Oregon Health Authority
2026 Mental Health Parity Evaluation
Treatment Limitation Review Tool
Guidance Document

1. Overview

Mental Health Parity (MHP) regulations are intended to ensure that coverage and access to services for the treatment of mental health (MH) and substance use disorder (SUD) conditions are provided in parity with treatments provided for medical and surgical (M/S) conditions. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) governs how MH/SUD treatments delivered by managed care organizations and limitations on MH/SUD benefits must be comparable to and applied no more stringently than the limitations applied to M/S benefits. Provisions of the MHPAEA became applicable to the Oregon Health Plan (OHP) in October 2017 when the Medicaid Parity Final Rule (42 Code of Federal Regulations [CFR] §438 Subpart K) went into effect. The rule requires parity in the following key areas:

- Aggregate lifetime and annual dollar limits (AL/ADLs)
- Financial requirements (FRs)—e.g., copays
- Quantitative treatment limitations (QTLs)—e.g., day and visit limits
- Non-quantitative treatment limitations (NQTLs)—e.g., prior authorization

Additional MHP regulations require that criteria for medical necessity determinations for MH/SUD benefits be made available to beneficiaries and providers upon request, as well as the reason for denial of reimbursement or payment for MH/SUD benefits.

The 2026 MHP Treatment Limitation Tool was designed to standardize and improve the Coordinated Care Organizations' (CCOs') and Oregon Health Plan Fee-for-Service's (OHP FFS') documentation of compliance with MHP requirements specifically targeting the collection of information on CCO/OHP FFS policies, procedures, and practices that may affect parity in the administration of MH/SUD and M/S benefits. The following document has been prepared to provide additional guidance on completing the tool to ensure complete and accurate submission of all information. The guidance document includes general guidance in completing the tool, definitions for key MHP concepts, and expectations for addressing each element.

As you complete your responses and submit required documentation, please do not hesitate to reach out to HSAG's MHP Evaluation lead, Stacy Wittkamper at swittkamper@hsag.com.

2. General Guidance

The MHP Treatment Limitation Review Tool is a required, fillable Word document that allows CCOs and OHP FFS to identify all treatment limitations used by the organization to manage MH/SUD and M/S benefits for inpatient (IP), outpatient (OP), pharmacy (Rx), and emergency care (EC) services. Each respective section (i.e., FR, AL/ADL, QTL or NQTL) will require documentation on whether the treatment limitation is used by the organization and applied to MH/SUD and M/S benefits.

Below are key considerations when preparing and submitting responses in the MHP Treatment Limitation Tool.

- All responses, data, and information provided in the tool should be associated with the following measurement period: **Calendar Year (CY) 2025, January 1, 2025 – December 31, 2025.**
- Do not alter the formatting or file type of the MHP Treatment Limitation Review Tool.
- Do not embed documents in the MHP Treatment Limitation Review Tool. All supporting documents must be submitted as separate documents and posted to HSAG's Secure Access File Exchange (SAFE) site at https://safe.hsag.com/Home. Be sure to clearly list all supplemental documentation in the MHP Treatment Limitation Review Tool and clearly label uploaded files.
- Only include documents that are relevant to the specific requirement. **The organization should not submit policies or other supplemental documentation that does not specifically relate to treatment limitations (i.e., FR, AL/ADL, QTL, or NQTL) and service classification (IP, OP, Rx, and EC) being addressed; any unrelated policies should not be included.**
- Indicate precisely which components, paragraphs, or pages directly support narrative responses or demonstrate compliance.
- All questions and elements must be answered.
- The gray text box (i.e., Click to Enter Description) will expand automatically when listing supporting documentation and providing descriptive responses.
- All supplemental documentation provided in support of this tool should be associated with the designated review period—**CY 2025**.

Please Note: If a CCO would like HSAG to use documentation previously submitted for the Compliance Monitoring Review activity as part of the MHP NQTL review, please identify the applicable standard, document title, and relevant page numbers that address the MHP Treatment Limitation tool element.

Benefits and Services

OHA's *Guide to Mapping Oregon Medicaid Benefits and Services* (updated February 25, 2022) should be used as the basis for defining mental health (MH), substance use disorder (SUD) and medical/surgical

(M/S) benefits, and classifying inpatient (IP), outpatient (OP), pharmacy (Rx), and emergency care (EC) services.

Available at:
https://www.oregon.gov/oha/HSD/OHP/Tools/Guide%20to%20Mapping%20Oregon%20Medicaid%20Benefits%20and%20Services.pdf.

Definitions

- **Benefits**
  - **Mental health (MH):** benefits for items or services related to mental health conditions classified under ICD-10 Chapter 5 (F), specifically diagnostic codes F01-F09 and F20-F99
  - **Substance use disorder (SUD):** benefits for items or services related to substance use disorder conditions classified under ICD-10 Chapter 5 (F), specifically diagnostic codes F10-F19
  - **Medical/surgical (M/S):** benefits for items or services related to medical conditions or surgical procedures classified in ICD-10, excluding services for conditions classified under ICD-10 Chapter 5 (F)
- **Service Classifications**
  - **Emergency care (EC):** covered inpatient and outpatient services that are as follows: (1) furnished by a provider that is qualified to furnish these services, and (2) needed to evaluate or stabilize an emergency medical condition (based on 42 CFR §438.114)
  - **Inpatient (IP):** covered services or items (including medications) provided to a member while in a setting (other than home and community-based setting as defined in 42 CFR Part 441) that requires an overnight stay (based on 42 CFR §440.2)
  - **Outpatient (OP):** covered services for a member received from a practitioner, clinic or facility, or distinct part of that facility who is expected to receive and who does receive professional services for less than a 24-hour period regardless of the hour of admission, whether or not a bed is used, or whether or not the patient remains past midnight. Outpatient includes all covered services that do not otherwise meet the definition of inpatient, emergency care, or prescription drugs. (based on 42 CFR §440.2)
  - **Prescription Drug (Rx):** simple or compound substances or mixtures of substances prescribed for the cure, mitigation, or prevention of disease, or for health maintenance that are: (1) Prescribed by a physician or other licensed practitioner of the healing arts within the scope of this professional practice as defined and limited by Federal and State law; (2) Dispensed, in an outpatient pharmacy, by licensed pharmacists and licensed authorized practitioners in accordance with the State Medical Practice Act; and (3) Dispensed, in an outpatient pharmacy, by the licensed pharmacist or practitioner on a written prescription that is recorded and maintained in the pharmacist's or practitioner's records. (based on 42 CFR §440.120)

Written Design and Application of NQTL

Demonstration of parity, or assuring the comparability and stringency of NQTLs applied to MH/SUD and M/S benefits, **as written** means that CCOs and OHP FFS are required to provide details on the strategies, evidentiary standards, and factors that are used in the design and application of an NQTL.[1]

Operational Application of NQTL

Demonstration of parity, or assuring the comparability and stringency of NQTLs applied to MH/SUD and M/S benefits, **in operation** means that CCOs and OHP FFS are required to evaluate outcomes that result from the application of NQTLs to explain:

- material differences in outcomes, AND
- the basis for concluding that differences in outcomes **are not** attributed to differences in comparability or relative stringency of the NQTL.

This evaluation includes the analysis of measures that have been or are being implemented to mitigate any material differences in access with respect to MH/SUD benefits as compared to M/S benefits.[2]

Additional resources include:

- Employee Benefits and Executive Compensation Advisory, August 29, 2023, Alston and Bird
- Federal Register, Requirements Related to the Mental Health Parity and Addiction Equity Act, September 23, 2024
- Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA)

[1] Office of the Federal Register, National Archives and Records Administration, "Requirements Related to the Mental Health Parity and Addiction Equity Act," Federal Register, 89 FR 77586, Sept. 23, 2024, https://www.govinfo.gov/app/details/FR-2024-09-23/2024-20612. Last Accessed: February 27, 2026.
[2] Office of the Federal Register, National Archives and Records Administration, "Requirements Related to the Mental Health Parity and Addiction Equity Act," Federal Register, 89 FR 77586, Sept. 23, 2024, https://www.govinfo.gov/app/details/FR-2024-09-23/2024-20612. Last Accessed: February 27, 2026.

3. Tx Limitation Tool Guidance

The following section contains specific guidance on each part of the **MHP Treatment Limitation Tool**, and provides key definitions for each limitation, guidance on responding to each element within the tool, and specific notes to regarding response expectations.

Section 1 – Organization Information

Information provided in this section by the CCOs and OHP FFS is used to track organization submissions, resubmissions, and any clarifying comments regarding the organization's submission(s).

Response Guidance

See Table 1 for guidance on responding to *Section 1 – Organization Information*.

Table 1—Organization Information Elements and Response Guidance

Element	Response Guidance
Organization Name	Use the drop-down arrow to select your CCO or OHP FFS.
Submitter Name	Enter the name of primary point-of-contact for the CCO's/OHP FFS' responses.
Submitter Email Address	Enter the email address of the primary POC.
Date of Submission	Enter the date the MHP Tx Limitation Review Tool was uploaded to SAFE.
Initial Submission	Enter "Yes" or "No"
Resubmission Reason	If an updated MHP Tx Limitation Review Tool is resubmitted and uploaded to SAFE, please provide a brief reason for the resubmission. This information is used to focus HSAG's review of the revised material(s).
Comments	Enter any clarifying text you feel is appropriate to address the content, format, or structure of your responses within the tool; this includes any caveats relevant to the information being provided.

Section 2 – Financial Requirements

Information provided in this section by the CCOs and OHP FFS is used to assess whether the CCOs/OHP FFS have designed and implemented any financial requirements for MH/SUD and M/S benefits for any classification of service—i.e., inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC).

Definition

Financial Requirements (FRs): payments by members for services received that are in addition to payments made by the State or CCO (e.g., co-payments and deductibles).

Response Guidance

See Table 2 for guidance on responding to *Section 2 – Financial Requirements*.

Table 2—FR Elements and Response Guidance

Element	Question
1	Does your organization apply any **FRs** to mental health/substance use disorder (MH/SUD) and/or medical/surgical (M/S) benefits for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services? **Response Guidance** • Mark "**No**" if your organization does not apply any FRs to MH/SUD or M/S benefits for any classification of services—i.e., IP, OP, Rx, or EC. • Mark "**Yes**" if your organization applies FRs to MH/SUD, M/S, or both types of benefits for any classification of services. Use the additional check boxes to indicate whether the FRs are applied to: – M/S benefits only – MH/SUD benefits only – MH/SUD and M/S benefits **Note(s)** • If "**No**" FRs are used by the organization, or if FRs are applied to **M/S benefits only**, skip to *Section 3 – Aggregate Lifetime or Annual Dollar Limits,* otherwise, the organization must answer Element 2.

Element	Question
2	Please describe how your organization ensures that the implementation of **FRs** meets parity requirements; provide evidence that demonstrates your compliance. **Response Guidance** If the organization applies any FRs to MH/SUD benefits, it must describe how it ensures parity in the design and implementation of those FRs. This explanation must include the method used to confirm that FRs applied to MH/SUD benefits are no more restrictive than the **predominant** FR of that type that applies to **substantially all** M/S benefits in the same classification[3], where: • **predominant** refers to FRs where the level (or magnitude) of the type of FR (e.g., copayment) applied to MH/SUD benefits applies to more than one-half of the FRs (or payments) for M/S benefits within the same classification, and • **substantially all** refers to FRs where the type of FR applied to MH/SUD benefits applies to at least two-thirds of the expected payments in a year for all M/S benefits of the same classification. **Note(s):** • Separate deductibles or financial requirements that only apply to MH/SUD benefits **are not** permitted. • Consistent with the OHP regulatory framework, it is not expected that CCOs or OHP FFS will apply FRs in the administration of MH/SUD and M/S benefits across services.

[3] Centers for Medicare & Medicaid Services. *Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children's Health Insurance Programs*, January 17, 2017. Available at: https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf. Accessed on: January 20, 2026.

Section 3 – Aggregate Lifetime or Annual Dollar Limits

Information provided in this section by the CCOs and OHP FFS is used to assess whether the CCOs/OHP FFS have designed and implemented aggregate lifetime (AL) or annual dollar limits (ADLs) for MH/SUD and M/S benefits for any classification of service—i.e., inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC).

Definition

Aggregate Lifetime or Annual Dollar Limits (AL/ADLs): dollar limits on the total amount of a specified benefit that may be paid over a lifetime (e.g., gender transformation surgeries up to a maximum of $25,000 lifetime), or during a 12-month period (e.g., coverage for SUD residential treatment services up to $20,000/year).

Response Guidance

See Table 3 for guidance on responding to *Section 3 – Aggregate Lifetime or Annual Dollar Limits*.

Table 3—AL/ADL Elements and Response Guidance

Element	Question
1	Does the organization apply an **AL** or any **ADLs** to mental health/substance use disorder (MH/SUD) and/or medical/surgical (M/S) benefits for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services? **Response Guidance** • Mark "**No**" if your organization does not apply an AL or any ADLs to MH/SUD or M/S benefits for any classification of services—i.e., IP, OP, Rx, or EC. • Mark "**Yes**" if your organization applies an AL or any ADLs to MH/SUD, M/S, or both types of benefits for any classification of services. Use the additional check boxes to indicate whether the AL/ADLs are applied to: – M/S benefits only – MH/SUD benefits only – MH/SUD and M/S benefits **Note(s)** • If "**No**" AL/ADLs are used by the organization, or the AL/ADLs are applied to **M/S benefits only**, skip to *Section 4 – Quantitative Treatment Limitations,* otherwise, the organization must answer Element 2.

Element	Question
2	Please describe how your organization ensures that the implementation of **AL/ADLs** meets parity requirements; provide evidence that demonstrates your compliance. **Response Guidance** If the organization applies any AL/ADLs to MH/SUD benefits, it must describe how it ensures parity in the design and implementation of those AL/ADLs. This explanation must include the method used to confirm that AL/ADLs: • are not imposed on MH/SUD benefits when AL/ADLs of the same type and classification apply to less than one-third of expected payments for M/S benefits, or • when the AL/ADLs apply to at least two-thirds of all expected payments for M/S benefits in a year, – are applied equally to MH/SUD and M/S benefits, or – is not applied more restrictively than the AL/ADLs applied to M/S benefits. **Note(s):** • Consistent with the OHP regulatory framework, it is not expected that CCOs or OHP FFS will apply AL/ADLs in the administration of MH/SUD and M/S benefits across services.

Section 4 – Quantitative Treatment Limitations

Information provided in this section by the CCOs and OHP FFS is used to assess whether the CCOs/OHP FFS have designed and implemented quantitative treatment limitations (QTLs) for MH/SUD and M/S benefits for any classification of service—i.e., inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC).

Definition

Quantitative Treatment Limitations (QTLs): Absolute limits on the scope or duration of a benefit that are expressed numerically (e.g., 120-day limit on inpatient SUD treatment).

- Please note that soft limits, or QTLs that allow for an individual to exceed defined numerical limits for M/S or MH/SUD benefits based on medical necessity, are considered *non-quantitative treatment limitations* (NQTLs) and should not be reported in this section.

Response Guidance

See Table 4 for guidance on responding to *Section 4 – Quantitative Treatment Limitations*.

Table 4—QTL Elements and Response Guidance

Element	Question
1	Does your organization apply any **QTL**s to mental health/substance use disorder (MH/SUD) and/or medical/surgical (M/S) benefits for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services? **Response Guidance** • Mark "**No**" if your organization does not apply QTLs to MH/SUD or M/S benefits for any classification of services—i.e., IP, OP, Rx, or EC. • Mark "**Yes**" if your organization applies QTLs to MH/SUD, M/S, or both types of benefits for any classification of services. Use the additional check boxes to indicate whether the AL/ADLs are applied to: – M/S benefits only – MH/SUD benefits only – MH/SUD and M/S benefits **Note(s)** • If "**No**" QTLs are used by the organization, or the QTLs are applied to **M/S benefits only**, skip to *Section 5 – Non-Quantitative Treatment Limitations,* otherwise, the organization must answer Element 2.

Element	Question
2	Please describe how your organization ensures that the implementation QTLs meets parity requirements; provide evidence that demonstrates your compliance. **Response Guidance** If the organization applies any QTLs to MH/SUD benefits, it must describe how it ensures parity in the design and implementation of those QTLs. This explanation must include the method used to confirm that QTLs applied to MH/SUD benefits are no more restrictive than the **predominant** QTL of that type that applies to **substantially all** M/S benefits within the same classification[4], where: • **predominant** refers to QTLs where the level (or magnitude) of the type of FR (e.g., visit limit) applied to MH/SUD benefits applies to more than one-half of the QTLs (or payments) for M/S benefits within the same classification, and • **substantially all** refers to QTLs where the type of QTL applied to MH/SUD benefits applies to at least two-thirds of the expected payments in a year for all M/S benefits of the same classification. **Note(s):** • Consistent with the OHP regulatory framework, it is not expected that CCOs or OHP FFS will apply QTLs in the administration of MH/SUD and M/S benefits across services.

[4] Ibid.

Section 5 – Non-Quantitative Treatment Limitations

Information provided in this section by the CCOs and OHP FFS is used to assess whether the CCOs/OHP FFS have designed and implemented non-quantitative treatment limitations (NQTLs) for MH/SUD and M/S benefits for any classification of service—i.e., inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC). This section of the MHP Treatment Limitation Review Tool is comprised of six NQTLs across two NQTL categories and requires CCOs and OHP FFS to provide parity related information for each classification of service. These components are listed below:

- Medical Management NQTLs
  - Prior Authorization *for* IP, OP, Rx, and EC
  - Concurrent Review *for* IP, OP, Rx, and EC
  - Step Therapy/Fail First *for* IP, OP, Rx, and EC
- Provider Network NQTLs
  - Provider Enrollment and Credentialing *for* IP, OP, Rx, and EC
  - Geographic Restrictions *for* IP, OP, Rx, and EC
  - Reimbursement Rates *for* IP, OP, Rx, and EC

Within each NQTL and classification, CCOs and OHP FFS are required to provide responses and documentation to address the following elements.

- Confirmation on whether NQTL is applied to the classification and to which benefits (MH/SUD and/or M/S) they are applied.
- If applicable, the **strategies**, **evidentiary standards, processes,** and **factors** used in the design and implementation of the NQTL.

Definition

Non-Quantitative Treatment Limitations (QTLs): Limits on the scope or duration of benefits, such as prior authorization or network admission standards, which are not numerical in nature. This includes *soft limits* that allow an individual to exceed defined numerical limits for MH/SUD or M/S benefits based on medical necessity.

RESPONSE GUIDANCE

Element 0 – Gating Question

Element 0 in *Section 5 – Non-Quantitative Treatment Limitations* serves as a gating question to determine if NQTLs are applied to MH/SUD or M/S benefits for any service classification with your organization. See Table 5 for guidance on responding to Element 0 in *Section 5 – Non-Quantitative Treatment Limitations*.

Table 5—NQTL Element 0 Response Guidance

Element	Question
0	Does your organization apply any NQTLs to mental health/substance use disorder (MH/SUD) and/or medical/surgical (M/S) benefits for inpatient (IP), outpatient (OP), pharmacy (Rx), or emergency care (EC) services? **Response Guidance** • Mark "**No**" if your organization does not apply NQTLs to MH/SUD or M/S benefits for any classification of services—i.e., IP, OP, Rx, or EC. • Mark "**Yes**" if your organization applies NQTLs to MH/SUD, M/S, or both types of benefits for any classification of services. Use the additional check boxes to indicate whether the NQTLs are applied to: – M/S benefits only – MH/SUD benefits only – MH/SUD and M/S benefits **Note(s)** • If "**No**" NQTLs are used by the organization, or the NQTLs are applied to **M/S benefits only**, skip to *Section 6 – Availability of Information,* otherwise, the organization must answer the applicable elements for each type of NQTL used by the organization that is applied to MH/SUD and M/S benefits. • Mark "**Yes**" if your organization applies NQTLs to **MH/SUD benefits only** or **MH/SUD and M/S benefits** for any classification of services. Proceed to each type of NQTL in the tool and complete the required elements by selecting the appropriate check boxes, entering descriptions, and providing supplemental documentation.

Elements for NQTL Types and Classification

If NQTLs are applied to MH/SUD benefits, CCOs and OHP FFS must respond to all six NQTLs (i.e., prior authorization, concurrent review, step therapy/fail first, provider enrollment and credentialing, geographic restrictions, and reimbursement rates) across two NQTL categories (i.e., medical management and provider network) for each applicable service classification (i.e., IP, OP, Rx, and EC). The structure of the evaluation elements are the same for each NQTL type and associated service classification.

Element 1 – Identification and Description of NQTL

See Table 6 for guidance on responding to Element 1 for each NQTL and classification type in *Section 5 – Non-Quantitative Treatment Limitations.*

Table 6—NQTL Element 1 Response Guidance

Element	Question
1	List and describe the MH/SUD and M/S benefits and services to which this NQTL applies. Note: *If an NQTL type is not applicable for a given benefit, select Not Applicable.* **Response Guidance** • Mark "**Not Applicable**" if your organization does not apply the NQTL to the selected service classification. • **MH/SUD –** List and describe the MH/SUD benefits and associated services to which the NQTL is applied. • **M/S –** List and describe the M/S benefits and associated services to which the NQTL is applied. **Note(s)** • Types of services associated with **Prior Authorization** include, but are not limited to: – IP services – surgery, hospitalization, psychiatric care, and detox services – OP service – stabilization services, rehabilitative therapy, and diagnostic services – EC services – ambulance, psychiatric emergency services, and SUD crisis stabilization • Types of services associated with **Concurrent Review** include, but are not limited to: – IP services – readmissions, observation care, and admissions following outpatient procedures – OP service – detox services, intensive outpatient services, and ongoing therapy – EC services – observation care, acute psychiatric stabilization, and emergency surgery follow-up • Types of services associated with **Step Therapy/Fail First** include, but are not limited to: – IP services – detox or rehabilitation facility, psychiatric hospitalization, and surgery – OP service – intensive outpatient program, Applied Behavior Analysis, and imaging/procedures – EC services – SUD services and acute psychiatric stabilization • Types of services associated with **Provider Enrollment and Credentialing** include, but are not limited to board certification, state licensure, and education for any classification of service (IP, OP, Rx, or EC). • Types of services associated with **Geographic Restrictions** include, but are not limited to, out-of-state services, out-of-network services, telehealth restrictions, etc. • Types of services associated with **Reimbursement rates** include, but are not limited to, methodology, payment structures, fixed or adjusted rates, etc. • **Only include relevant documents** that describe the scope of benefits and services addressed by the NQTL and applicable service classifications.

Element 2 – Strategies

Definition

Strategies are practices, methods, or internal metrics that an organization considers, reviews, or uses to design an NQTL. Examples of practices and methods include, but are not limited to:

- the development of the clinical rationale used in approving or denying benefits whether and how to deviate from generally accepted standards of care in concurrent reviews.
- the selection of information deemed reasonably necessary to make medical necessity determinations.
- the reliance on treatment guidelines provided by third-party organizations.
- the rationales used in selecting and adopting certain threshold amounts to apply an NQTL, professional protocols to determine utilization management standards, and fee schedules used to determine provider reimbursement rates used as part of the NQTL.

Strategies also include the method of creating and determining the composition of the staff and other representatives of the organization that deliberates, or otherwise makes decisions on the design of NQTLs, including the organizations' methods for making decisions related to:

- the qualifications of staff involved
- the number of staff members allocated and time allocated
- the breadth of sources and evidence considered
- consultations with panels of experts in designing the NQTL
- the composition of the panels used to design the NQTL

Internal metrics reviewed may include, but are not limited to, excessive utilization, recent medical cost escalation, high variability in cost of care per episode of care, high levels of variation in length of stay, claim types with high percentage of fraud, current and projected demand for services.

Element Response

See Table 7 for guidance on responding to Element 2 for each NQTL and classification type in *Section 5 – Non-Quantitative Treatment Limitations.*

Table 7—NQTL Element 2 Response Guidance

Element	Question
2	**Strategies**: What are the strategies (i.e., practices, methods, or internal metrics) that the organization used to **design the NQTL**, as written and in operation? If there are no differences in your approach to MH/SUD and M/S benefits, insert a statement confirming that no differences exist.

Element	Question
	Response Guidance • **MH/SUD –** List and describe the practices, methods, and internal metrics used to design the NQTL for MH/SUD benefits and associated service classifications. – If there is NO difference in the practices, methods, and internal metrics of the NQTL between MH/SUD and M/S benefits and service classifications, then insert a statement confirming: *No difference exists in the strategies used to design and implement <NQTL Type> for MH/SUD and M/S benefits for <Service Classification> services.* • **M/S –** List and describe the practices, methods, and internal metrics used to design the NQTL for M/S benefits and associated service classifications. **Note(s)** • **Only include relevant documents** that describe the practices, methods, and internal metrics used in the design of the NQTL and applicable service classifications. • Responses should include a description of the application of strategies **as written** and **in operation**.

Element 3 – Evidentiary Standards

Definition

Evidentiary standards are any evidence, sources, or professional standards that an organization considered or relied on in designing or applying a factor in an NQTL and include specific benchmarks and thresholds.[5] Evidentiary standards may be empirical, statistical, or clinical in nature. They include sources acquired or originating from an objective third party including, but not limited to:

- recognized medical literature, professional standards, and protocols such as:
  - comparative effectiveness studies and clinical trials
  - published research studies,
- payment rates for items and services such as publicly available databases of the "usual, customary, and reasonable" rates paid for items and services
- clinical treatment guidelines
- internal plan data such as:
  - claims or utilization data
  - criteria for assuring a sufficient mix and number of network providers
- benchmarks or thresholds such as:
  - measures of excessive utilization, cost levels
  - time or distance standards

[5] Ibid.

– network participation percentage thresholds.

Note: Evidentiary standards are used to develop factors but are not factors.

Element Response

See Table 8 for guidance on responding to Element 3 for each NQTL and classification type in *Section 5 – Non-Quantitative Treatment Limitations.*

Table 8—NQTL Element 3 Response Guidance

Element	Question
3	**Evidentiary Standards:** What evidentiary standards (i.e., any evidence, sources, or any professional standards or protocols) did the organization consider or rely upon to design the factor(s) applied to the NQTL, including specific benchmarks or thresholds? **Response Guidance** • **MH/SUD** – List and describe the relevant evidence, sources, and professional standards used to design the NQTL for MH/SUD benefits and associated service classifications. – If there is NO difference in the relevant evidence, sources, and professional standards used to design NQTL between MH/SUD and M/S benefits and service classifications, then insert a statement confirming: *No difference exists in the evidentiary standards used to design and implement <NQTL Type> for MH/SUD and M/S benefits for <Service Classification> services.* • **M/S** – List and describe the relevant evidence, sources, and professional standards used to design the NQTL for M/S benefits and associated service classifications. **Note(s):** • **Only include relevant documents** that describe the evidence, sources, and professional standards used to design the factors applied to the NQTL and applicable service classifications. • Organizations **should not** submit copies of the evidentiary standards themselves.

Element 4 – Processes

Definition

Processes are actions, steps, or procedures that an organization uses to apply an NQTL. They can include actions, steps, or procedures established by the organization that members must use to access benefits, including through the actions of a member's authorized representative or a provider or facility. Examples of processes include, but are not limited to:

- procedures to submit information to authorize coverage for an item or service prior to receiving the benefit or while treatment is ongoing (including requirements for peer or expert clinical review of the information);

- provider referral requirements that are used to determine when and how a member may access certain services; and the development and approval of a treatment plan used in a concurrent review process to determine whether a specific request should be granted or denied.

Processes also include the specific procedures used by staff or other representatives of a plan (or the service provider of a plan) to administer the application of nonquantitative treatment limitations, such as:

- how a panel of staff members applies the nonquantitative treatment limitation, including the qualifications of staff involved, number of staff members allocated, and time allocated.
- consultation with panels of experts in applying the nonquantitative treatment limitation.
- the degree of reviewer discretion in adhering to criteria hierarchy when applying a nonquantitative treatment limitation.

Element Response

See Table 9 for guidance on responding to Element 4 for each NQTL and classification type in *Section 5 – Non-Quantitative Treatment Limitations.*

Table 9—NQTL Element 4 Response Guidance

Element	Question
4a	What are the processes (i.e., actions, steps, or procedures) that the organization uses to apply the NQTL, as written and in operation? **Response Guidance** • **MH/SUD –** List and describe the actions, steps, and/or procedures used to apply the NQTL for MH/SUD benefits and associated service classifications. – If there is NO difference in the relevant processes used to apply the NQTL for MH/SUD and M/S benefits and service classifications, then insert a statement confirming: *No difference exists in the processes used to apply <NQTL Type> for MH/SUD and M/S benefits to <Service Classification> services.* • **M/S –** List and describe the actions, steps, and/or procedures used to apply the NQTL for M/S benefits and associated service classifications. **Note(s)** • **Only include relevant documents** that describe the actions, steps, and/or procedures used to apply the NQTL and applicable service classifications. • Responses should include a description of the application of strategies **as written** and as **in operation**. • For **prior authorization** NQTLs, different requirements across MH/SUD and M/S benefits may indicate a potential parity concern and require further review. Consider the following examples when responding to *Element 4a – Processes*.

Element	Question
	– For **IP Services** – If the organization classifies covered intermediate levels of care, such as skilled nursing care and residential treatment, as IP benefits, but imposes a restriction on room and board for MH/SUD residential care, this would be considered a difference and must be explained. – For **OP Services** – If the organization requires prior authorization for OP MH/SUD services after a certain number of visits but allows a greater number of OP M/S visits before imposing prior authorization, this would be considered a difference and must be explained. – For **Rx Services –** If an organization requires prior authorization for MH/SUD medications every three months but does not impose comparable prior authorization requirements for similar chronic M/S medications, this would be considered a difference and must be explained. • For **concurrent review** NQTLs, be sure to include information regarding second-level or peer-to-peer reviews that occur as part of these processes, including any differences in their application to MH/SUD and M/S benefits. • For **step therapy/fail first** NQTLs, differences in "progress/treatment-attempt" requirements or the stringency of requirements should be included in your responses as they may raise potential parity concerns. Consider the following examples when responding to *Element 4a – Processes.* – For **all service classifications** include relevant information on exception or override procedures that are available, when clinically appropriate. – For **IP Services** – If IP MH/SUD services require evidence of unsuccessful outpatient treatment while IP M/S services do not, this difference must be addressed. – For **Rx Services –** If the organization requires MH/SUD medications to fail two prior treatments before approval but does not impose comparable requirements for M/S medications, this variation must be explained. • For **provider enrollment and credentialing** NQTLs, different application and enrollment requirements may indicate a potential parity concern and require further review. For example, if the organization requires additional credentialing time or documentation of supervised hours for MH/SUD providers compared to M/S providers, this variation must be explained. • For **geographic restriction** NQTLs, different requirements (e.g., provider network status) for MH/SUD and M/S providers and treatment services may indicate a potential parity concern and require further review. For example, if the organization imposes geographic- or contract-based restrictions for IP, OP, or EC MH/SUD benefits (i.e., inpatient psychiatric hospitals) but does not impose comparable limits on comparable IP, OP, or EC M/S benefits, this variation must be explained. • For **reimbursement rate** NQTLs, different reimbursement rates or the stringency in which they are applied to MH/SUD and M/S providers may indicate a potential parity concern and require further explanation. For example, if the organization imposes fixed reimbursement rates for MH/SUD treatment but uses adjustable reimbursement rates based on provider documentation for M/S benefits, this variation must be explained. • For **reimbursement rate** NQTLs, include the methods for determining reimbursement rates.

Element	Question
4b	Describe how the NQTL process operates in practice, including the duration of the process, documentation requests and requirements, exceptions, stringency used in the analysis of submitted materials, and reviewer qualifications. **Response Guidance** • **MH/SUD –** List and describe how the NQTL is implemented and managed by CCO and OHP FFS staff for MH/SUD benefits and associated service classifications. The description and documentation should outline and document the lifecycle of the NQTL from start to finish as it relates to the provision of MH/SUD services to members. – If there is **NO** difference in how the NQTL processes for MH/SUD and M/S benefits and service classifications are governed, then insert a statement confirming: *No difference exists in the how the <NQTL Type> process operates for MH/SUD and M/S benefits for <Service Classification> services.* • **M/S –** List and describe how the NQTL is implemented and managed by CCO and OHP FFS staff for M/S benefits and associated service classifications. The description and documentation should outline and document the lifecycle of the NQTL from start to finish as it relates to the provision of M/S services to members. **Note(s)** • **Only include relevant documents** that describe how the NQTL processes are implemented and managed for applicable service classifications. • For **concurrent review** NQTLs, include the frequency of concurrent review for IP, OP, and Rx benefits (e.g., every 10 days, every 20 visits, and every 3 refills).
4c	Based on the process explained above, identify and describe any exceptions in the applicability of these processes to how the NQTL is applied to MH/SUD benefits compared to M/S benefits. If there are no exceptions to the processes described in Element 4b, insert a statement confirming that there are no differences in the organization's application of the NQTL to MH/SUD benefits. **Response Guidance** • List and describe any differences, or exceptions, to the NQTL processes for MH/SUD and M/S benefits that are implemented and managed by CCO and OHP FFS staff for applicable service classifications. – If there are **NO** differences or exceptions in how the NQTL processes for MH/SUD and M/S benefits and service classifications are governed, then insert a statement confirming: *No differences or exceptions exist in the how the <NQTL Type> process operates for MH/SUD and M/S benefits for <Service Classification> services.* **Note(s)** • **Only include relevant documents** that describe the exceptions to the application of NQTL processes for applicable service classifications.

Element	Question
4d	For each exception identified, provide a description of how the organization established the exception (e.g., the rationale for applying an exception). Select *Not Applicable* if there are no exceptions to the processes described in 4b. **Response Guidance** • Mark "**Not Applicable**" if there are no exceptions to the processes described in 4b. • If **there are differences** in how the NQTL processes for MH/SUD and M/S benefits are implemented and managed by CCO and OHP FFS staff for applicable service classifications, describe the organization's rationale for applying an exception to the MH/SUD, M/S, or both benefits. **Note(s)** • If there is any variation in how a guideline or standard is applied between MH/SUD and M/S benefits, the organization must explain the process and the factors used to establish that variation. The organization should: – Determine whether exception processes exist and under what circumstances they may be applied. – Determine how much discretion is allowed in applying the NQTL and whether such discretion is afforded comparably for processing MH/SUD benefit claims and M/S benefits claims. – Determine who makes denial determinations and if the decision-makers have comparable expertise with respect to MH/SUD and M/S benefits. – Check sample claims to determine whether a particular NQTL warrants additional review. A plan may have written processes that are compliant on their face, but those processes may not be compliant in practice. – Determine average denial rates and appeal overturn rates for concurrent review and assess the parity between these rates for MH/SUD benefits and M/S benefits. – Document your analysis, as a best practice. • **Only include relevant documents** that describe the rational for applying an exception to the NQTL and applicable service classifications.
4e	Describe the mechanisms for ensuring consistent application of the NQTL processes for MH/SUD and M/S benefits (e.g., interrater reliability activities) and remediation when the organization identifies inconsistencies. If there are no differences in your approach to MH/SUD and M/S benefits, insert a statement confirming that no differences exist. **Response Guidance** • **MH/SUD** – List and describe the mechanisms (e.g., interrater reliability, training, etc.) used by your organization to ensure consistent application of NQTL processes for MH/SUD benefits, including the steps and resolutions taken to address identified inconsistencies. – If there are **NO** differences in mechanisms used to ensure consistent application of NQTL processes to MH/SUD and M/S benefits and service classifications, then insert a statement confirming: *No difference exists in the mechanisms used to ensure consistent and reliable*

Element	Question
	application of <NQTL Type> processes for MH/SUD and M/S benefits for <Service Classification> services. • **M/S** – List and describe the mechanisms (e.g., interrater reliability, training, etc.) used by your organization to ensure consistent application of NQTL processes for M/S benefits, including the steps and resolutions taken to address identified inconsistencies. **Note(s)** • **Only include relevant documents** that describe the mechanisms used to ensure consistent application of NQTL processes for MH/SUD and M/S benefits for applicable service classifications.

Element 5 – Factors

Definition

Factors include all information that a group health plan relied on to design an NQTL. The preamble to the federal regulation emphasized that "factors" should be read broadly and include all information, including processes and strategies, which were relied on in developing the NQTL. Processes and strategies are then treated as subsets of factors.

Factors would also include information that was considered but rejected. This definition has a nonexhaustive list of factors, including, but not limited to:

- provider discretion in determining a diagnosis or type or length of treatment
- clinical efficacy of any proposed treatment or service
- licensing and accreditation of providers
- claim types with a high percentage of fraud
- quality measures
- treatment outcomes
- severity or chronicity of condition
- variability in the cost of an episode of treatment
- high-cost growth
- variability in cost and quality
- elasticity of demand
- geographic location

Examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs include, but are not limited to, the following:

- Excessive utilization as a factor to design the NQTL when utilization is two standard deviations above the average utilization per episode of care.
- Recent medical cost escalation may be considered as a factor based on internal claims data showing that medical costs for certain services increased 10 percent or more per year for two years.
- Lack of adherence to quality standards may be considered as a factor when deviation from generally accepted national quality standards for a specific disease category occurs more than 30 percent of the time based on clinical chart reviews.
- High level of variation in length of stay may be considered as a factor when claims data shows that 25 percent of patients stayed longer than the median length of stay for acute hospital episodes of care.
- High variability in cost per episode may be considered as a factor when episodes of outpatient care are two standard deviations higher in total cost than the average cost per episode 20 percent of the time in a 12-month period.
- Lack of clinical efficacy may be considered as a factor when more than 50 percent of outpatient episodes of care for specific diseases are not based on evidence-based interventions (as defined by nationally accepted best practices) in a 12-month sample of claims data.

Element Response

See Table 10 for guidance on responding to Element 5 for each NQTL and classification type in *Section 5 – Non-Quantitative Treatment Limitations.*

Table 10—NQTL Element 5 Response Guidance

Element	Question
5	What other factors (i.e., information **not already addressed** in the strategies and process questions, including information considered and rejected in establishing this NQTL) did the organization consider or rely upon to **design the NQTL** or to **determine how the NQTL applies** to the benefit? If there are no differences in your approach to MH/SUD and M/S benefits, insert a statement confirming that no differences exist. **Response Guidance** • **MH/SUD –** List and describe the factors, not discussed in Element 4a – 4e that were used to design the NQTL for, or how the NQTL was applied to, MH/SUD benefits and associated service classifications. – If there are **NO** differences in the other type of factors used to design and apply NQTLs to MH/SUD and M/S benefits and service classifications, then insert a statement confirming: *No difference exists in the other factors used to design and apply <NQTL Type> to MH/SUD and M/S benefits for <Service Classification> services.* • **M/S –** List and describe the factors, not discussed in Element 4a – 4e that were used to design the NQTL for, or how the NQTL was applied to, M/S benefits and associated service classifications.

Element	Question
	Note(s) • For **concurrent review** NQTLs, factor examples for: – **IP benefits** include, but is not limited to, excessive utilization, high variation in length of stay, and high variability in cost per care episode – **OP benefits** include, but is not limited to, the cost of treatment, type or length of treatment, and high-cost growth. – **Rx benefits** include, but is not limited to, high-cost treatments, length of treatment, and over- or under-utilization. • **Only include relevant documents** that describe the factors used to design and determine how to apply NQTLs to MH/SUD and M/S benefits and applicable service classifications.

Element 6 – Other NQTLs Not Previously Listed

Element 6 in *Section 5 – Non-Quantitative Treatment Limitations* assesses whether CCOs or OHP FFS have developed, implemented, and applied any additional NQTLs to the administration of MH/SUD and M/S benefits across service classifications. See Table 11 for guidance on responding to Element 6 in *Section 5 – Non-Quantitative Treatment Limitations.*

Table 11—NQTL Element 6 Response Guidance

Element	Question
6	Identify the NQTL and describe the MH/SUD and M/S benefits and services to which this NQTL applies. **Response Guidance** • For the **NQTL** column – Enter the name or brief description of the NQTL • For the **Benefit Type** column – Mark *MH/SUD* and/or *M/S* to identify to which benefit the NQTL applies. You may mark all options that apply. • For the **Service Type** column – Mark *Inpatient*, *Outpatient, Pharmacy,* and/or *Emergency Care* to identify to which service classification the NQTL applies. You may mark all potions that apply. • For the **Brief Description** column – Enter a brief description of the NQTL. Include the specific benefits and services affected by the NQTL and an outline of the processes used to implement the NQTL. **Note(s)** • NQTLs listed in this section should not include those previously described in this section. • HSAG will review information provided and determine whether the submission of additional documentation is required.

Section 6 – Availability of Information

Information provided in this section by the CCOs and OHP FFS is used to assess how CCOs/OHP FFS make the criteria for medical necessity determinations of MH/SUD and M/S benefits available to members, potential members, and contracting providers, upon request.

Definition

Criteria for Medical Necessity Determinations: clinical and professional standards and guidelines used by health plans and providers to determine if a service, treatment, or drug is essential to prevent, diagnose, or treat an illness or injury based on accepted clinical guidelines.

Response Guidance

See Table 12 for guidance on responding to *Section 6 – Availability of Information*.

Table 12—Availability of Information Elements and Response Guidance

Element	Question
1a – IP **2a – OP** **3a – Rx** **4a - EC**	Identify the criteria used to make medical necessity determinations for MH/SUD benefits and services. **Response Guidance** • **MH/SUD –** List and describe the criteria used to determine whether an MH/SUD service or treatment is medically necessary. For example, the organization may reference established practice guidelines or resources such as the Prioritized List of condition and treatment pairs used to determine Medicaid coverage. • **M/S –** List and describe the criteria used to determine whether an M/S service or treatment is medically necessary. For example, the organization may reference established practice guidelines or resources such as the Prioritized List of condition and treatment pairs used to determine Medicaid coverage. **Note(s)** • **Only include relevant documents** that describe the criteria used to make medical necessity determinations. • Organizations **should not** submit copies of the criteria themselves.

Element	Question
1b – IP **2b – OP** **3b – Rx** **4b - EC**	Describe the mechanism(s) for dissemination to members, potential members, and providers. **Response Guidance** • **MH/SUD –** List and describe the methods by which medical necessity criteria for MH/SUD benefits are communicated to members, prospective members, and network providers. This may include member handbooks, provider manuals, publicly accessible CCO/OHP FFS websites, and notices sent when coverage or reimbursement for an MH/SUD service is denied. • **M/S –** List and describe the methods by which medical necessity criteria for M/S benefits are communicated to members, prospective members, and network providers. This may include member handbooks, provider manuals, publicly accessible CCO/OHP FFS websites, and notices sent when coverage or reimbursement for an M/S service is denied. **Note(s)** • **Only include relevant documents** that describe the mechanisms for communicating MH/SUD and M/S medical necessity criteria to members, prospective members, and providers.