JOE LOMBARDO
Governor

DR. KRISTOPHER SANCHEZ
Director

STATE OF NEVADA

Ned Gaines
Commissioner

DEPARTMENT OF BUSINESS AND INDUSTRY
DIVISION OF INSURANCE
1818 East College Pkwy., Suite 103
Carson City, Nevada 89706
(775) 687-0700 • Fax (775) 687-0787
Website: doi.nv.gov
E-mail: insinfo@doi.nv.gov

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

NON-QUANTITATIVE TREATMENT LIMITS

SUMMARY REPORT

Hometown Health Plan, Inc.

NAIC #95350

9/30/2025

(PURSUANT TO NRS 687B.404)

TABLE OF CONTENTS

Glossary of Acronyms and Terms

Below are definitions of the various abbreviations and acronyms used throughout this Report.

ACA: Affordable Care Act

Act: Nevada Mental Health Parity Act

CAR: Comparative Analysis Report

Data Call Responses: Company submissions including the Data Call Template and all supporting materials necessary to show compliance with MHPAEA comparative analysis provisions.

Data Review Team: Regulatory Insurance Advisors, LLC and Division staff

Data Call Template: Excel workbook and data request developed by the Data Review Team to support collection of MHPAEA compliance data and materials.

INN: In-Network

MH/SUD: Mental Health / Substance Use Disorder

MHPAEA: Mental Health Parity and Addiction Equity Act of 2008

Med/Surg: Medical/Surgical

NQTL: Non-Quantitative Treatment Limitation

Division: Nevada Division of Insurance

OON: Out-of-Network

RIA: Regulatory Insurance Advisors, LLC

U.S.C. – United States Code

I. INTRODUCTION & AUTHORITY

NRS 687B.404 (1) requires an insurer or other organization providing health coverage pursuant to chapters 689A, 689B, 689C, 695A, 695B, 695C, 695F or 695G of the Nevada Revised Statutes, including, without limitation, a health maintenance organization or managed care organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid, to adhere to the applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"), Public Law 110-343, Division C, Title V, Subtitle B, and any federal regulations issued pursuant thereto.

NRS 687B.404 (2) also requires the Commissioner of Insurance, on or before July 1st of each year, to prescribe and provide a data request that solicits information necessary to evaluate the compliance of an insurer or other organization with MHPAEA, including the comparative analyses specified in 42 U.S.C. § 300gg-26(a)(8).

Further, NRS 687B.404 (5) requires the Commissioner, on or before December 31st of each year, shall compile a report summarizing the information submitted to the Commissioner pursuant to this section and submit the report to:

(a) The Patient Protection Commission created by NRS 439.908;
(b) The Governor; and
(c) The Director of the Legislative Counsel Bureau for transmittal to:

(1) In even-numbered years, the next regular session of the Legislature; and
(2) In odd-numbered years, the Joint Interim Standing Committee on Health and Human Services.

II. PROCESS & METHODOLOGY

The Division engaged Regulatory Insurance Advisors ("RIA") to create the data request required under NRS 687B.404 (1) and to review subsequent responses. The information requested from the Company included: Comparative Analysis Reports; Medical Management Guidelines utilized to determine Utilization Management ("UM") criteria; UM Requirements for Prior-Authorization ("PA"), Concurrent Review ("CR") and Retrospective Review ("RR"); Network Adequacy; Credentialing Criteria for MH/SUD and Med/Surg providers; Reimbursement Rates; and Claims Ratios and Modification Ratios.

This information is considered the "as written" documentation, in which the Company provides internal processes and procedures, written narratives, summaries, medical management guidelines and additional documentation outlining how they apply Non-Quantitative Treatment Limits (NQTLs) to ensure compliance with Mental Health Parity requirements. Information and supporting documentation was received from the

Company in order to evaluate the Company's Data Call submission and to assess the following:

- Complete and accurate list of covered services, including sufficient supporting documentation (e.g., Certificates of Coverage, Schedules of Benefits).
- Complete and accurate classification of covered services, including:
    - Accurate definitions of services as MH/SUD or Med/Surg,
    - Appropriate classification of services as in-network inpatient, out-of-network inpatient, in-network outpatient (office and other if subclassifying), out-of-network outpatient (office and other if subclassifying), pharmacy, and emergency visits.
- Complete and accurate comparisons of Medical Management protocols, including sufficient supporting documentation,
    - For PA, CR, and RR, narratives for comparability both "as written" and "in operation".
- Complete and accurate comparisons of each Network-related Non-Quantitative Treatment Limitation ("NQTL"), including sufficient supporting documentation, with narratives identifying comparability for "as written" and "in operation".
- Complete and accurate comparisons of application of medical necessity to covered services, including supporting documentation with narratives identifying comparability for as "written" and "in operation".

Federal Regulations define an NQTL as follows:

> **45 CFR 146.136: Parity in mental health and substance use disorder benefits**
>
> (a) Meaning of terms. For purposes of this section, except where the context clearly indicates otherwise, the following terms have the meanings indicated:
>
> …
>
> *(4) Nonquantitative treatment limitations—*
> *(i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification* ***are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in***

the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.

(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include—

(A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;

(B) Formulary design for prescription drugs;

(C) Standards for provider admission to participate in a network, including reimbursement rates;

(D) Plan methods for determining usual, customary, and reasonable charges;

(E) Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail first policies or step therapy protocols); and,

(F) Exclusions based on failure to complete a course of treatment

It is important to understand that an NQTL in and of itself is not a violation, but pursuant to Federal Regulation, the NQTL must be comparable to, and applied no more stringently to MH/SUD providers than to Med/Surg providers. For example, assume a claims administrator has discretion to approve benefits for treatment based on medical necessity. If that discretion is routinely used to approve Med/Surg benefits while simultaneously used to deny MH/SUD benefits and recognized clinically appropriate standards of care do not permit such a difference, the processes used in applying the medical necessity standard are applied more stringently to MH/SUD benefits. The use of discretion in the matter would be an NQTL parity violation.

Additional information in the form of universe data files for claims, including pharmacy, credentialing activity, and utilization management activity for the period was requested from the Company. “In operation” data reviews include identifying and reviewing how the Company is performing and providing services in application, to insureds, to identify NQTL concerns or potential violations, as well as but not limited to the following:

- Clinical review practices which include the act of providing clinical judgment to a utilization review case, typically involving a utilization review manual. An NQTL concern or violation would occur when the Clinical review practices that are utilized in application as compared to the “as written” materials presented are inconsistent.
- Expert reviewer consultation in which the Company seeks out the opinion of a practitioner or reviewer who manages the care in question. For example, a health plan may need to seek out the opinion of a dermatologist if they do not have one on their medical director staff, and when a request may be for a service or item in which dermatology is the appropriate prescribing specialty. An NQTL concern or

violation would occur when the Company utilizes expert reviewer consultation for Med/Surg reviews and determinations with the appropriate background and education, but does not utilize experts with the appropriate background and education for MH/SUD reviews and determinations.

- Company application of medical or professional judgement that includes a professional exercising the scope of their expertise or licensure, likely acting only within that scope, and not consulting a utilization review manual. An NQTL concern or violation would occur if the Company used medical or professional judgement with appropriate background and education for Med/Surg reviews and developing medical management guidelines, while using medical or professional judgement that do not have the appropriate background and education to perform MH/SUD reviews and develop medical management guidelines.
- Provider contract negotiation involves staff from the health plan entering into agreement and terms of a contract with a medical or behavioral health provider. This process may include negotiating rates upon which the provider will be reimbursed when submitting claims for services. An NQTL concern or violation would occur when more stringent or difficult provider contract negotiations exist for MH/SUD providers than Med/Surg providers, and decreased reimbursements for the same services.
- In network and out-of-network utilization refers to the actual number of claims utilized or submitted for in-network, contracted plan providers, versus out-of-network, non-contracted providers. An NQTL concern or violation may occur when access to in-network providers is more prominent for Med/Surg benefits than MH/SUD benefits.

The “in operation” data request required the Company to submit raw data universes for the 2024 period. The data request was specific to: Claims, including Pharmacy, Utilization Management, and Credentialing. This raw data was also utilized to determine Network Adequacy and Reimbursement Rates. Comprehensive data analytics were performed on the data provided to compare the “as written” responses to the “in operation” data. For example, if a Company states in their “as written” documentation that they do not require prior authorization on any MH/SUD benefits, analytics were performed to identify any MH/SUD claims that were denied for no prior authorization.

III. AS WRITTEN FINDINGS

During review of the Company’s submitted “as written” documentation several areas were noted as being deficient.

- The Comparative Analysis Report lacked sufficient documentation to support the Company’s analysis of NQTLs, including factors used and the evidentiary standards relied upon to design and apply them, required definitions for PA, CR, and RR, and Summary of Benefit (SOB) documentation.

- The list of covered services to which PA, CR, and RR applies could not be reconciled to the supporting Certificates of Coverage or other supporting documentation provided.
- During review of Certificates of Coverage ("COC") it was noted that Consumers, providers, and vendors are not given consistent and clear information about how PA, CR and RR reviews are submitted and handled.

IV. IN OPERATION FINDINGS

Data analytics performed identified clear NQTL violations as well as indications of violations where additional reviews may be beneficial with the "in operation" data.

A. UTILIZATION MANAGEMENT/MEDICAL MANAGEMENT

Concerns were identified with the consistent application of utilization management for the Company, including inadequate information or documentation being presented.

Utilization Management was broken down into three categories: 1. Prior Authorization 2. Concurrent Review and 3. Post Service/Retro Review. Within these concerns, MHPAEA NQTL violations were identified.

Concerns:

1. The examiners reviewed the "in operation" data and noted that MH/SUD services that require UM services have a significantly higher OON rate than Med/Surg services that require UM services.

2. The examiners reviewed the "in operation" data and noted that MH/SUD services not only have a higher PA requirement rate than Med/Surg services but also that the rate of denial for those PAs is significantly higher for MH/SUD services than that of Med/Surg services.

3. The examiners reviewed the "in operation" data and noted that MH/SUD services that require urgent UM decisions have a significantly higher denial rate than Med/Surg services that require urgent UM decisions.

Violations:

1. Data analytics confirmed that MH/SUD UM cases not only have a higher PA requirement rate than Med/Surg cases but also that the rate of denial for those PAs was significantly higher for MH/SUD cases that that of the Med/Surg cases. Data analytics showed that **5%** of Med/Surg UM cases required PA, compared to **7%** of MH/SUD UM cases that required PA. It was additionally noted that Med/Surg UM cases that required PA were denied **9%** of the time versus MH/SUD UM cases that required PA being denied **25%** of the time.

2. Data analytics confirmed that MH/SUD services that required urgent UM decisions have a significantly higher rate of denial than Med/Surg services that required urgent UM decisions. Data analytics showed that **2%** of Med/Surg urgent UM cases were denied versus **8%** of MH/SUD urgent UM cases.

These two (2) findings rise to the level of a violation of **45 CFR 146.136** because the "as written" and "in operation", processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits for Utilization Management/Medical Management **are NOT comparable to, and are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.**

Because of these disparities, there are additional barriers to obtaining services and treatments for MH/SUD benefits than presented for standard Med/Surg benefits.

B. NETWORK ADEQUACY

Violations:

1. Data analytics confirmed a significantly higher percentage of MH/SUD cases that require UM were for OON providers than Med/Surg cases. Data analytics showed that **3%** of Med/Surg UM cases were for OON providers, compared to **7%** of MH/SUD UM cases.

2. Claims totals were analyzed to determine the composition of In-Network (INN) providers versus Out-of-Network providers. For Med/Surg providers **96%** of claims were for INN providers, and **4%** were for OON providers compared to **94%** of claims being INN for MH/SUD and **6%** were OON. MH/SUD claims comprised approximately 9% of the claims volume.

3. Claims were then analyzed to determine the volume of denials due to services being rendered by an OON provider. The Company had a denial rate *of **1% as OON** for Med/Surg* claims versus ***3% OON** for MH/SUD* claims. Additionally, approximately 3% of the total UM cases were for MH/SUD claims, but ***7% applied to OON*** providers compared to ***3% for OON*** Med/Surg providers.

These three (3) findings rise to the level of a violation of **45 CFR 146.136** because the "as written" and "in operation", processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits for Network Adequacy **are NOT comparable to, and are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.**

The greater frequency of denials for OON providers for MH/SUD benefits shows that there is an issue with network adequacy, and the access to a network provider is much more prominent in the MH/SUD area than in the Med/Surg area, which presents an additional barrier for MH/SUD services and treatments.

C. CREDENTIALING & REIMBURSEMENT

Concerns:

1. Due to the extremely low reimbursement rates for MH/SUD office visit procedure codes (90833 and 90844), the claims data confirmed that MH/SUD healthcare providers are frequently billing under a general office visit Evaluation and Management (E&M) code (99213, 99214, and 99215) to obtain higher reimbursement rates. Under these circumstances the data documents that MH/SUD providers are still reimbursed at a lower rate than Med/Surg providers for the same procedure code and diagnosis.

2. In reviewing the credentialing and reimbursement data against the claims data, it was also indicated that the same carrier could have several different fee schedules with the Company and was not reimbursed at a consistent rate for all treatments. This occurred with more frequency for the MH/SUD providers than the Med/Surg providers.

Violations:

1. Data Analytics of claims payments confirmed that reimbursement rates were consistently lower for MH/SUD services compared to Med/Surg services for the Company. The following table represents the most commonly used Procedure Codes for office visits and the average reimbursement rates for the services billed under these codes for Med/Surg claims in contrast to MH/SUD claims and the % of difference. This information was derived directly from the “in operation” claims payments data provided by the Company.

The following table reflects the disparity in reimbursement rates between licensed Medical Doctors (MD’s), and licensed Psychologists (PhD’s)

Procedure Code	Average Med/Surg Reimbursement Rate	Average MH/SUD Reimbursement Rate	% difference
99213	$117.06	$114.20	2%
99214	$174.06	$164.86	5%
99215	$245.28	$227.49	8%

These findings rise to the level of a violation of **45 CFR 146.136** because the “as written” and “in operation”, processes, strategies, evidentiary standards, or other factors

used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits for credentialing and reimbursement rates **are NOT comparable to, and are applied more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification, except to the extent that recognized clinically appropriate standards of care may permit a difference.**

While on the surface, it can be argued that the disparity in reimbursement rates is based on educational level, or contractual negotiations, the reality is that it greatly impacts patient access to care and is also a greater exposure for MH/SUD patients. MH/SUD providers are not privy to the reimbursement rates provided to their Med/Surg counterparts so have limited to no negotiating powers to have comparable reimbursement rates. Oftentimes, if the MH/SUD provider is operating under a facility contract, rate negotiations are performed at the facility level and not disclosed to the provider. Further, sole member providers have less negotiation capabilities and oftentimes must take a rate that is offered which does not cover the cost of services.

The overarching issue from a Mental Health Parity perspective is not the amount of income received by the provider, but rather whether the provider accepts the lower reimbursement rate. Many providers have determined that the reimbursement rates for network providers are too low to cover operating expenses, so they choose not to participate in the network which decreases access to an already thin MH/SUD provider network for consumers. Further, if a member chooses to go to an OON provider, they incur greater out of pocket expenses than if they were to go to an INN provider. Because of the perpetuated problems with access to INN providers for MH/SUD benefits, the member is forced to go to an OON MH/SUD provider and must either pay for the entire service/benefit out of pocket or has to pay for anything above the Usual and Customary allowance. This creates a disparity in not only access to network MH/SUD providers, but also requires a greater financial exposure to the consumer, which perpetuates barriers to treatment for MH/SUD benefits and services.

D. CLAIMS

Claims data was utilized as a secondary verification for disparities that were seen in Utilization Management/Medical Management, Network Adequacy, and Credentialing and Reimbursement. Where data analytics provided indications of violations in these areas, the claims data provided a secondary validation step. For example, claims data was analyzed to identify the percentage of denials for Med/Surg claims versus MH/SUD. Then, taking this information further, the data was analyzed to identify the top reasons for denials for each area. This allowed the Data Review Team to determine that significant disparities existed for the denials due to Prior Authorization and Network Providers in the MH/SUD claims versus the Med/Surg claims.

Claims data was also analyzed to confirm the average payments for services for Med/Surg services compared to MH/SUD services and to identify discrepancies and disparities in payments. Because the claims information was derived directly from the

Company's payment systems, it confirmed the actions of the Company's "in operation" activities.

V. SUMMARY & RECOMMENDATIONS

Performing reviews of "as written" information in conjunction with comprehensive data analytics performed on "in operation" data provided by the Company allowed the team to identify and confirm areas of concern in regard to NQTL violations, in the areas of Utilization Management/Medical Management, Network Adequacy, and Credentialing and Reimbursements.

Recommendations:

The Review Team believes that the Division has several options for proceeding and is providing our recommendations accordingly.

1. The Division could consider a strategic targeted market conduct examination of the Company for the areas where violations were evident. This targeted examination would entail obtaining a sample of the files that were identified as violations to review to provide comprehensive documentation supporting the violation. The Division can then take administrative action and levy fines against the Company.

2. The Division could also consider presenting the violations identified to the Company separately to have the Company provide an explanation and action plan for correcting deficiencies identified.

In each of these scenarios, it would be recommended that the Company reprocess claims correctly and make the consumers and providers whole, where appropriate.

A. IMPROVEMENT OPPORTUNITIES FOR THE COMPANY

The Data Review Team recommends that the Company cross references their submitted CARs for consistencies to promote efficiency and accuracy in future Data Calls. The Company should also ensure they provide accurate and complete supporting documentation for the responses presented. In addition, internal references within the Data Call Templates may also be used if the analyses for different NQTLs are the same. For example, if the factors used for a particular covered service are the same for all other covered services within the NQTL tab, the company may reference other cells within the tab. Further, if the analyses are the same for multiple NQTLs, the company may reference other tabs within the workbook. The Data Review Team also recommends that the Company provides clearly defined medical management ratios in support of "in operation" analyses.