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MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

NON-QUANTITATIVE TREATMENT LIMITS

SUMMARY REPORT

(PURSUANT TO NRS 687B.404)

July 3, 2024

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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: Insurer 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 chapter 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 31 of each year, the Commissioner 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.

Based on the Authority presented in NRS 687B.404 (1), the Nevada Division of Insurance ("Division") provided a data request to the insurers for the 2022 plan year. A report was subsequently presented to the Governor's office by the Division outlining the initial processes and deficiencies identified through the review of the data presented. As several deficiencies were identified with the information presented from insurers in response to the data request, the Division sent a Phase II data request to the insurers to obtain additional information.

This report summarizes the findings identified after comprehensive review of Phase II data. This report serves as the follow-up to the initial report that was submitted in December 2023.

II. PROCESS & METHODOLOGY

The Division engaged Regulatory Insurance Advisors ("RIA"), a contracted Division vendor, to create the data request required under NRS 687B.404 (1) and to review subsequent responses. The information requested from the insurers included: Comparative Analysis Reports; Medical Management Guidelines utilized to determine Utilization Management criteria; Utilization Management Requirements for Prior-Authorization, Concurrent Review and Retrospective Review; Network Adequacy; Credentialing Criteria for MH/SUD and Med/Surg providers; Reimbursement Rates; Claims Ratio's and Modification Ratio's. This information is considered the "as written" documentation, in which the insurer's provide 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 were received from sixteen (16) health insurers operating in the NV Marketplace.

The team evaluated the Data Call submissions and assessed 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), and emergency visits.
- Complete and accurate comparisons of Medical Management protocols, including sufficient supporting documentation,
    - For prior authorization, concurrent review, and retroactive/retrospective review, 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 as written and in operation.
- Complete and accurate comparisons of application of medical necessity to covered services, including supporting documentation with narratives identifying comparability as written and in operation.

Deficient or inaccurate responses were identified and noted within each insurer's submission. Examples of the deficiencies included, but were not limited to:

- Insurers state that all inpatient procedures require prior authorization, but further documentation shows prior authorization for inpatient treatments **being applied more stringently** for MH/SUD providers then for Med/Surg providers.
- Insurers stating that they utilize the Milliman Care Guidelines (MCG) for Utilization Management for Med/Surg procedures but utilizing "internally created proprietary Utilization Management Criteria" for MH/SUD treatments. This does not tell us what the

basis for the criteria is, nor who was involved in the creation, and if they possess the expertise to develop the criteria.

- Disparities in the application of Reimbursements between MH/SUD providers versus Med/Surg providers.
- More stringent credentialling processes for MH/SUD providers versus Med/Surg providers.
- Network access disparities for MH/SUD providers. *Of note, disparities in reimbursements and difficulty in credentialing are a factor for network access disparities but could also be the result or a shortage of access to MH health care providers across the country.

As a result of the identified “as written” deficiencies, the Division and RIA collaborated to create a Phase II data request which encompassed the “in operation” data. “In operation” data includes identifying and reviewing how the insurer is performing and providing services in application to identify NQTL concerns or confirm violations. “In operation” may include:

- 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 insurer 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 insurer utilizes expert reviewer consultation for Med/Surg reviews and determinations with the appropriate background and education, but not utilizing experts with the appropriate background and education for MH/SUD reviews and determinations**.
- Insurers apply 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 insurer used medical/professional judgement with appropriate background and education for Med/Surg reviews and developing medical management guidelines, while using medical/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 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*

Nevada Revised Statute 687B.404(1) provides the authority for the Division to enforce this federal law:

NRS 687B.404 Adherence by insurer or organization providing health coverage to certain federal laws regarding mental health and addiction data request; submission of data or report to Commissioner; confidentiality of information; report by Commissioner; regulations.

1. An insurer or other organization providing health coverage pursuant to chapter 689A, 689B, 689C, 695A, 695B, 695C, 695F or 695G of NRS, 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, shall adhere to the applicable provisions of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, Public Law 110-343, Division C, Title V, Subtitle B, and any federal regulations issued pursuant thereto.

It is important to understand that an NQTL in and of itself is not a violation, but pursuant to the 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 denying 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 a NQTL parity violation.

The data request is specific to Claims, Utilization Management, and Credentialing. This raw data was also utilized to determine Network Adequacy and Reimbursement Rates. 2022 data responses were received from sixteen (16) insurers. Comprehensive data analytics were performed on the data provided from each of the insurers to compare the Phase I "as written" responses to the Phase II "in operation" data. For example, if an insurer states in their Phase I response that they do not require prior authorization on any MH/SUD benefits, Phase II analytics were performed to identify MH/SUD claims that were denied for no prior authorization.

III. PHASE II 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. This report presents a breakdown of the violations and indicators by data category.

A. UTILIZATION MANAGEMENT/MEDICAL MANAGEMENT

Concerns were identified with the consistent application of utilization management, including prior authorization/precertification, for all insurers providing data. Within these concerns, MHPAEA NQTL Violations were identified.

***Concerns*:**

1. The Utilization Management as written documentation provided for multiple insurers only presented one (1) to three (3) instances where Prior Authorization (PA) was applied to MH/SUD claims, however the raw claims data presented documented a greater number of claims that were denied for "no prior authorization". This **indicates** the insurers are not correctly identifying Utilization Management (UM) cases in their data, or that the data was presented incompletely. Additionally, UM data files for certain insurers document no UM files for PA. However, claims

data indicates high denial rates with denial codes that **indicate** medical management occurring post-service. These include:

- "Claim Denied Due to Information Not Received Following Requests for Information"
- "This Service, Supply, or Procedure is Not Medically Necessary According to the Plan Definition"

2. Insurers use the terms "Prior Authorization" and "Pre-Certification" interchangeably and inconsistently throughout their Certificates of Coverage (COC's) and in online guidance to consumers. The COC's outline services requiring Pre-Certification, and online guidance outlines services requiring Prior Authorizations. Numerous instances were noted whereby claims were denied for not having "Prior Authorization", but the denial reasons presented were for lack of "Pre-Certification". The inconsistent application of the terms is ambiguous and lead to significant consumer confusion in knowing when it is a requirement to obtain Prior-Authorization. This has been proven to lead to a consumer not obtaining proper Prior-Authorization which results in denials of claims.

<u>Violations:</u>

1. Multiple insurers provided Not Applicable (N/A) in the Phase I responses when asked to identify which benefits required Prior Authorization or Pre-Certification. However, the Phase II analytics confirmed that PA requirements were applied.

2. It was also identified that multiple insurers provided a listing on their website of diagnosis or place of service that required PA and those that did not. Utilization Management denials documented multiple instances of claims that were denied due to not having PA when the website confirmed that PA was not required.

3. Data analytics confirmed that PA is applied more frequently to MH/SUD benefits than to Med/Surg benefits. For one insurer only 27% of Med/Surg benefits required PA while 67% of MH/SUD required PA.

4. Data analytics confirmed that prior authorization denials often occurred with much greater frequency for MH/SUD claims versus Med/Surg claims. For one insurer 51% of MH/SUD denied claims were denied for "No Prior Auth or Referral" as compared to only 20% of Med/Surg denied claims being denied for "No Prior Auth or Referral". This also is a further **indicator** that PA is being applied with greater frequency to MH/SUD benefits than Med/Surg. Additionally, the denial rate for MH/SUD is not commensurate with the volume of services. For example, the data provided by one insurer confirmed that only 7% of claims were for MH/SUD diagnosis, however MH/SUD claims comprised 11% of all denials for PA.

These four (4) 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 **<u>are NOT comparable to, and are applied more stringently than, the processes, strategies, evidentiary standards, or other</u>**

<u>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.</u>

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

B. NETWORK ADEQUACY

<u>Concerns:</u>

1. Data analytics confirmed that a significant number of claims were denied as "not submitted timely" more frequently for MH/SUD claims compared to Med/Surg claims. This **indicates** potential credentialing delays for MH/SUD providers in which the providers are awaiting confirmation of being credentialed as in-network, and then claims are subsequently denied as not submitted timely because the timeframe from treatment to when the providers are credentialed has exceeded the timeframe for submission. This could also **indicate** that providers are forced to hold on to claims while awaiting credentialing into the network.

<u>Violations:</u>

1. Data analytics confirmed that the frequency for denial of claims as Out of Network (OON) were consistently higher across *all* insurers for MH/SUD claims versus Med/Surg claims, which confirms that network adequacy deficiencies are more prominent for obtaining MH/SUD services than Med/Surg services.

While the issue was identified for all sixteen (16) insurers we are providing examples of the disparity for illustrative purposes.

For example, one insurer had a denial rate *of 20% as out-of-network for Med/Surg* claims versus *48% out-of-network for MH/SUD* claims. Additionally, *27% of Utilization Management denials for Med/Surg* were due to out-of-network compared to *67% of denials for MH/SUD Utilization* Management.

For another insurer, data analytics confirmed the following: *Claims Total: Approximately 6% of total claims are MH/SUD,* however 91% of total claims are for In Network Providers (INN) and 8% for OON providers for Med/Surg benefits, while 74% of total claims are for INN Providers and 26% for OON provider for MH/SUD benefits. Additionally, MH/SUD claims are approximately *10% of the denied claims* population, however the volume of denials as OON is very disparate compared to the weighed volume. Additionally, claims denials for Med/Surg services are comprised of 54% for INN providers and 41% for OON providers*, while claims denials for MH/SUD services are comprised of 14% for INN providers and 86% for OON Providers. Further, benefits for Med/Surg claims that required prior authorization comprised of 29% of INN providers for Med/Surg and 71% OON, while benefits for MH/SUD claims that required prior authorization comprised of 0% INN providers versus 100% of OON providers.

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 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 the issue with network adequacy, and the access to a network provider is much more prominent in the MH/SUD area then in the Med/Surg area, which presents an additional barrier for MH/SUD services and treatments.

*5% of Med/Surg claims were listed as N/A for network status.

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 several MH/SUD healthcare providers are frequently billing a general office visit 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 and was not reimbursed at a consistent rate for all treatments. This occurred with much 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. 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 claim payments data provided directly from the insurers. Please note that procedure codes 90833 and 90834 are office visits specific to MH/SUD treatment. This 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
99215	162.61	135.20	18%
99214	122.98	111.82	10%

99213	84.23	73.81	13%
90833	112.20	48.74	79%
90834	207.00	99.58	48%

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 also is 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 the 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 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. This decreases access to an already thin MH/SUD provider network for the consumers. 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

The 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.

The 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 insurers payment systems, this confirmed the actions of the insurers "in operation".

IV. CONCLUSION

While performing the review of the information received in response to the Phase I request, the Data Review Team identified deficiencies in responses that indicated potential NQTL violations. Obtaining and reviewing the data obtained through the Phase II data request allowed the team to perform comprehensive data analytics to confirm these areas of concern and identify additional indicators of violations. NQTL Violations were confirmed in Utilization Management/Medical Management, Network Adequacy and Credentialing and Reimbursements. Indicators for additional NQTL violations were also identified through the analytics.

The Division will be acting to move insurers into compliance with MHPAEA. These actions could include administrative fines and strategic targeted market conduct examinations for the areas where violations were evident. These targeted examinations will entail obtaining a sample number of the files that were identified as violations to provide comprehensive documentation supporting the violation. They will also allow the Division to confirm corrective actions taken by insurers to address violations. A summary of the administrative actions by the Division will be included within its report for the 2023 plan year to be delivered on or before December 31, 2024.