rater reliability surveys*.

The FFS Program/LTSS and Dental also report review of some types of claims monitoring including *service preauthorized and not received* and *number of days or visits authorized per review*. Although the FFS Program/LTSS does not monitor this NQTL using a formal inter-rater reliability survey, it does monitor the *frequency with which reviews are conducted*, *the degree of discretion exercised by utilization review staff*, and *evaluation of annual concurrent reviews and prior authorization reviews completed on a quarterly basis*.

5. Summary/Parity Assessment--OP-Prior Authorization (PA) NQTL

MDH determined that parity exists for the OP PA NQTL as applied to MH, SUD, and M/S benefits. The definitions of the factors used by the ASO for both MH and SUD benefits are comparable to and no more stringent to those used by the MCOs/FFS Program for M/S benefits. The processes, strategies, and evidentiary standards used to apply PA to both MH and SUD services are comparable to, and no more stringently applied than, the processes, strategies, and evidentiary standards used to apply PA requirements to OP M/S services.

g. Outpatient Benefits--Service Limitations

1. Definition of OP-Service Limitations (SL) NQTL

Coding edits or other limitations on delivery of a benefit such as (1) prohibitions on same-day claims for certain services; and (2) reimbursement restrictions for multiple services in a single day, week, or month.

Note: Implementation of National Correct Coding Initiative (NCCI) edits should not be reported. Section 6507 of the Affordable Care Act requires each state Medicaid program to implement compatible methodologies of the NCCI, to promote correct coding, and to control improper coding leading to inappropriate payment. Compliance with federal requirements for implementing NCCI methodologies does not require an NQTL analysis under the Medicaid and CHIP parity rules.¹⁴

2. Benefits Subject to OP-Service Limits (SL) NQTL

The ASO reports applying the SL NQTL to some but not all MH and some but not all SUD benefits in the outpatient benefits classification. A comprehensive overview of all SL currently in place for MH and SUD services can be found in Appendix G. The SL NQTL is not used for the M/S benefits administered by most MCOs, with the exception of MedStar and UHC. The SL NQTL is not used for M/S benefits administered by the FFS Program.

3. Summary/Parity Assessment--OP-Service Limits (SL) NQTL

As the SL NQTL is not used for M/S benefits, subject to certain exceptions by MedStar and United, this NQTL represents a per se parity violation. Further consultation with CMS is required to determine the best means of remedying this potential concern. While MDH identified the similarity of SL and NCCI edits in its 2020 report, no operational changes will be made absent further guidance from CMS.

4. Prescription Benefits

MDH reviewed the MH and SUD services delivered by the FFS Program. The FFS Program identifies four NQTLs as in use for MH and/or SUD Prescription Benefits: Fail First/Step Therapy (FF/ST), Medical Necessity Criteria (MNC), Prior Authorization (PA), and Tiered Drug Formulary (TDF). These NQTLs are also in use for M/S Prescription benefits delivered by all

¹⁴ Frequently Asked Questions: Mental Health and Substance Use Disorder Parity Final Rule for Medicaid and CHIP, October 11, 2017, see Q6, <https://www.medicaid.gov/federal-policy-guidance/downloads/faq101117.pdf>.

nine MCOs and M/S prescription benefits delivered by the FFS Program. An in-depth discussion of each of these NQTLs as it relates to the Prescription Classification is included below.

a. Prescription Benefits--Fail First/Step Therapy

1. Definition of Prescription Benefits-Fail First/Step Therapy (FF/ST) NQTL

Requiring members to attempt lower or lesser levels of care and demonstrate ineffectiveness before allowing the participant to attempt higher or more intensive levels of care.

A requirement that a patient try a less expensive treatment first before they can be approved for the higher cost treatment ordered by their provider.

2. Benefits Subject to Prescription Benefits-Fail First/Step Therapy (FF/ST) NQTL

The FFS Program reports applying the Fail First/Step Therapy NQTL to some, but not all drugs in the MH Prescription benefits classification and to some but not all drugs in the SUD Prescription benefits classification.

The 9 MCOs report applying FF/ST to some, but not all, of their M/S prescription benefits.

Additionally, the FFS Program reports applying the FF/ST NQTL to all M/S drugs paid for on a FFS basis.

Please refer to the report for each benefit administered to participants for each MCO to review the specific Prescription benefits subject to FF/ST (Appendix F).

3. In-writing comparability and stringency-- Prescription Benefits-Fail First/Step Therapy (FF/ST) NQTL

The factor the FFS Program relies upon in deciding to apply and designing this NQTL to MH and SUD drug benefits are identical for both the MH and SUD classifications. Specifically, the FFS Program reports the following factor, *Fail-first protocol or requirement to try a generic, less expensive, or lower efficacy drug for a certain trial period before receiving approval for a new drug*. In name and definition, this factor encompasses elements of both cost/utilization control as well as medical necessity. The FFS Program identifies several evidentiary standards for this factor including, compliance with professionally recognized treatment guidelines; medical literature review; and reliance on FDA Prescribing Information & Official Compendium.

The FFS Program is also responsible for delivery of select M/S pharmacy therapies to the HealthChoice population. The same factor the FFS Program identifies for MH and SUD benefits is relied upon for M/S drugs. The factor is defined identically.

The factors the MCOs rely upon in the design of this NQTL are comparable to and at least as stringent as those used by the FFS Program for MH and SUD drugs. All MCOs report at least one factor considered in the design of the NQTL that can be categorized as focused on

controlling costs and utilization and at least one factor focused on validating medical necessity of the benefits.

All MCOs report one or more factors considered in the design of the NQTL that can be categorized as focused on establishing medical necessity in compliance with recognized treatment guidelines in a manner that is comparable to and at least as stringent as the factors upon which the ASO/BHA relies. Most factors the MCOs identify that fall under this type of categorization are directly named and defined in relation to the review of clinical treatment criteria (e.g., *clinical appropriateness; clinical indications and/or evidence; clinical literature; FDA drug information; industry standards; lack of adherence to quality standards; lack of clinical efficiency of treatment or service; medical effectiveness; medical necessity; National Practice Criteria; patient safety; provider recognition of accreditation by certain accrediting bodies; and severity or chronicity of illness*). KP adopts a different definition for use of the factor *lack of clinical efficiency* than is used for IP and OP services, “Significant potential for off label indications without data to support widespread utilization.”

Factors the MCO identify related to cost/utilization control include *appropriateness of utilization* (Jai-based on patient history), *claim types with a high percentage of fraud; claims evaluation, reporting, and analytics* (UHC-where there is statistically significant variation in the costs of services and it is sufficiently high that potential for savings exceeds the cost of monitoring requirements); *current and projected demand for services; elasticity of demand; fiscal responsibility; high cost of care relative to similar therapies; high variability in cost per episode of care; lower generic cost; discretion in determining diagnosis; and recent medical cost escalation*. Therefore, the MCOs are relying on some factors that are potentially more stringent than the factors used by the ASO in the same classification.

Certain MCOs define a factor in a way that encompasses both validating medical necessity and cost/utilization management. Amerigroup defines the factor *current and projected demand for services* as intended to “reduce the event of fraud waste and abuse and prevent members from experiencing harm by using medications for non FDA-approved indications and/or indications that are not medically accepted.” The factor *excessive utilization* encompasses elements of both cost/utilization control as well as medical necessity as defined by each of the MCOs. Amerigroup indicated that it monitors aggregated data or non-identifiable utilization reports to detect and correct potential under-and over-utilization in comparison to benchmark and comparative data sources based on medical expert review in tandem with internal claims and internal market and competitive analysis. Similarly, KP defines the *excessive utilization* factor for this NQTL as follows: “Excessive utilization is determined by one or more of the following considerations: significant potential for inappropriate use, narrow safety margin, requires specialty expertise, reserved for second or third line therapy, actual or potential short supply, medication safety concerns, or potential for waste or diversion associated with high cost.” Both MPC and Priority identify *formulary design or use of a tiered drug formulary* as a factor for this NQTL; as discussed below, both rely on both medical necessity and cost/utilization factors in the design of these tiers under the TDF NQTL.

4. In-operation comparability and stringency-- Prescription Benefits-Fail First/Step Therapy (FF/ST) NQTL

The FFS Program reports use of three measures for monitoring in-process operations for the FF/ST NQTL. One measure is linked to monitoring of claims data--*utilization trends*. Although the FFS Program does not monitor this NQTL using a formal inter-rater reliability survey, it does conduct *internal monitoring of prior authorizations to determine compliance of treatment/service plans for drug efficacy based on concurrent review of treatment plans, service usage, and drug utilization and type* and monitor *the level of documentation (e.g., chart notes, lab results, treatment plans, etc.) the health plan requires from providers during review as means of oversight*.

These same measures are in place through the FFS Program for the M/S drug benefit.

All but three MCOs (Aetna, MPC, and UHC) report use of data reporting to monitor this NQTL. Examples include *utilization trends, dollar spend trends, and authorization denial rates*. Four MCOs (Amerigroup, CF, MedStar, and Priority) also identify use of *inter-rater reliability surveys*. KP and UHC also report monitoring *the frequency with which reviews are conducted*.

5. Summary/Parity Assessment-- Prescription Benefits-Fail First/Step Therapy (FF/ST) NQTL

MDH determined that parity exists for the Prescription Benefits FF/ST NQTL, as applied to MH, SUD, and M/S benefits. The definitions of the factors used for the FFS Program for the MH and SUD Prescription Benefits classification were comparable to and no more stringent to those used by the FFS Program and MCOs for the M/S Prescription Benefits classification. The processes, strategies, and evidentiary standards used to apply FF/ST to both MH and SUD Prescription Benefits are comparable to, and no more stringently applied than, the processes, strategies, and evidentiary standards used to apply FF/ST requirements to M/S Prescription Benefits.

b. Prescription Benefits--Medical Necessity

1. Definition of Prescription Benefits-Medical Necessity (MNC) NQTL

All Medicaid benefits, irrespective of delivery system, are universally subject to medical necessity requirements pursuant to state regulation. "Medically necessary" means that the service or benefit is:

- (a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition;
- (b) Consistent with current accepted standards of good medical practice;
- (c) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and
- (d) Not primarily for the convenience of the consumer, the consumer's family, or the provider.

2. Benefits Subject to Prescription Benefits-Medical Necessity (MNC) NQTL

The FFS Program reports applying the MNC NQTL to all drugs in the MH Prescription Benefits Classification and to all drugs in the SUD Prescription Benefits Classification.

The 9 MCOs report applying MNC to all of their M/S prescription benefits.

Additionally, the FFS Program reports applying the MNC NQTL to all M/S drugs paid for on a FFS basis.

3. In-writing comparability and stringency--Prescription Benefits-Medical Necessity (MNC) NQTL

The factors the FFS Program relies upon in deciding to apply and designing this NQTL to MH and SUD drug benefits are identical and defined identically for both the MH and SUD classifications. Specifically, the FFS Program reports two factors intended to ensure the medical necessity of a service, *clinical appropriateness/medical necessity* and *Medication status on Preferred Drug List (PDL) as determined by the Preferred Drug Program via recommendations by the Pharmacy & Therapeutics (P&T) Committee*. Both factors rely on identical evidentiary standards, including professionally recognized treatment guidelines, medical literature reviews, as well as FDA Prescribing Information & Official Compendium. The FFS Program also identifies a single factor related to cost/utilization control, *Fiscal Responsibility/Cost Effectiveness*, which it defines as “Examination of a drug’s actual cost and rebateable status for the State with an emphasis on cost conservation and reduction of waste for the Department while still maintaining the accessibility of care to participants.” The FFS Program is also responsible for delivery of select M/S pharmacy therapies to the HealthChoice population. The same factors the FFS Program identifies for MH and SUD benefits are relied upon for M/S drugs. The factors are defined identically.

The factors the MCOs rely upon in the design of this NQTL are comparable to and at least as stringent as those used by the FFS Program for MH and SUD drugs. All MCOs (except Aetna) report at least one factor considered in the design of the NQTL that can be categorized as focused on controlling costs and utilization and all MCOs report at least one factor focused on ensuring medical necessity of the benefits.

All MCOs report one or more factors considered in the design of the NQTL that can be categorized as focused on establishing medical necessity in compliance with evidentiary standards related to recognized treatment guidelines. Most factors the MCOs identify that fall under this type of categorization are directly named and defined in relation to the review of clinical treatment criteria (e.g., *clinical indications and/or evidence; clinical literature; efficacy demonstrated in rare conditions only; FDA dosage limit; industry standards; lack of adherence to quality standards; lack of clinical efficiency of treatment or service; medical necessity; patient safety; pervasive use of non-FDA approved diagnosis; recognition of accreditation by certain accrediting bodies* (Amerigroup-In order to use evidentiary standards, including any published standards and treatment guidelines created by professional guild associations or other third-party entities, publicly available or proprietary from consulting or other organization); *safety risks; and severity or chronicity of an illness*). KP adopts a different definition for use of the

factor *lack of clinical efficiency* than it utilizes for IP and OP services, “Significant potential for off label indications without data to support widespread utilization.

All but two MCO (Aetna, MPC) identify factors related to cost/utilization control. Factors the MCOs identify related to cost/utilization control include *appropriateness of utilization* (Jai-based on patient history; Priority-based on medical necessity and efficient service use), *claim types with a high percentage of fraud*; *claims evaluation, reporting, and analytics* (UHC-where there is statistically significant variation in the costs of services and it is sufficiently high that potential for savings exceeds the cost of monitoring requirements); *current and projected demand for services*; *elasticity of demand*; *fiscal responsibility*; *high variability in cost per episode of care*; *provider discretion - type or length of treatment*; *provider discretion-diagnosis*; *recent medical cost escalation*; and *waste of Medicaid funds*.

Certain MCOs define a factor in a way that encompasses both validating medical necessity and cost/utilization management. The factor *excessive utilization* encompasses elements of both cost/utilization control as well as medical necessity as defined by each of the MCOs. Amerigroup indicates that it monitors aggregated data or non-identifiable utilization reports to detect and correct potential under-and over-utilization in comparison to benchmark and comparative data sources based on medical expert review in tandem with internal claims and internal market and competitive analysis. Similarly, KP defines the *excessive utilization* factor for this NQTL as follows: “Excessive utilization is determined by one or more of the following considerations: significant potential for inappropriate use, narrow safety margin, requires specialty expertise, reserved for second or third line therapy, actual or potential short supply, medication safety concerns, or potential for waste or diversion associated with high cost.” MedStar defines the factor *excessive utilization* as “the potential to be used for cosmetic purposes that are not medically necessary....the potential for off-label use that is not medically necessary (ex. Viagra) or a potential for abuse (ex. controlled substances greater than 90 MMEs)” and identifies use of FWA software to identify outliers. CF defines the *excessive utilization* factor for this NQTL “the identification of specific services and/or CPT codes that lead to circumstances where the potential for harm for fraud, waste, and abuse exceeds the potential for benefit” and identifies use of compliance with recognized industry standards. With respect to *medical necessity*, in addition to being defined according to whether a service met Interqual Criteria, Jai’s definition also encompasses considerations for costs “Is this the safest, cheapest option of covered services available for this situation?”

4. In-operation comparability and stringency--Prescription Benefits-Medical Necessity (MNC) NQTL

The FFS Program reports use of three measures for monitoring in-process operations for the FF/ST NQTL. One measure is linked to monitoring of claims data--*utilization trends*. Although the FFS Program does not monitor this NQTL using a formal inter-rater reliability survey, it does conduct *internal auditing of prior authorizations to determine compliance of treatment/service plans for drug efficacy based on concurrent review of treatment plans, service usage, and drug utilization and type* and monitor *the level of documentation (e.g., chart notes, lab results, treatment plans, etc.) the health plan requires from providers during review* as means of oversight.

These same measures are in place through the FFS Program for the M/S drug benefit.

All but two (MPC, and Priority) report use of data reporting to monitor this NQTL. Examples include *utilization trends*, *dollar spend trends*, and *authorization denial rates*. Seven MCOs (Aetna, Amerigroup, CF, Jai, MedStar, MPC, and Priority) also identify use of *inter-rater reliability surveys*. KP and UHC also report monitoring *the frequency with which reviews are conducted*, while CF monitors *prior authorization statistics*.

5. Summary/Parity Assessment--Prescription Benefits-Medical Necessity (MNC) NQTL

MDH determined that parity exists for the Prescription Benefits MNC NQTL, as it is utilized for the MH, SUD, and M/S Prescription benefits classifications. The definitions of the factors used by the ASO for both MH and SUD benefits are comparable to and no more stringent to those used by the MCOs/FFS Program for M/S benefits. The processes, strategies, and evidentiary standards used to apply MNC to both MH and SUD Prescription Benefits are comparable to, and no more stringently applied than, the processes, strategies, and evidentiary standards used to apply MNC requirements to M/S Prescription benefits.

c. Prescription Benefits--Prior Authorization

1. Definition of Prescription Benefits-Prior Authorization (PA) NQTL

The approval required from the Department or its designee (including the MCO) before a service can be rendered by the provider and reimbursed.

2. Benefits Subject to Prescription Benefits-Prior Authorization (PA) NQTL

The FFS Program reports applying the PA NQTL to some, but not all drugs in the MH Prescription Benefits Classification and to some but not all drugs in the SUD Prescription Benefits Classification.

The 9 MCOs report applying PA to all of their M/S prescription benefits.

Additionally, the FFS Program reports applying the PA NQTL to all M/S drugs paid for on a FFS basis.

Please refer to the report for each benefit administered to participants for each MCO to review the specific Prescription benefits subject to PA (Appendix F).

3. In-writing comparability and stringency--Prescription Benefits-Prior Authorization (PA) NQTL

The factors the FFS Program relies on in deciding to apply, and designing this NQTL to MH and SUD drug benefits are identical and defined identically for both the MH and SUD classifications.

Specifically, the FFS Program reports one factor intended to ensure the medical necessity of a service, *clinical appropriateness/medical necessity* based on several evidentiary standards, including professionally recognized treatment guidelines, medical literature reviews, as well as FDA Prescribing Information & Official Compendium. The FFS Program also identifies a single factor that encompasses elements of both cost/utilization control and validating medical necessity, *Fail-first protocol or requirement to try a generic, less expensive, or lower efficacy drug for a certain trial period before receiving approval for a new drug*, based on several evidentiary standards, including professionally recognized treatment guidelines, medical literature reviews, as well as FDA Prescribing Information & Official Compendium

The FFS Program is also responsible for delivery of select M/S pharmacy therapies to the HealthChoice population. The same factor the FFS Program identifies for MH and SUD benefits is relied upon for M/S drugs. The factors are defined identically.

The factors the MCOs rely in the design of this NQTL are comparable to and at least as stringent as those used by the FFS Program for MH and SUD drugs. All MCOs (except Aetna) report at least one factor considered in the design of the NQTL that can be categorized as focused on controlling costs and utilization and all MCOs report at least one factor focused on validating medical necessity of the benefits.

All MCOs report one or more factors considered in the design of the NQTL that can be categorized as focused on establishing medical necessity in compliance with evidentiary standards related to recognized treatment guidelines in a manner that is comparable to and at least as stringent as the factors upon which the ASO/BHA relies. Most factors the MCOs identify that fall under this type of categorization are directly named and defined in relation to the review of clinical treatment criteria (e.g., *clinical indications and/or evidence, Clinical and Practice Guidelines, industry standards, lack of adherence to quality standards, lack of clinical efficiency of treatment or service, meets evidenced based clinical criteria for medical necessity; patient safety; recognition of accreditation by certain accrediting bodies; safety risks; and severity or chronicity of illness* (Aetna-does the medication match severity of the illness; Amerigroup-severity and length of time of an illness), and *utilization patterns*. KP also identifies *Medicare/Medicaid Program Participation eligibility* as a factor, which it defines in relation to medical necessity standards ("KPMAS Regional P&T Committee is allowed to establish PA's and PA criteria for any drug covered by KPMAS as long as it does not conflict with PA criteria established by Maryland Department of Health. Pharmacy service authorization will include medical necessity determinations for coverage under the pharmacy benefit for drugs that have the Maryland Department of Health approved prior authorization criteria. All applicable federal, state and local jurisdiction mandates shall supersede P&T decisions, recommendations and guidelines.").

All but one MCO (Aetna) identify factors related to cost/utilization control. The factors the MCOs identify related to cost/utilization control include *administrative burden/cost; appropriateness of utilization* (Priority-based on medical necessity and efficient service use); *claim types with a high percentage of fraud*; availability of clinically similar lower cost medications to treat the condition; *current and projected demand for services; elasticity of demand; fiscal responsibility; high variability in cost per episode of care; and recent medical cost escalation - Pharmacy*. Therefore, the MCOs are relying on some factors that are potentially more stringent than the

factors used by the ASO in the same classification.

Certain MCOs define a factor in a way that encompasses both validating medical necessity and cost/utilization management. Priority defines the factor *appropriateness of utilization* as “Utilization based on medical necessity, and efficient use of healthcare services and facilities as directed by the Plan benefits.” The factor *excessive utilization* also encompasses elements of both cost/utilization control as well as medical necessity as defined by each of the MCOs. Amerigroup indicates that it monitors aggregated data or non-identifiable utilization reports to detect and correct potential under-and over-utilization in comparison to benchmark and comparative data sources based on medical expert review in tandem with internal claims and internal market and competitive analysis. Similarly, KP defines the *excessive utilization* factor for this NQTL as follows: “Excessive utilization is determined by one or more of the following considerations: significant potential for inappropriate use, narrow safety margin, requires specialty expertise, reserved for second or third line therapy, actual or potential short supply, medication safety concerns, or potential for waste or diversion associated with high cost.” MedStar defines the factor *excessive utilization* as “the potential to be used for cosmetic purposes that are not medically necessary....the potential for off-label use that is not medically necessary (ex. Viagra) or a potential for abuse (ex. controlled substances greater than 90 MMEs)” and identifies use of FWA software to identify outliers. MedStar defines the factor *lack of clinical efficiency of treatment or service* as “Pre authorization, concurrent review, or retrospective review may be required to ensure that procedure/service is performed at most appropriate level of care or that the least costly (dollars or clinical impact) medication has been prescribed and/or that more conservative treatment has been tried and failed, or medication is medically appropriate for the condition.” With respect to *medical necessity*, in addition to being defined according to whether a service met Interqual Criteria, Jai’s definition also encompasses considerations for costs “Is this the safest, cheapest option of covered services available for this situation?”

4. In-operation comparability and stringency--Prescription Benefits-Prior Authorization (PA) NQTL

The FFS Program reports use of three measures for monitoring in-operation processes for the PA NQTL. One measure is linked to monitoring of claims data--*utilization trends*. Although the FFS Program does not monitor this NQTL using a formal inter-rater reliability survey, it does conduct *internal auditing of prior authorizations to determine compliance of treatment/service plans for drug efficacy based on concurrent review of treatment plans, service usage, and drug utilization and type and monitor the level of documentation (e.g., chart notes, lab results, treatment plans, etc.) the health plan requires from providers during review* as means of oversight.

These same measures are in place through the FFS Program for the M/S drug benefit.

All nine MCOs report use of data reporting to monitor this NQTL. Examples include *utilization trends, dollar spend trends, and authorization denial rates*. Four MCOs (Amerigroup, CF, Jai, Priority) also identify use of *inter-rater reliability surveys*. KP and MedStar also report monitoring *the frequency with which reviews are conducted*, while CF monitors *prior authorization statistics*.

5. Summary/Parity Assessment--Prescription Benefits-Prior Authorization (PA) NQTL

MDH determined that parity exists for the Prescription Benefits PA NQTL, as it is utilized for the MH, SUD, and M/S Prescription Benefits classifications. The definitions of the factors for the FFS Program for the MH and SUD Prescription Benefits classification were comparable to and no more stringent than those used for the FFS Program and MCOs for the M/S Prescription Benefits classification. The processes, strategies, and evidentiary standards used to apply PA to both MH and SUD Prescription Benefits are comparable to, and no more stringently applied than, the processes, strategies, and evidentiary standards used to apply PA requirements to M/S Prescription Benefits.

d. Prescription Benefits--Tiered Drug Formulary

1. Definition of Prescription Benefits-Tiered Drug Formulary (TDF) NQTL

Tiered drug formularies involve groupings of drugs subject to different levels of cost-sharing or utilization management, such as prior authorization or step-therapy protocol requirements.

2. Benefits Subject to Prescription Benefits-Tiered Drug Formulary (TDF) NQTL

The FFS Program reports applying the TDF NQTL to all drugs in the MH Prescription Benefits Classification and to all drugs in the SUD Prescription Benefits Classification.

The 9 MCOs report applying TDF to all of their M/S prescription benefits.

Additionally, the FFS Program reports applying the TDF to all M/S drugs paid for on a FFS basis.

3. In-writing comparability and stringency-- Prescription Benefits-Tiered Drug Formulary (TDF) NQTL

The factors the FFS Program relies upon in deciding to apply and designing this NQTL to MH and SUD drug benefits are identical and defined identically for both the MH and SUD classifications. Specifically, the FFS Program reports two factors intended to ensure the medical necessity of a service, *clinical appropriateness/medical necessity* and *Medication status on Preferred Drug List (PDL) as determined by the Preferred Drug Program via recommendations by the Pharmacy & Therapeutics (P&T) Committee*. Both factors rely on identical evidentiary standards, including professionally recognized treatment guidelines, medical literature reviews, as well as FDA Prescribing Information & Official Compendium. The FFS Program also identifies a single factor related to cost/utilization control, *fiscal responsibility/cost effectiveness*, which it defines as "Examination of a drug's actual cost and rebateable status for the State with an emphasis on cost conservation and reduction of waste for the Department while still maintaining the accessibility of care to participants." The FFS Program did not report that *the potential to collect revenues through cost-sharing* is a factor in the development of the TDF NQTL.

The FFS Program is also responsible for delivery of select M/S pharmacy therapies to the HealthChoice population. The same factors the FFS Program identifies for MH and SUD

benefits by the FFS Program are also relied upon for M/S drugs. The factors are defined identically. The factors the MCOs rely upon in the design of this NQTL are comparable to and at least as stringent as those used by the FFS Program for MH and SUD drugs in definition. All MCOs report at least one factor considered in the design of the NQTL that can be categorized as focused on controlling costs and utilization and at least one factor focused on validating medical necessity of the benefits. None of the MCOs report that *the potential to collect revenues through cost-sharing* is a factor in the development of the TDF NQTL.

All but one MCO (UHC) report one or more factors considered in the design of the NQTL that can be categorized as focused on validating medical necessity in compliance with evidentiary standards related to recognized treatment guidelines. Most factors the MCOs identify that fall under this type of categorization are directly named and defined in relation to the review of clinical treatment criteria (e.g., *clinical appropriateness; clinical efficacy; clinical effectiveness; clinical literature; clinical practice guidelines and recommendations; FDA Drug Information; industry standards; lack of adherence to quality standards; lack of clinical efficiency of treatment or service; Medispan; National Practice Guidelines; recognition of accreditation by certain accrediting bodies; safety profile; safety risks, and severity or chronicity of an illness* (Aetna, Amerigroup).

All but one MCO (MPC) identify factors related to cost/utilization control including *absence of formulary alternative or failure to respond to formulary medication; claim types with high percentage of fraud; cost effectiveness; current and projected demand for service; elasticity of demand fiscal responsibility; high variability in cost per episode of care; impact of drug on overall medical resource utilization and cost; provider discretion- diagnosis; provider discretion-type or length of treatment; and recent medical cost escalation*. Therefore, the MCOs are relying on some factors that are potentially more stringent than the factors used by the ASO in the same classification.

Certain MCOs define a factor in a way that encompasses both validating medical necessity and cost/utilization management. The factor *excessive utilization* also encompasses elements of both cost/utilization control as well as medical necessity as defined by each of the MCOs. Amerigroup indicates that it monitors aggregated data or non-identifiable utilization reports to detect and correct potential under-and over-utilization in comparison to benchmark and comparative data sources based on medical expert review in tandem with internal claims and internal market and competitive analysis. Similarly, KP defines the *excessive utilization* factor for this NQTL as follows: "Excessive utilization is determined by one or more of the following considerations: significant potential for inappropriate use, narrow safety margin, requires specialty expertise, reserved for second or third line therapy, actual or potential short supply, medication safety concerns, or potential for waste or diversion associated with high cost." MedStar defines *excessive utilization* as "the potential to be used for cosmetic purposes that are not medically necessary....the potential for off-label use that is not medically necessary (ex. Viagra) or a potential for abuse (ex. controlled substances greater than 90 MMEs" and identifies use of FWA software to identify outliers. MedStar defines the factor *lack of clinical efficiency of treatment or service* as "Pre authorization, concurrent review, or retrospective review may be required to ensure that procedure/service is performed at most appropriate level of care or that the least costly (dollars or clinical impact) medication has been prescribed and/or that more

conservative treatment has been tried and failed, or medication is medically appropriate for the condition.”

4. In-operation comparability and stringency--Prescription Benefits-Tiered Drug Formulary (TDF) NQTL

The FFS Program reports use of three measures for monitoring in-operation processes for the PA NQTL. One measure is linked to monitoring of claims data--*utilization trends*. Although the FFS Program does not monitor this NQTL using a formal inter-rater reliability survey, it does conduct *internal auditing of prior authorizations to determine compliance of treatment/service plans for drug efficacy based on concurrent review of treatment plans, service usage, and drug utilization and type and monitor the level of documentation (e.g., chart notes, lab results, treatment plans, etc.) the health plan requires from providers during review as means of oversight*.

These same measures are in place through the FFS Program for the M/S drug benefit.

All MCOs report use of data reporting to monitor this NQTL. Examples include *utilization trends, dollar spend trends, and authorization denial rates*. Two MCOs (Amerigroup and CF) also identify use of *inter-rater reliability surveys*. MedStar also reported monitoring the *type and level of documentation (e.g., chart notes, lab results, treatment plans, etc.) the health plan requires from providers during reviews*. UHC monitors the *frequency with which reviews are conducted*, while CF monitors *prior authorization statistics*.

5. Summary/Parity Assessment--Prescription Benefits-Tiered Drug Formulary (TDF) NQTL

MDH determined that parity exists for the Prescription Benefits TDF NQTL, as applied to MH, SUD, and M/S benefits. The definitions of the factors used for the FFS Program for the MH and SUD Prescription benefits classification were comparable to and no more stringent to those used for the FFS Program and MCOs for the M/S Prescription benefits classification are comparable and no more stringent. The processes, strategies, and evidentiary standards used to apply TDF to both MH and SUD Prescription Benefits are comparable to, and no more stringently applied than, the processes, strategies, and evidentiary standards used to apply TDF requirements to M/S Prescription Benefits.

IV. Conclusions and Next Steps

MDH found that in nearly all areas addressed by this analysis, MH/SUD benefits are being delivered and managed in a comparable and no more stringent manner to the way M/S benefits are managed. In particular, there are no AL/ADL in place for any benefits. Based on CMS' directive that waiver of co-pays by certain MCOs results in a FR that fails the substantially all test, MDH is committed to working with MCOs to eliminate the option to voluntarily waive drug co-pays for M/S drugs within 60 days of the end of the COVID-19 PHE. This requirement is included in MCO contract language for CY 2022. MCOs will require time in order to operationalize the change and make needed system updates. There are no QTLs relevant to the parity analysis on any MH or SUD benefits. In addition, as described in detail above, all NQTL types analyzed are being implemented in a comparable and no more stringent manner for MH/SUD and M/S services in the emergency, inpatient, and prescription drug classifications.

The analysis raised two areas of concern with respect to the application of NQTLs to outpatient benefits: Data Collection (DC) and Service Limitations (SL). Additionally, MDH has identified the provider reimbursement rate methodology as an NQTL that will require further analysis in future reports following completion of a planned rate study. In addition, MDH plans to strengthen the existing alignment between the in-operation comparability and stringency for the different benefits classifications in the coming months. Updates to this report will continue to be issued on an annual basis on October 1.

A. Potential Parity Violations

MDH identified two potential parity violations with respect to the delivery of outpatient benefits: Data Collection and Service Limits.

1. Data Collection (DC)

MDH's prior reports identified DC requirements as a potential parity violation. To remedy this potential issue, MDH commenced a stakeholder process in September 2018 to determine the best pathway to ensure the continued completeness and utility of the data collection system while minimizing the risk of violating MHPAEA. MDH used these forums to solicit input from the provider community and the broader public. Following re-procurement of the ASO contract in 2019, MDH has now addressed the concerns raised. Mandatory completion of the ASO Data Capture Form was phased out beginning August 30, 2020, and made optional for all levels of care effective September 11, 2020. Medicaid and BHA are engaged in ongoing discussion regarding opportunities to incentivize data collection going forward now that it is no longer required for any services as a condition of the preliminary or continued authorization of services and payment to the MH and SUD providers and are seeking guidance from CMS.

2. Service Limitations (SL)

The ASO reported applying the SL NQTL to some but not all MH and some but not all SUD benefits in the outpatient benefits classification. The SL NQTL is not used for the M/S benefits administered by most MCOs, with the exception of MedStar and UHC, or by the FFS Program.

Specific service limitations in place at the time of this report are included in Appendix G. The SL in place are longstanding and have been in place at MDH's direction since prior to the beginning of the new ASO contract in 2020. These limitations are currently hard edits in both the ASO and MDH systems. This means that when two providers bill for the same service on the same day, the claim is automatically denied for the second provider to bill. Current system edits prevent this limit from being overridden on the basis of medical necessity.

As noted above, based on discussions with the MCOs, most impose all the coding edits called for under the NCCI, and this process results in the use of a significant number of administrative quantitative coverage edits on M/S benefits that are substantively analogous to the SLs in place for MH/SUD services. In effect, the exclusion of the NCCI from the NQTL analysis results in the creation of a per se parity violation that likely would not exist if the NCCI were analyzed as an NQTL. MDH raised this concern in its last report and awaits further guidance from CMS on how best to address this unique situation and potential per se parity violation. MDH believes that the SLs in place for MH/SUD services are comparable and no more stringent to the NCCI edits applied to M/S benefits by all the MCOs.

In addition, MDH in partnership with the ASO will be reviewing all services implicated by the limitations to assess whether it may be separately appropriate to make policy changes to the SLs, such as establishing a process for medical necessity exceptions.

B. Other Issues Identified for Future Reports

1. Provider Rates

MDH recognizes that the provider rate setting methodology is an NQTL type that is subject to parity analysis, but has not been addressed in this report. MDH began preliminary data collection from the MCOs with respect to this NQTL as part of the reporting process for this analysis. Information collected from the MCOs varied in quality and will need to be supplemented further for inclusion in future reports. Rates for services delivered on a FFS basis by MCOs are typically benchmarked against Medicare.

Pursuant to the requirements of *HB1329/SB967—Heroin & Opioid Prevention Effort (HOPE) & Treatment Act of 2017 (Chs. 571 and 572 of the Acts of 2017)*, MDH must conduct an independent cost-driven, rate-setting study to set community provider rates for community-based behavioral health services that includes a rate analysis and an impact study that considers the actual cost of providing community-based behavioral health services. This study will be conducted in two stages through two Requests for Proposals (RFPs). The first is to select a contractor to develop cost reports for community behavioral health providers and provide related technical assistance. The RFP for the first proposal was first issued on July 1, 2022 and a contractor had not yet been selected as of the time of this report.¹⁵ The rate study itself and implementation of the resulting rates will comprise the second phase of the project and occur at a later date. MDH will take steps to ensure that the rate setting methodology developed pursuant to HB1329/SB967 complies with the parity requirements of the Final Rule.

¹⁵ See Public Solicitations on eMMA, MDH/OCMP-22-19518 Behavioral Health Rate Setting, <https://emma.maryland.gov/>.

To effectuate this, MDH will continue to collect NQTL information from the MCOs on the reimbursement rate methodology NQTL in order to provide a guardrail for the rate setting process under HB1329/SB967. This will ensure that the processes, strategies, sources, evidentiary standards, and other factors relied upon by MDH in developing and implementing the new rates are comparable to and no more stringent to those in use by the MCOs and M/S FFS program for the same classification.

2. In-operation comparability and stringency analysis and oversight

The ASO, MCOs, and FFS Program consistently reported use of both claims data and internal audits or inter-rater reliability assessments when monitoring NQTLs in operation across all benefits classifications. In order to improve alignment and uniformity of the measures in use across the system of care, MDH plans to develop a core set of operations measures to be monitored by the ASO, MCOs, and FFS Program.

MDH has begun the process of creating a framework of commonly-used factors and operations measures in order to increase the consistency of approaches to designing, implementing, and monitoring NQTLs across the MCOs, FFS Program, and the ASO. The use of consistently defined factors are essential to a comparability and stringency analysis across delivery systems. For example, MDH will provide consistent definitions for concepts such as cost escalation and fraud risk that are used as factors to determine if/how to apply NQTLs to particular benefits.

Similarly, the use of consistently defined operations measures is necessary to ensure that metrics for monitoring each NQTL are consistent across the MCOs, FFS program, and ASO which is necessary to perform a comparability and stringency analysis in-operation. These measures will include items like denial rates, appeal overturn rates, etc. that are used to monitor the in-operation of NQTL analyses. MDH hopes to be able to report on these changes in the 2022 report.

C. Ongoing Monitoring

MDH will review the parity analysis on an annual basis to determine whether MH and SUD benefits continue to meet parity requirements. Any changes to the state plan or waivers that impact MH and SUD benefits will be reviewed for compliance. MDH will also conduct reviews on an ad hoc basis as needed in response to concerns raised by stakeholders and complaints filed by participants.

Appendices

Appendix A: Resource Documents

Appendix A1. Maryland Medicaid Parity Definitions

Appendix A2. Maryland Medicaid Factors Guide

Appendix B. Benefits Mapping (Standards 5 & 8)

Appendix B1. Benefits Mapping (IP, OP, Emergency), by Benefit Package and Delivery System (Standard 5)

Appendix B2. Benefits Mapping and NQTLs Subject to Parity Analysis Crosswalk, by Delivery System (Standard 8)

Appendix C. NQTL Overview, by Classification and Delivery System (Standard 8)

Appendix D. NQTL In-Writing Comparability and Stringency Factors Crosswalk, by NQTL and Classification (Standard 9)

Appendix E. NQTL In-Operation Comparability and Stringency Measures Crosswalk (Standard 10)

Appendix E1. Measures Used to Monitor NQTLs In-Operation, by Delivery System

Appendix E2. Supporting Documentation Reported for Measures Used to Monitor NQTLs In-Operation, by Delivery System

Appendix F. Prescription Drugs Subject to NQTLs, by Delivery System

Appendix F1. Aetna Better Health (Aetna)

Appendix F2. Amerigroup Community Care (Amerigroup)

Appendix F3. CareFirst Blue Cross Blue Shield (CF) Appendix

F4. Jai Medical Systems (Jai)

Appendix F5. Kaiser Permanente (KP) Appendix

F6. Maryland Physicians Care (MPC) Appendix

F7. MedStar Family Choice (MedStar) Appendix

F8. Priority Partners (Priority) Appendix F9.

UnitedHealthcare (UHC)

Appendix F10. Fee-for-Service Program (MH, SUD, M/S)

Appendix G. MH and SUD Services Subject to Service Limitations (SL) NQTL

Appendix H. Parity Manager Reports

Reports are inclusive of all information reported across the system of care with the exception of prescription drug information, which is also addressed in Appendix F.

Appendix H1. Aetna Better Health (Aetna)

Appendix H2. Amerigroup Community Care (Amerigroup)

Appendix H3. CareFirst Blue Cross Blue Shield (CF)

Appendix H4. Jai Medical Systems (Jai)

Appendix H5. Kaiser Permanente (KP)

Appendix H6. Maryland Physicians Care (MPC)

Appendix H7. MedStar Family Choice (MedStar)

Appendix H8. Priority Partners (Priority)

Appendix H9. UnitedHealthcare (UHC)