Appendix A. Resource Documents

Appendix A1. Maryland Medicaid Definitions for Parity Analysis

Appendix A2. Maryland Medicaid Factors Guide

Appendix A1: Maryland Medicaid Definitions for Parity Analysis

Nonquantitative Treatment Limitations (NQTLs) Definitions

	NQTL	Definition
1	Concurrent Review	"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	Fail First Requirements/ Step Therapy	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.
3	Medical Necessity Criteria	"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.
4	Outlier Management	Procedures that are designed to review services after they have been delivered to assess medical necessity and/or detect and prevent fraud, waste, and abuse through investigation of unusual patterns in service utilization, billing, prescribing, and denials.
5	Prior Authorization/ Preauthorization	The approval required from the Department or its designee (including the MCO) before a service can be rendered by the provider and reimbursed.

	NQTL	Definition
6	Provider Rates	The methodology by which rates are set in order to reimburse practitioners for providing services to Medicaid participants. E.g., DRG, per-diem, bundled rates FFS, PMPM, sub-cap.
7	Service limitations	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.
8	Data Collection	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.
9	Tiered Drug Formulary	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.

Benefits Classifications Definitions

Benefits Classification	Definition
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 classifications also includes all covered services or items provided to a beneficiary when a physician has written an order for admission to a facility.

Benefits Classification	Definition
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. For purposes of the financial requirements (FR) and quantitative treatment limit (QTL) analyses, these benefits can be subdivided into "Outpatient-Office" and "Outpatient-Other". Outpatient-Office services are those delivered in an office setting.
Prescription	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.
Medical/Surgical (M/S)	M/S conditions definitions are consistent with the M/S conditions listed in ICD-10-CM, Chapters 1-4, Chapters 5-subchapter 1, 8, and 9, and Chapters 6-20.
Mental Health/Substance Use Disorder (MH/SUD)	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.

NQTL Analysis Definitions

NQTL Analysis	Definition
As written	As used in the development of and decision whether or not to apply a non-quantitative treatment limitation (NQTL) type to a particular benefit, as reflected in the Applicant's written policies, procedures, and related documents.
Comparable	Although this term is not defined in federal regulations or guidance, in common usage, "comparable" means "like", "equal", "equivalent" and "similar". For purposes of NQTL analysis for Parity Accreditation, it means "like, equal, equivalent and similar."
Evidentiary standard	The plan's defined level and type of evidence necessary to evaluate whether a given factor is present/triggered which would then result in determination to apply or not apply an NQTL to which that factor relates.
Factor	A circumstance, fact, or influence that contributes to the development and/or implementation of an NQTL.

NQTL Analysis	Definition
In Operation	As used in the implementation of NQTLs, including the administration of benefits.
No More Stringently	No more strict or rigorous.
Nonquantitative Treatment Limitations (NQTLs)	Treatment limitations, other than QTLs, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage.
Operations Measures	The operational data used by the Applicant to assess its own compliance in the implementation of an NQTL (i.e. the "in operation" phase of the NQTL analysis). Operations Measures include the frequency medical necessity reviews are performed, utilization rates, grievances trends, appeals trends, dollar expenditure trends, denial rates, out of network utilization rates, and provider reimbursement rates among many others.
Process	A series of actions or steps taken during the design or application of an NQTL.
Source	Information obtained that contributes to or documents the development and/or implementation of an NQTL.
Strategy	A plan, a method, or series of steps to carry out the design or application of an NQTL.

Maryland
DEPARTMENT OF HEALTH

Appendix A2: Maryland Medicaid Factors Guide

What is a factor?
A factor is what a plan uses to assess or consider when to apply an NQTL to a benefit or service. A NQTL may not apply to behavioral health benefits in a classification unless the factors (e.g., strategies, evidentiary standards, processes), as written and in operation, used in applying those limitations are comparable to and no more stringent than the factors used in applying limitations for medical and surgical benefits (42 CFR § 438.910(d)).

How do factors relate to the overall parity analysis?
MDH had already defined many of the higher-level aspects of the parity analysis for you. This includes identifying benefit packages, defining the benefits classifications and mapping each benefit to a classification, and defining the NQTLs.

For each NQTL analysis, there are two parts:

- In writing - The identification and definition of factors relied upon in the policy making decision of whether or not to apply an NQTL to some benefits and not others and how to apply an NQTL as a policy matter prospectively.
- In operation - The identification and definition of measures to monitor the results of how an NQTL is applied in practice.

As an example, when considering inpatient (classification) stays of recovery after surgery (benefit/service), a plan might consider applying Concurrent Review (NQTL) because of high variability in lengths of stay (factor).

What makes a good factor definition?

- Definitions should be specific as possible and should reflect back to the processes you have in place when making decisions
- Definitions can either be qualitatively or quantitatively based depending on your policies and processes
- Not all factors may have the same definitions across benefit classifications or NQTLs, but they should somehow relate back to the benefits/services or classifications they are applied to
    - For example, you may have a different committee looking at prior authorizations for pharmacy than for inpatient services; that should be reflected in the definition

Model Factor Examples:

Factor	Definition	NQTLs	Classification
Variation in Length of Stay	When, in the professional judgment and experience of the members of the utilization management department, inpatient services show a significant variation between the length of stay between patients.	Outlier management Prior authorization Concurrent review	Inpatient
Recent cost escalation	Services for which, in the assessment of the members of the utilization management department, the unit price for the service has demonstrated recent and rapid escalation.	Outlier management Prior authorization Concurrent review	All
Variability in quality	Services for which, in the experience and judgment of the members of the utilization management department, there is substantial difference in quality between providers, such as inconsistent compliance with generally accepted national quality standards	All	All
Severity or chronicity of illness	Services that, in the professional judgment of the members of the utilization management committee are specifically for the treatment of severe or chronic conditions	Medical necessity criteria Outlier management Prior authorization Concurrent review	All
Lack of clinical efficiency	Services which, in the professional judgment of members of the utilization management committee, are not based on evidence as defined by nationally accepted best practices	Outlier management Prior authorization Concurrent review	Outpatient
Safety Risks	Risk of drug or service; drugs or services, which, in the experience and judgment of the members of the utilization management committee present a higher risk of or number of adverse outcomes or events when compared to similar drugs, treatments, or services when alternatives are available.	All	All
Excessive Utilization	Services which the members of the utilization management committee have identified from experience monitoring various qualitative and quantitative data sets demonstrate high rates of medically unnecessary utilization.	Outlier management Prior authorization Concurrent review	All