

NORTH CAROLINA DEPARTMENT OF INSURANCE

**MHPAEA Compliance Checklist to be Completed by Regulated Entity (Insurers, HMOs, Municipal Cooperative Health Benefit Plans and Student Health Plans)**

REQUIREMENT	REFERENCE	DESCRIPTION OF STANDARDS OR REQUIREMENTS	DOCUMENTATION	COMPLIANT
<b>MENTAL HEALTH &amp; SUBSTANCE USE DISORDER SERVICES (MH/SUD)</b>		<p><i>The MHPAEA requirements below apply to any group health plan that had more than 50 total employees, for plan years beginning on or after October 3, 2009.</i></p> <p><i>The MHPAEA requirements below apply to health insurance coverage issued in the individual and small group markets on and after January 1, 2014. NB: Acceptance by the Department does not absolve the submitting entity from future findings of non-compliance.</i></p>		<p><i>For Department Use Only.</i></p>
Defining MH/SUD benefits	42 U.S.C. 300gg-26 42 U.S.C. 18031(j) 45 CFR 146.136(a) 45 CFR 156.115(a)(3)	The policy or contract shall define mental health benefits or substance use disorder benefits to mean items or services for the treatment of a mental health condition or substance use disorder, as defined by the policy or contract or applicable state law. Any condition or disorder defined as not a mental health condition or substance use disorder must be consistent with generally recognized independent standards of current medical practice and applicable state law. Please list, if any, all MH/SUD conditions excluded from coverage.	<p><input type="checkbox"/> Describe which independent standards were used to define mental health conditions, substance use disorders, and medical/surgical conditions and how these standards and definitions are consistent with applicable state law.</p> <p><input type="checkbox"/> Describe how the issuer determines that services and items are mental health benefits, substance use disorder benefits, or medical/surgical benefits, particularly for services and items that could be for multiple types of benefits (eg occupational therapy). List all services and items that are considered mental health benefits, substance use disorder benefits, and medical/surgical benefits.</p>	Compliant? Yes <input type="checkbox"/> No <input type="checkbox"/>

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<p>Classifying benefits</p>	<p>42 U.S.C. 300gg-26                  42 U.S.C. 18031(j)                  45 CFR 146.136(c)(2)(ii)(A)                  45 CFR 146.136(c)(3)(iii)(A)                  45 CFR 146.136(c)(3)(iii)(B)                  45 CFR 146.136(c)(3)(iii)(C)                  45 CFR 156.115(a)(3)</p>	<p>The issuer shall assign MH/SUD benefits to each of the six classifications and permitted sub-classifications. The issuer must apply the same standards to medical/surgical benefits and to mental health or substance use disorder benefits in determining the classification or sub-classification in which a particular benefit belongs. The issuer shall demonstrate that mental health or substance use disorder benefits are covered in each classification in which medical/surgical benefits are covered.</p>	<p><input type="checkbox"/> The issuer shall provide a list that specifies which benefits were assigned to each of the six classifications and permitted sub-classifications. Describe the standards used in assigning benefits to classifications or sub-classifications for MH/SUD benefits and demonstrate that the same standards were used in assigning medical/surgical benefits to classifications and sub-classifications.</p>	<p>Compliant?                  Yes <input type="checkbox"/> No <input type="checkbox"/>  <i>Note: Acceptance by the Department does not absolve the submitting entity from future findings of non-compliance.</i></p>
<p>Financial requirements and quantitative treatment limitations</p>	<p>42 U.S.C. 300gg-26(a)(3)(A)                  42 U.S.C. 18031(j)                  45 CFR 146.136(c)(2)(i)                  45 CFR 146.136(c)(3)(i)(A)                  45 CFR 146.136(c)(3)(i)(B)(1)                  45 CFR 146.136(c)(3)(i)(B)(2)                  ACA FAQ 34 Q3                  45 CFR 156.115(a)(3)</p>	<p>The policy or contract shall not apply any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any classification (or applicable sub-classification) that is more restrictive than the predominant financial requirement or quantitative treatment limitation of that type applied to substantially all medical/surgical benefits in the same classification (or applicable sub-classification).</p>	<p><input type="checkbox"/> Provide a list of all financial requirements and quantitative treatment limitations imposed upon MH/SUD benefits in each classification of benefits and applicable sub-classification. The issuer shall demonstrate that any type of financial requirement quantitative treatment limitation applied to mental health or substance use disorder benefits in a classification (or applicable sub-classification) applies to at least two-thirds of expected plan payments on medical/surgical benefits within that classification (or</p>	<p>Compliant?                  Yes <input type="checkbox"/> No <input type="checkbox"/>  <i>Note: Acceptance by the Department does not absolve the submitting entity from future findings of non-compliance.</i></p>

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			<p>applicable sub-classification).</p> <p><input type="checkbox"/> The issuer shall demonstrate that the level of financial requirement or quantitative treatment limitation imposed upon mental health or substance use disorder benefits in a classification (or applicable sub-classification) is no more restrictive than the level of financial requirement imposed upon more than one-half of expected plan payments that are subject to the financial requirement within that classification for medical/surgical benefits. The issuer shall demonstrate how it combined levels of the financial requirement to satisfy the predominant test if there is no single level that applies to more than one-half of medical/surgical benefits in the classification.</p> <p><input type="checkbox"/> The issuer shall provide a certification from an actuary that an actuarial cost model was built to test each financial requirement and quantitative treatment</p>	
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			limitation. An issuer shall use appropriate and sufficient data to perform the analysis in compliance with applicable Actuarial Standards of Practice.	
Cumulative financial requirements and cumulative quantitative treatment limitations	42 U.S.C. 300gg-26(3) 45 CFR 146.136(c)(3)(v)	The issuer shall not apply any cumulative financial requirement or quantitative treatment limitation to mental health or substance use disorder benefits in a classification that accumulates separately from any established for medical/surgical benefits in the same classification.	<input type="checkbox"/> The issuer shall attest that it has performed a thorough review of all policies and contracts and has determined that there are no separate cumulative financial requirements or quantitative treatment limitations form mental health or substance use disorder benefits.	Compliant? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Note: Acceptance by the Department does not absolve the submitting entity from future findings of non-compliance.</i>
Nonquantitative treatment limitations (NQTLS)	42 U.S.C. 300gg-26(a)(3)(A) 42 U.S.C. 300gg-26(a)(8)(A) 42 U.S.C. 18031(j) 45 CFR 146.136(c)(i) 45 CFR 156.115(a)(3) <b>ACA FAQ 45</b>	The issuer shall justify the application of any NQTL to mental health or substance use disorder benefits within a classification of benefits (or applicable sub-classification) such that any processes, strategies, evidentiary standards, or other factors used to apply a limitation, as written and in operation, are comparable to, and are applied no more stringently, than the processes, strategies, evidentiary standards, or other factors used to apply the limitation to medical/surgical benefits within the classification (or applicable sub-classification).  NQTLs shall be categorized as such: 1) medical management- which includes issuer prior authorization, concurrent review and retrospective review protocols and the medical necessity criteria utilized in conjunction with them; 2) exclusions of coverage; e.g., experimental or investigational; 3) plan provider network matters-credentiating criteria, network tiering; 4) network adequacy; i.e. plan MH/SUD network performance; 5) provider reimbursement rates; 6) prescription drugs; 7) other NQTLs as identified by the issuer- restrictions on facility type, geographic location.	<input type="checkbox"/> The issuer shall provide a list of all NQTLS imposed upon mental health or substance use disorder benefits within each classification of benefits (or applicable sub-classification), including the methodology used to identify those NQTLS.  <input type="checkbox"/> The issuer shall provide an attestation that for each NQTL imposed on MH/SUD benefits, in each classification the limitation is imposed, the issuer has performed an analysis that contains the following:	Compliant? Yes <input type="checkbox"/> No <input type="checkbox"/> <i>Note: Acceptance by the Department does not absolve the submitting entity from future findings of non-compliance.</i>

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			<p>1) The specific plan or coverage terms or other relevant terms regarding the NQTL and a description of all MH/SUD and medical or surgical benefits to which each such term applies in each respective benefits classification</p> <p>2) The factors used to determine that the NQTL will apply to MH/SUD benefits and medical or surgical benefits</p> <p>3) The evidentiary standards used for the factors identified, when applicable, provided that every factor shall be defined, and any other source or evidence relied upon to design and apply the NQTL to MH/SUD benefits and medical or surgical benefits</p> <p>4) The comparative analyses demonstrating that the processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply</p>	
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			<p>the NQTL to medical/surgical benefits in the benefits classification</p> <p>5) The specific findings and conclusions reached by the issuer, including any results of the analyses that indicate that the issuer is or is not in compliance with the MHPAEA requirements</p> <p>The analyses must be available upon request within X business days.</p>	
<p>Disclosure</p>	<p>42 U.S.C. 300gg-26(a)(4)                      45 CFR 146.136(d)(1)                      45 CFR 146.136(d)(2)                      45 CFR 146.136(d)(3)                      45 CFR 147.136(b)(2)                      45 CFR 147.136(b)(3)</p>	<p>The issuer shall ensure that it complies with all availability of policy or contract information and related disclosure obligations regarding: 1) criteria for medical necessity determinations; 2) reasons for denial of services; 3) information relevant to medical/surgical, mental health, and substance use disorder benefits 4) rules regarding claims and appeals, including the right of claimants to free reasonable access and copies of documents, records and other information including information on medical necessity criteria for both medical/surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a NQTL with respect to medical/surgical benefits and mental health or substance use disorder benefits under the plan.</p>	<p><input type="checkbox"/> The issuer shall demonstrate the method by which it makes available to any current or potential participant, beneficiary, or contracting provider upon request the medical necessity criteria used to make mental health or substance use disorder medical necessity determinations.</p> <p><input type="checkbox"/> The issuer shall demonstrate that it provides the reason for any denial of reimbursement for mental health or substance use disorder benefits.</p> <p><input type="checkbox"/> The issuer shall demonstrate its method for</p>	<p>Compliant?                      Yes <input type="checkbox"/> No <input type="checkbox"/>  <i>Note: Acceptance by the Department does not absolve the submitting entity from future findings of non-compliance.</i></p>

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			<p>responding to requests for all documents, records, and other information relevant to the claimant’s claim for benefits after an adverse benefit determination. This shall include the issuer’s protocol for ensuring that it discloses medical necessity criteria for both medical/ surgical benefits and mental health and substance use disorder benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply a NQTL with respect to medical/ surgical benefits and mental health or substance use disorder benefits under the policy or contract, when those specific items are requested.</p> <p><input type="checkbox"/> The issuer must demonstrate that all claims processing and disclosure regarding adverse benefit determinations complies with the federal claims and appeals regulations</p>	
<p>Issuer coordination with vendors</p>	<p>78 FR 68250</p>	<p>If the issuer contracts with a managed behavioral health organization (MBHO) to provide any or all of the issuer’s mental health or substance use disorder benefits it shall ensure that it coordinates with the MBHO to secure compliance with MHPAEA.</p>	<p><input type="checkbox"/> The issuer must attest that it coordinates with its MBHO (if applicable) to ensure that mental health or substance use disorder benefits are designed and</p>	

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			applied no more restrictively than how medical/surgical benefits are designed and applied.	
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