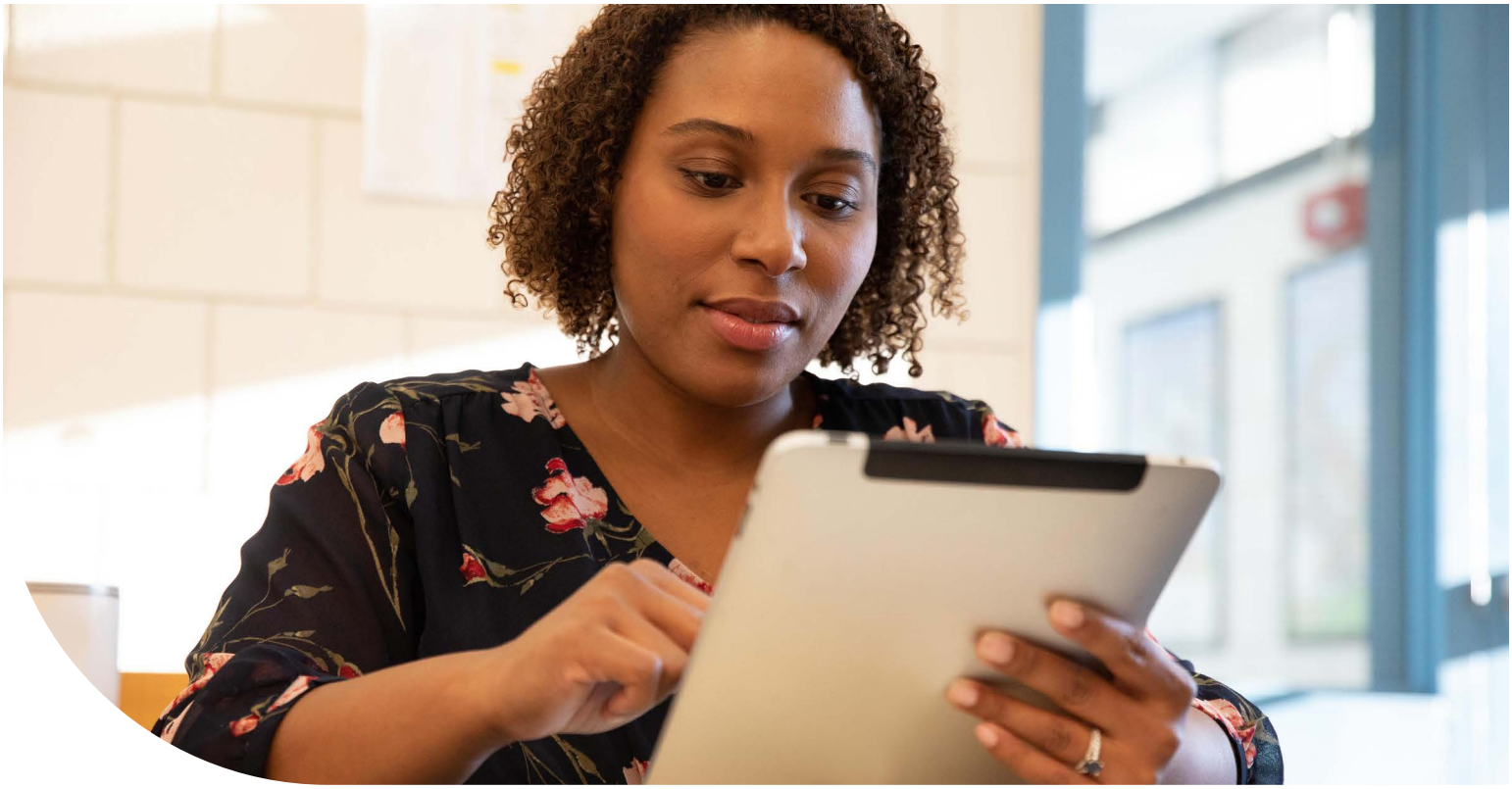

Employer Federal Mental Health Parity and Addiction Equity Act NQTL Fact Sheet 2023

MHPAEA summary for non-quantitative treatment limits

The Mental Health Parity and Addiction Equity Act (MHPAEA) is a federal law that generally prevents group health plans and health insurance issuers that provide mental health or substance use disorder (MH/SUD) benefits from imposing less favorable benefit limitations on those benefits than on medical/surgical (M/S) benefits.

MHPAEA applies to most fully insured and self-funded employment-based group health coverage. MHPAEA does not apply to small self-funded employer group (fewer than 50 employees) plans or church plans. Plans for state and local government employees who are self-insured may opt out of MHPAEA's requirements.

MHPAEA requires testing of three types of limitations: financial limitations, quantitative treatment limitations (QTL), and non-quantitative treatment limitations (NQTLs). Financial limitations and QTLs are numerical limitations such as visit limits, which require actuarial testing and are not covered in this document. NQTLs are non-numerical limitations that limit the scope or duration of benefits for treatment. MHPAEA requires that any processes, strategies, evidentiary standards, and other factors used in applying NQTLs to mental health or substance use disorder benefits in a classification must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards and other factors used in applying the limitation with respect to medical/surgical benefits in such classification.

Humana.

The MHPAEA classifications are outpatient in-network, outpatient out-of-network, inpatient in-network, inpatient out-of-network, emergency care, and prescription drugs.

This document provides a general summary of Humana policies regarding the NQTLs specified below.*

The criteria described in this document are applied to services without regard to whether the services are medical/surgical or mental health/substance use disorder in nature.

Please note that this summary is applicable to standard Humana plan designs. If you have made customized changes for your plan, this summary may not be applicable to you.

Please also note while Humana strives to ensure our standard plans are MHPAEA compliant, employer groups are ultimately responsible for ensuring their plans satisfy MHPAEA requirements. Information regarding conducting a self-assessment for MHPAEA compliance can be found on the DOL's website: Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA) (dol.gov). If you have further questions about the factors, evidentiary standards, or other information used to develop our policies, please reach out to your Account Representative.

*Information is subject to change

Medical necessity NQTL

Medically necessary means health care services that a health care practitioner exercising prudent clinical judgment would provide to his or her patient for the purpose of preventing, evaluating, diagnosing or treating a sickness or bodily injury or its symptoms. Such health care service must be:

- In accordance with nationally recognized standards of medical practice
- Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's sickness or bodily injury
- Not primarily for the convenience of the patient, physician or other health care provider
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the patient's sickness or bodily injury
- Performed in the least costly site

For the purpose of determining whether an item or service is medically necessary, generally accepted standards of medical practice means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of physicians practicing in relevant clinical areas and any other relevant factors.

Experimental, investigational NQTL

Experimental, investigational or for research purposes means a drug, biological product, device, treatment or procedures that meets any one of the following criteria, as determined by Humana:

- Cannot be lawfully marketed without the final approval of the United States Food and Drug Administration (FDA) and lacks such final FDA approval for the use or proposed use, unless (a) found to be accepted for that use in the most recently published edition of the United States Pharmacopeia-Drug Information for Healthcare Professional (USP-DI) or in the most recently published edition of the American Hospital Formulary Service (AHFS) Drug Information; (b) identified as safe, widely used and generally accepted as effective for that use as reported in nationally recognized peer-reviewed medical literature published in the English language as of the date of service; or (c) is mandated by state law
- Is a device required to receive Premarket Approval (PMA) or 510K approval by the FDA but has not received a PMA or 510K approval
- Is not identified as safe, widely used and generally accepted as effective for the proposed use as reported in nationally recognized peer-reviewed medical literature published in the English language as of the date of service
- Is the subject of a National Cancer Institute (NCI) Phase I, II or III trial or a treatment protocol comparable to a NCI Phase I, II or III trial, or any trial not recognized by NCI regardless of phase
- Is identified as not covered by the Centers for Medicare & Medicaid Services (CMS) Medicare National Coverage Determinations Manual, a CMS Operational Policy Letter or a CMS National Coverage Determinations, except as required by state or federal law

Preauthorization NQTL

In network and out of network
Members and/or providers are required to obtain preauthorization for some services and procedures. A current listing of these services can be found at: **Humana.com/pal**

Services can be selected based on one or more of the following:

- The service improves quality of care provided to our members/improve safety and efficacy
- The service improves appropriate selection of members for services, procedures and treatments
- The service decreases the variability in the cost per episode (encourage adherence with clinical literature/ clinical practice guidelines)
- The service is a new/emerging technology or new/emerging indication for an existing technology, which may have limited indications where demonstrated safe and efficacious
- The service has estimated savings for utilization management

Utilization review NQTL

Services on the preauthorization list may require clinical review, in which case the provider will be required to submit clinical information outlining the member's clinical situation/treatment plan to aid in the review process. Humana uses internally and externally developed, evidence-based standardized guidelines. Clinical reviews are managed within the parameters established by published NCQA guidance, as well as applicable state and federal regulatory requirements and follow all guidelines set by the benefits plan.

Exclusions for completing a course of treatment NQTL

Humana does not exclude benefits for failure to complete treatment.

Geographic restrictions that limit duration or scope of benefits for services NQTL

Humana may restrict the geographic location in which services can be received based on the exclusions outlined in the member's Evidence of Coverage. Examples include:

- Restrictions of expenses incurred for service received outside of the United States, except as required by law for emergency care services
- Restrictions to in-network and out-of-network facilities

Pharmacy formulary design NQTL

Pharmacy and Therapeutics (P&T) Committee considers the following criteria as part of an evidence-based review process that guides P&T coverage decisions:

- The pharmaceutical must be approved for marketing by the FDA
- The pharmaceutical should reasonably improve the net health outcome. The pharmaceutical's known beneficial effects on health outcomes as demonstrated by the evidence review should outweigh any known harmful effects on health outcomes
- The improvement must be attainable outside the investigational setting

P&T Committee uses an evidence-based review process to support its coverage decisions. The evidence-based process may include the following:

- Assessing peer-reviewed medical literature including randomized clinical trials (especially drug comparison studies), undisputed articles in medical journals, generally accepted medical textbooks, pharmacoeconomic studies, and outcomes research data
- Reviewing medically accepted indications
- Employing published practice guidelines, developed by an acceptable evidence-based process Reviewing the AMCP Formulary Dossier
- Comparing the efficacy as well as the type and frequency of side effects and potential drug interactions among alternative drug products
- Assessing the likely impact of a drug product on patient compliance when compared to alternative products
- Basing formulary system decisions on a thorough evaluation of the benefits, risks and potential outcomes for consumers; risks encompass adverse drug events (adverse drug reactions and medication errors, such as those caused by confusing product names or labels)
- Consideration of new and existing utilization management (preauthorization, step therapy, quantity limits) policies for consistency with best practices

Pharmaceutical preauthorization and step therapy review NQTL

Certain pharmacy services require preauthorization or step therapy. This list is located at **Humana.com/pal**.

The following factors are used for services selected for preauthorization and/or step therapies within the following sources:

- The review of medical literature (this includes, but is not limited to, peer-reviewed journals, nationally recognized compendia, e.g. American Hospital Formulary Service (AHFS) Compendium, Thomson Micromedex/DrugDex Compendium, National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium, Elsevier Gold Standard's Clinical Pharmacology Compendium) and national treatment guidelines)
- Manufacturer product information
- Consultation with medical professionals

Provider admission into the network NQTL

Acceptance in the provider network is based on network participation requirements. Criteria for participation include:

- Provider must meet credentialing requirements
- Provider has not had previous quality or significant administrative issues
- Provider is willing to accept standard Humana contract reimbursement and abide by all provisions of the contract and the Provider Manual, including state and federal regulations
- Provider's specialty is not subject to any existing exclusive Provider Agreement
- Provider fills geographic coverage or member access needs

Provider credentialing requirements NQTL

Providers must meet all criteria as required by Humana's Credentialing and Re-credentialing Policy. This includes, but is not limited to:

- Licensure (current and valid in states where the practitioner providers care to Humana members)
- Drug Enforcement Administration (DEA) or a Controlled Dangerous Substance (CDS) certificate (current and valid in states where the practitioner provides care to Humana members), as applicable.
- Education and training includes; graduation from medical or professional school; residency, if appropriate; and board certification, if appropriate
- Work history
- Malpractice history
- National Provider Identifier (NPI) and Healthcare Provider Taxonomy
- State sanctions or restrictions on licensure
- Medicare and Medicaid sanctions and exclusions

Provider reimbursement NQTL

There are several in-network reimbursement methodologies that can be used, such as fee schedule, per diem, and per case. The in-network negotiated reimbursement rate is based on several factors, including:

- Centers for Medicare & Medicaid Services (CMS) guidelines and benchmarking
- Service type
- Provider specialty
- Level of provider expertise
- Geographic location
- Demand for services
- Supply of providers
- Medicare reimbursement rates
- Comparison of rates from one or more regional or national database or schedules for the same or similar services
- Programs that review quality

Similarly there are several out-of-network methodologies that can be used, including maximum allowable fee methodology. This means that, except for emergency services, the covered expenses from an out-of-network provider will be paid at the lesser of:

- The fee charged by the provider for the services
- The fee that has been negotiated with the provider whether directly or through one or more intermediaries or shared savings contracts for the services
- The fee established by Humana by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographical area determined by Humana
- The fee based upon rates negotiated by Humana or other payers with one or more network providers in a geographic area determined by us for the same or similar services
- The fee based upon the provider's cost for providing the same or similar services as reported by such provider in its most recent publicly available Medicare cost report submitted to the Centers for Medicare & Medicaid Services (CMS) annually
- The fee based on a percentage determined by Humana of the fee Medicare allows for the same or similar services provided in the same geographic area

The out-of-network reimbursement rates for emergency care is also based on a maximum allowable fee methodology that is an amount equal to the greatest of:

- The fee negotiated with network providers
- The fee calculated using the same method to determine payments for non-network provider services
- The fee paid by Medicare for the same services

Important!

At Humana, it is important you are treated fairly.

Humana Inc. and its subsidiaries do not discriminate or exclude people because of their race, color, national origin, age, disability, sex, sexual orientation, gender, gender identity, ancestry, marital status, or religion. Discrimination is against the law. Humana and its subsidiaries comply with applicable Federal Civil Rights laws. If you believe that you have been discriminated against by Humana or its subsidiaries, there are ways to get help.

- You may file a complaint, also known as a grievance:
  Discrimination Grievances, P.O. Box 14618, Lexington, KY 40512-4618
  If you need help filing a grievance, call **1-877-320-1235** or if you use a **TTY**, call **711**.
- You can also file a civil rights complaint with the **U.S. Department of Health and Human Services**, Office for Civil Rights electronically through their Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or at **U.S. Department of Health and Human Services**, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019**, **800-537-7697 (TDD)**.
- **California residents:** You may also call California Department of Insurance toll-free hotline number: **1-800-927-HELP (4357)**, to file a grievance.

Auxiliary aids and services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Humana provides free auxiliary aids and services, such as qualified sign language interpreters, video remote interpretation, and written information in other formats to people with disabilities when such auxiliary aids and services are necessary to ensure an equal opportunity to participate.

Language assistance services, free of charge, are available to you. 1-877-320-1235 (TTY: 711)

Español (Spanish): Llame al número arriba indicado para recibir servicios gratuitos de asistencia lingüística.
繁體中文 (Chinese): 撥打上面的電話號碼即可獲得免費語言援助服務。
Tiếng Việt (Vietnamese): Xin gọi số điện thoại trên đây để nhận được các dịch vụ hỗ trợ ngôn ngữ miễn phí.
한국어 (Korean): 무료 언어 지원 서비스를 받으려면 위의 번호로 전화하십시오 .
Tagalog (Tagalog – Filipino): Tawagan ang numero sa itaas upang makatanggap ng mga serbisyo ng tulong sa wika nang walang bayad.
Русский (Russian): Позвоните по номеру, указанному выше, чтобы получить бесплатные услуги перевода.
Kreyòl Ayisyen (French Creole): Rele nimewo ki pi wo la a, pou resevwa sèvis èd pou lang ki gratis.
Français (French): Appelez le numéro ci-dessus pour recevoir gratuitement des services d'aide linguistique.
Polski (Polish): Aby skorzystać z bezpłatnej pomocy językowej, proszę zadzwonić pod wyżej podany numer.
Português (Portuguese): Ligue para o número acima indicado para receber serviços linguísticos, grátis.
Italiano (Italian): Chiamare il numero sopra per ricevere servizi di assistenza linguistica gratuiti.
Deutsch (German): Wählen Sie die oben angegebene Nummer, um kostenlose sprachliche Hilfsdienstleistungen zu erhalten.
日本語 (Japanese): 無料の言語支援サービスをご要望の場合は、上記の番号までお電話ください。
فارسی (Farsi)
برای دریافت تسهیلات زبانی بصورت رایگان با شماره فوق تماس بگیرید.
Diné Bizaad (Navajo): Wódahí béésh bee hani'í bee wolta'ígíí bich'į' hódíílnih éí bee t'áá jiik'eh saad bee áká'ánída'áwo'dęę nika'adoowoł.
العربية (Arabic)
الرجاء الاتصال بالرقم المبين أعلاه للحصول على خدمات مجانية للمساعدة بلغتك