MHPAEA Technical Training FAQs
(Updated 12/2/24, 1/2/25, 3/20/25)

General Questions

Q: Since March 1st falls on a Saturday this year, should we submit on Friday February 28th or Monday March 3rd?
A: The deadline for submissions has been extended to April 1, 2025.

Q: The newly amended regulation 4-2-64 Section 10.12.e states the NQTL comparative analyses must be signed, but the new template does not have a signature line. Will a new version be provided that includes a signature line? Or can we provide 1 signature for all 10 required NQTLs in an attestation document?
A: The instructions linked here also reference this on page 3, stating: "Carriers shall also provide an original signature or approved electronic signature on the NQTL Templates and Comparative Analysis Attestation form to verify information submitted in the NQTL templates."

Q: Where can I find recordings of the technical trainings and the associated materials?
A: Recordings of the technical trainings and all associated materials are available on the Division's website. You can access them [here].

Q: What MHPAEA filing documents will no longer be required beginning with FY25?
A: The following documents are being retired and will not be required for FY25:

- NQTL Behavioral Health/Mental Health Questionnaire
- NQTL Substance Use Disorder Questionnaire
- NQTL Medical/Surgical Questionnaire
- NQTL Pharmacy Services Questionnaire
- NQTL Confidential Network Development Questionnaire (duplicated in error)
- Network Adequacy Provider Credentialing and Network Admission
- NQTL Confidential Network Provider Template

Q: When will the Network Adequacy NQTL be discussed?
A: Data templates assessing information relevant to network adequacy were reviewed during **Training Session 4 - Claims Data, 12/19/24**. The following relevant templates and guidance document were shared during that session:

- Out-of-Network & Gap Exception Utilization Data
- NQTL Provider Network Engagement and Availability
- NQTL Network Development and Adequacy Guidance Document

Q: Are the templates reviewed in the sessions the final versions?
A: Yes, but any typos or calculation errors will be corrected, and the official finalized versions were made available on the Division's landing page website when the final filing instructions were released.

Q: What is the ask? ("What is due and by when?")
A: These templates must be completed and submitted with MHPAEA filings in SERFF, typically by the **March 1 deadline** as required by Colorado Regulation 4-2-64. Additionally, carriers must review the comparative output data and address it in the applicable NQTL comparative analysis.

Q: Can you please confirm that the scope of this report includes only members residing in Colorado insured under a Colorado contract situs (no extraterritorial)?
A: All covered lives must be included in the reporting, regardless of their residence.

Q: What does the term “market level” mean?
A: The term “market level” refers to categories such as individual, small group, large group, student health, or short-term limited duration plans.

Q: If a specific template includes something that is not applicable or not reportable, how should we handle it?
A: Use the following indicators based on the situation:

- **0**: If there are no occurrences for a value.
- **N/A**: If a value is not applicable.
- **N/R**: If a value is not reportable.

Q: What is the required data set period for MHPAEA templates that rely on fully adjudicated claims for FY25?
A: For templates reliant on fully adjudicated claims, the dataset period for FY25 is January 1 through September 30, 2024. These templates include:

- Out-of-Network & Gap Exception Utilization Data
- Confidential Network Development Medicare Template
- Office Visit In-Network Allowed Rates Analysis
- Provider Network Engagement & Availability
- NQTL Verifications

This approach aligns with the typical 90-day claims run-out period to ensure data completeness.

Q: Which MHPAEA templates are not dependent on fully adjudicated claims, and what is their required data set period for FY25?
A: Some templates do not rely on claims data or fully adjudicated claims. Instead, they require data based on requests or processes conducted during the reporting period, regardless of whether a claim was filed or a service was delivered. The dataset period for these templates is January 1 through December 31, 2024. These templates include:

- Pharmacy Medical Management

- Prior Authorization & Concurrent Review
- Provider Credentialing
- ASAM Criteria Utilization
- Eating Disorder BMI/IBW
- Colorado NQTL Comparative Analysis Six-Step Reporting
- NQTL Identification and Classification (including Medical Management)

Q: Are pharmacy outpatient claims to be included? Does the term "providers" refer to pharmacy services for outpatients as well?
A: Yes, pharmacy-related information is required for certain MHPAEA templates. The following templates include data or analysis specific to pharmacy services:

- NQTL Verifications
- Pharmacy Medical Management
- NQTL Identification and Classification (includes Medical Management)
- Colorado NQTL Comparative Analysis Six-Step Reporting: Pharmacy is a recognized MHPAEA classification that necessitates a Comparative Analysis.

This ensures compliance with MHPAEA requirements for the pharmacy classification.

Q: Are the templates reviewed during the meeting replacing all templates previously and currently located in the Division's Google Drive MHPAEA templates folder?
A: Yes, the templates reviewed during the technical trainings replace all previously required NQTL-related templates, including:

- Colorado Comparative Analysis Tool
- Medical Management Evaluation
- Network Adequacy Provider Credentialing and Network Admission Questionnaire
- Non-Quantitative Treatment Limitation Verifications Template
- Behavioral Health-Mental Health NQTL Questionnaire
- Pharmacy Services NQTL Questionnaire
- Substance Use Disorder NQTL Questionnaire
- Confidential Network Development NQTL Questionnaire
- Medical-Surgical Services NQTL Questionnaire
- NQTL Confidential Network Development Medicare Template (revised version provided during the trainings)
- NQTL Confidential Network Development Provider Template
- American Society of Addiction Medicine (ASAM) Criteria Utilization

The updated templates have been uploaded to the Division's website alongside the filing instructions for FY25.

Q: On templates where we are asked to define the Benefit Classification, if we don't normally subclassify outpatient services, should we do so here?

A: Yes, for templates requesting definitions of Benefit Classifications, you should review each category and provide the carrier's definition for the service or category listed.

Q: The carrier I work for is new to Colorado and I am unfamiliar with this process. Where can I find these templates?
A: These templates are part of the reporting requirements for Colorado Amended Regulation 4-2-64 Concerning Mental Health Parity in Health Benefit Plans, which outlines MHPAEA reporting requirements. All templates are available on the Division's website.

You can access all technical trainings and related materials, including the templates reviewed during these training sessions, at the following link: [Insert link].

Q: Will there be any guidance on analyzing percentages for parity compliance? For example, if there is an 8% denial rate for M/S services and a 9% denial rate for MH services—a 1% difference—would that be considered acceptable? Should such differences be addressed, and is there any guidance on determining incomparability or non-comparability?
A: Currently, it is up to carriers to conduct self-audits and determine whether differences are material. For this first year, the focus is on understanding the systems carriers have in place, the metrics used to assess parity compliance, and the guidelines applied to identify and address potential disparities. Carriers should include this information in their reporting.

BMI/IBW Template

Q: In question #4, partial hospitalization is listed twice. Is that correct?
A: No, this was an error in the template. It has been corrected and now only appears once.

Q: How should we categorize within this template those eating disorder diagnosis codes that a provider submits that don't fall under the eating disorders listed (e.g., Bulimia Nervosa, Atypical Anorexia Nervosa, Binge Eating Disorder, Avoidant Restrictive Food Intake Disorder, Anorexia Nervosa, restricting subtype, Binge Eating/Purging subtype). These include 50.9 (Eating Disorder, Unspecified) or 50.89 (Other Specified Eating Disorder).

A:

Colorado NQTL Six-Step Comparative Analysis Template
NQTL Comparative Analysis Instruction and Guidance Document

Q: Why is there no mention in the Comparative Analysis instructions of the federal regulation requirements related to Meaningful Benefits and the Prohibition of Discriminatory Factors?
A: Colorado is aligning with the timelines set forth in the federal regulation. These specific components will become effective on **January 1, 2026**, rather than **January 1, 2025**.

Q: The language in the Comparative Analysis Instruction and Guidance Document, as well as the Six-Step Analysis, does not include all the language in the federal regulation. Will a revised template and/or instructions be provided?
A: This document was created prior to the release of the final federal regulation. It is important to note that this guidance is supplemental and should be used alongside the regulatory language outlined in **4-2-64**, which adopts and reiterates the federal regulation requirements. Ultimately, the regulatory language in **4-2-64** and the adopted federal regulations take precedence.

Data Supplement Provider Credentialing

Q: The instruction tab advises that "No application should be categorized under more than one category (M/S, MH, or SUD) or more than one provider/facility type," which applies to the Credentialing/Recredentialing tabs where a provider is counted only once under M/S, MH, or SUD. A carrier categorizes facilities by state licensure, allowing dual classification for MH and SUD if licensed for both. For physicians and licensed non-physician providers, MH and SUD specialties are self-reported, so providers may treat both. How should we report in these instances?
A: Behavioral health providers or facilities that explicitly state they provide services for SUD (either as indicated in their credentialing materials or on their facility state licensure) should be categorized in the SUD column, even if they also provide MH services. Providers or facilities that do not explicitly state treatment for SUD should be categorized in the MH column.

Data Supplement Pharmacy Medical Management

Q: Can you please confirm the difference between Section 1 and Section 2 of this template? Is Section 1 reporting data on claims received and claims rejected (denied), while Section 2 focuses specifically on Prior Authorization reviews/denials?
A: Here is a breakdown of each section:

- **Section 1**: Reports on **all requests received** for pharmacy services and **all requests denied**, regardless of whether a medication was dispensed or a claim was submitted.
- **Section 2**: Focuses specifically on **Prior Authorization requests/reviews**, regardless of whether a medication was dispensed or a claim was submitted. It includes the outcomes of those reviews specific to Prior Authorization.
- **Section 3**: Focuses on **Formulary Exception Request reviews**, regardless of whether a medication was dispensed or a claim was submitted. It includes the outcomes of those exception requests.

Q: Should clinically administered medications reviewed outside the pharmacy team still be included in this template, even if most fields will remain blank?
A: Yes, all requests processed on the platform that manages pharmacy requests should be included in the Pharmacy Medical Management template in the appropriate section. If a request for a medication administered in a provider's office is reviewed on this platform, it should also be included in the template.

Prior Authorization and Concurrent Review Template

Q: Should grievances and/or appeals be included in the counts?
A: When filling out the template, we are asking that you look at the information available in the live moment of UM reviews/ the live actions of the UM teams. If the reviews go into a post-service appeal, that should not be included. In other words, if the appeal process is post discharge, post service, it should not be included in this data. If the patient is still in care, we want the data.

Q: Concurrent Review is listed twice in the spreadsheet. Was this intentional?
A: No this was a typo. Please complete one Concurrent Review column.

Q: Specifically focusing on Section 2 - Prior Authorization Escalation Data, could you please clarify if the term "escalation" in this context refers to appeals data?
A: This can be understood as any movement from one level of review to another. These are escalations that occur during treatment, in the UM database, not post-service escalations, in the Claims database.

Q: Can you provide an example under the Expedited Internal Review (line 16 under the Definitions tab)? The definition implies the peer-to-peer process has already taken place. Is this taking place under an appeal process?
A: Example of Expedited Internal Review - a case (either prior authorization or concurrent) that is eligible for an expedited internal review during the UM process (not at the post-service claim level) for example, a patient is in inpatient level of care and the services have been denied at peer-to-peer and an additional expedited review is requested (typically must be completed within 72 hours), this review is completed by a physician employed or contracted by the health plan, but must be a different physician than the physician that issued the peer-to-peer denial.

NQTL Identification & Classification (Medical Management) Template

Q: Can you please define the following NQTLs?

- Notification Only
- Failure to Complete/Initiate
- Written Treatment Plan

- Probability of Improvement

A: These NQTLs correspond directly to CMS guidance, titled "Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance."Some of these are also explicitly listed in Colorado Insurance Regulation 4-2-64 Section 7.

- Notification Only
    - This NQTL would be if there is a requirement for a pre-notification or notification for a benefit.
    - Non-exhaustive examples of this are:
        - Plan requires pre-notification or notification ASAP for non-scheduled MH/SUD admissions and reduces benefits 50% if pre-notification is not received.
        - Plan/insurer requires pre-notification for all mental health and substance use disorder inpatient services, intensive outpatient program treatment, and extended outpatient treatment visits beyond 45-50 minutes.
- Failure to Complete/Initiate
    - As illustrated in the Amended Regulation 4-2-64, this NQTL would be exclusions based on the failure to complete (or initiate) a course of treatment.
    - Non-exhaustive examples of this are:
        - Progress Requirements:
            - For coverage of intensive outpatient treatment for MH/SUD, the plan/insurer requires that a patient has not achieved progress with non-intensive outpatient treatment of a lesser frequency.
            - Treatment Attempt Requirements: For inpatient SUD rehabilitation treatment plan/insurer requires a member to first attempt two forms of outpatient treatment, including the intensive outpatient, partial hospital, outpatient detoxification, ambulatory detoxification or inpatient detoxification levels of care.
                - For any inpatient MH/SUD services, the plan/insurer requires that an individual first complete a partial hospitalization treatment program.
- Written Treatment Plan
    - As illustrated in Amended Regulation 4-2-64, an example of this NQTL would be "The carrier routinely approves a number of days without a treatment plan for medical/surgical inpatient, in-network, services, but approves, on a routine basis, a lesser number of days without a treatment plan for behavioral, mental health, and substance use disorders, inpatient-in-network."
    - Non-exhaustive examples of this are:
        - Written Treatment Plan: For MH/SUD benefits, plan/insurer requires a written treatment plan prescribed and supervised by a behavioral health provider.
        - Treatment Plan Required within a Certain Time Period: Plan/insurer requires that within seven days, an individualized problem-focused treatment plan be completed, including nutritional, psychological, social,

medical and substance abuse needs to be developed based on a complex biopsychosocial evaluation. Plan needs to be reviewed at least once a week for progress.
        - Treatment Plan Submission on a Regular Basis: Plan/insurer requires that an individual-specific treatment plan will be updated and submitted, in general, every 6 months.
- Probability of Improvement
    - This NQTL would be if there is a requirement for a certain likelihood or probability of improvement from a benefit or if there is a requirement for a measurable or substantial improvement within a certain amount of days.
    - Non-exhaustive examples of this are:
        - Likelihood of Improvement: For residential treatment of MH/SUD, the plan/insurer requires the likelihood that inpatient treatment will result in improvement.
        - Plan/policy only covers services that result in measurable and substantial improvement in mental health status within 90 days.

Q: Should we answer the question of whether a service is a covered benefit with the assumption that medical necessity is satisfied for that service? A member may have coverage for a service but the member may not satisfy the medical necessity requirement for that service to be a covered benefit based on the member's facts and circumstances at that moment. What is the applicability of the template data? Are we trying to evaluate if we would allow it in the specific setting?

A: When filling out this template, you are to focus on NQTL applications to benefits/ services. So, you should determine whether or not you would apply an NQTL within the specific setting for the specific benefit. A "No" suggests that the benefit will not have an NQTL applied in that specific setting. If there is never a circumstance where this would be covered in this setting, then you would also put no.
To further explain the process, you can think of the steps as a flow chart.

1. Does this benefit/ service apply in this setting?
2. If No, select No. If yes, move to 3.
3. In this setting do we impose any NQTLs?
4. If No, select no. If yes, move to 5.
5. Fill out the specific NQTLs applied.

“Does it apply” should be thought of as “in this setting are there any NQTLs applied to this benefit/service?” If no, then list no.

Q: What does Restricted mean?
A: Restricted can be understood as, if an NQTL is not applied 100% of the time and only in certain circumstances.

Q: What does N/A-No OON Benefits mean? Is it N/A because there are no OON benefits?

A: The latter. Applicable templates for this drop down would be in the OON pages. This was provided to give the option to think through plan designs. For example, federal requirements don't allow for a denial of coverage for a delivery in an OON hospital.

NQTL Verifications

Q: The instructions labeled “total unique claim count” seem to conflict with instructions in the CARC section. In the definitions it indicates “unique claims,” but in the CARC section it indicates to count each individual occurrence. When providing the data, should the count include a count of claims, or a count of the claim lines included on the claim? For past submissions, the DOI advised “…provide the data at the most granular level. If claim lines can be separated, then report them separately and provide the count at the line level.” Can you confirm we should proceed with a count of claim lines?

On each of the Benefit Classifications tabs under Section Three:Correction and Reversals (CR), Claim Adjustment Reasons Code (CARC), if the data is only including original claims, this section would be blank. Is that correct?

A: In response to question 1:

The instructions and definitions state that for the total number of unique claims, you will put the sum total of individual, non-duplicate claims. Any duplicates of the same claim, resubmissions, or corrections of the same claim should **not** be counted additionally towards the total. Voided, canceled, or test/dummy claims should also be excluded.
As for the CARC code counts, you will provide a count of all instances of a CARC code being used. In other words, the sum total of each individual occurrence of each CARC code, regardless of how many times it is associated with the same claim or across different claims. This does not conflict with the “Total # of Unique Claims” data in line 12.

In response to question 2:
No, that is not correct. Because the count of CARC codes is a separate count pulled from the individual, unique claims used in the total number of unique claims, you should still be reporting data in these sections. If a specific CARC code does not occur with the data set within the benefit classification and diagnostic category, then you will enter a zero (0).

As a recap:
Total Number of Unique Claims = the **FIRST** submission of each distinct claim, excluding duplicates, resubmissions, corrections, voided, canceled, and test/dummy claims.
CARC Code Counts = **ALL** individual occurrences of a CARC code in each specific benefit category and diagnostic category within the data collected for the total number of unique claims.

Q: How should we fill out the pharmacy tab if we do not use CARC codes for pharmacy denials? We use NCPDC Reject Codes instead.
A: Please map the NCPDP Reject codes to the CARC categories. Add a new tab and provide the evidence for how you mapped the codes.
