IAA1932 - University of Washington Consultants' Report of Findings and Recommendations to the Office of the Insurance Commissioner related to the Access to Behavioral Health Services Project

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In August 2018, The Office of Insurance Commissioner (OIC) was awarded a $284,000 grant from the Centers for Medicare and Medicaid Services (CMS)/Center for Consumer Information and Insurance Oversight (CCIIO) through its State Flexibility to Stabilize the Market grant program. The goal of this project is to confirm that health insurers offer comprehensive and affordable health benefit designs by examining access to mental health and substance use disorder treatment in the fully insured individual, small group and large group health insurance markets.

The grant provides for, among other activities, review of insurers' implementation of state and federal behavioral health parity statutes and rules. The project will provide the OIC with information needed to determine any gaps in access to behavioral health services coverage, and if there are, their causes and actions needed to address them. The project period is August 2018 to July 2020.

The project includes the following key activities:

- A First Market Scan was issued to carriers on March 1, 2019. Analysis of the responses to that scan began in May 2019. The data and information submitted by carriers through the First Market Scan is confidential under RCW 48. 37.080.

- In May 2019, OIC contracted with the University of Washington, School of Medicine, Department of Psychiatry and Behavioral Sciences to assist in a review of the First Market Scan responses. The First Market Scan responses and recommendations of the clinical consultants inform the focus areas for the Second Market Scan and claims data analysis.

- A Second Market Scan will be issued to carriers by OIC. The focus of this scan will be the impact of carriers' non-quantitative treatment limitation (NQTL) policies and procedures "in operation", and NQTL parity compliance analyses.

- Claims data analysis, which will be informed by the results of the market scans and the consultant's findings. OIC issued the data call to obtain necessary claims data for this analysis on July 26, 2019. Responsive claims data were submitted by carriers in October 2019. Claims data analysis will begin during the spring of 2020.

The outcome of the project activities will be compiled in a report detailing any issues detected and recommended solutions. The report will be issued in the fall of 2020.

This report reflects the findings and recommendations of the University of Washington consultants, under the leadership of Drs. Unützer and Carlo. The report addresses the following objective outlined in IAA1932: "review and analyze the development, substance, and application of Washington commercial health plans' prior authorization and utilization management policies and procedures." The consultants' primary task was to address these objectives from a clinician's perspective.

On 1 March 2019, the Washington OIC sent a Market Scan Questionnaire to eleven major commercial insurers throughout the state. The data and information submitted by carriers through the First Market Scan is confidential under RCW 48. 37.080. In May and early June 2019, this data was transferred to Drs. Unützer and Carlo at the University of Washington via a secure file transfer protocol. Per IAA 1932, data were classified as *Confidential Information Requiring Special Handling*. After detailed discussions with digital security authorities at the University of Washington and the OIC, the data were securely stored on the University of Washington's Microsoft One Drive for Business platform, a HIPAA-compliant cloud drive service.

In June and July 2019, Drs. Unützer and Carlo reviewed the available Market Scan data and formulated an analytic plan. On August 1 and 2, 2019, Drs. Unützer and Carlo conducted a two-day working meeting with a team of national experts on mental health, health insurance, health policy and parity. The following individuals participated:

1. Jürgen Unützer, MD MPH MA - University of Washington
2. Andrew D. Carlo, MD MPH - University of Washington
3. Jim Vollendroff, MHA - University of Washington
4. Henry Harbin, MD - Independent Consultant
5. Sean Corry, BA - Independent Consultant
6. Irvin I. 'Sam' Muszynski, JD - The American Psychiatric Association (APA)
7. Stephen P. Melek, BA - Milliman
8. Stoddard Davenport, MPH - Milliman

All individuals signed a non-disclosure agreement (NDA). Meetings occurred in person at the University of Washington and data were only available to participants while they were physically located on campus. Participants were not permitted to download data or take data away from the University of Washington campus. The meeting itinerary included full-group workshops, small groups and individual work. Available data from each of the eleven insurance companies were independently analyzed by at least one team member and each was discussed with the whole group. After the meeting, Drs. Unützer and Carlo consulted individually with several of the panelists to address remaining questions and to assist in the formulation of our final recommendations.

1. **General Comments, Questions and Concerns:**
   A. In its initial market scan, the OIC did a commendable job requesting large amounts of detailed information spanning multiple domains of parity. This may be one of the most in-depth and comprehensive evaluations of parity to date.
   B. The materials we were able to examine suggest that each of the carriers is making sincere efforts to implement parity between medical/surgical (M/S) and mental health/substance use disorders (MH/SUDs). Several carriers are, in fact, making commendable efforts to ensure parity. This is particularly evident in policies that affect care for individuals with opiate use disorders. Several of the carriers specifically reported that they had implemented policies to make it easier for patients to receive these potentially life-saving treatments.
   C. In some cases, the answers of carriers were inconsistent or incomplete. This may be partially due to the ways in which questions were asked. In many cases, however, carriers simply did not answer the questions as directed or provided vague or general answers without much evidence for statements, such as "there are no differences between approaches to medical/surgical (M/S) and MH/SUDs (Mental Health / Substance Use Disorders) services." One of the most commonly reported concerns about the available data was the lack of a "crosswalk" or specific comparison between M/S and MH/SUDs services. In some cases, carriers answered questions by reporting the specific policies for M/S and MH/SUDs in detail (often hundreds or even thousands of words), but they did not provide meaningful comparisons (even if this was specifically requested in the question) and simply add a concluding statement that there were "no differences" between the approaches to M/S versus MH/SUDs services. In many cases, additional data would be necessary to determine if the policies and procedures of specific carriers do meet parity regulations.
   D. According to the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), carriers must demonstrate parity in both policies/procedures and operation. Although both components are of critical importance, the latter is particularly relevant to clinicians and patients. The first phase market scan did provide some information on operationalization, but it was fairly limited compared to that provided on policies and procedures. We believe that more complete information about the real-world operationalization of policies and procedures could be procured through a claims data analyses of key quantitative (QTLs) and non-quantitative treatment limitations (NQTLs) domains.

E. In addition to detailed analyses of policies/procedures and claims, a thorough understanding of the actual rates of and use of MH/SUDs benefits across different insurance plans and products should be facilitated by future analyses.

2. Noteworthy Findings from Each Market Scan Section

A. **Section 1 - Background & Instructions:**
   a. **Possible Best Practices**
      i. Some carriers reported conducting periodic, internal parity analyses. This is a reassuring finding and consistent with the spirit of parity legislation.
   b. **Possible Concerns**
      i. **In some cases, carrier policy committees appeared imbalanced -** a number of carriers did not appear to have sufficient MH/SUDs experts or clinicians in parent policy committees. In a number of cases, MH or SUDs experts were in MH/SUDs sub-committees, but not on primary panels.
      ii. **Delegated Services -** some carriers delegate administration of MH/SUDs services to behavioral health organizations or other similar entities. Although this does not inherently imply a lack of parity, some delegated arrangements have historically failed to meet parity standards. We noted statements in multiple carriers' policies and procedures suggesting that delegating administration of behavioral health services did not lead to more stringent standards for MH/SUDs services. However, little evidence was provided to confirm that this is, in fact, true in practice.
      iii. **No internal parity analysis -** Some carriers did not specifically report any history of conducting an internal parity analysis. This could explain the lack of "crosswalk" between physical and MH/SUDs services noted in many of the policy and procedures responses. One carrier mentioned that they had not done an internal parity analysis.
      iv. **Number of covered lives -** Carriers did not consistently mention the total number of individuals covered per product. We believe that this would be helpful information in interpreting the data provided (e.g., rates of prior authorization and denials).

B. **Section 2 - Classification of Benefits - Phase 1 interrogatories:**
   a. **Possible Best Practices**
      i. Overall, carriers did a good job of mapping service types into appropriate categories. Coverage was, in general, quite comprehensive.
   b. **Possible Concerns**
      i. **Service classifications -** Each carrier classified the services using the categories stipulated by the Market Scan. However, some carriers did not provide detailed information on how they made decisions about categorizing various services. There were some examples of carriers classifying services in multiple categories. In other cases, carriers merged MH and SUDs into the same category, which was not the way the question was asked. Finally, some carriers inconsistently classified intermediate care services (e.g., partial hospitalization services) as either inpatient or outpatient services. Another matter concerned how plans defined emergency, urgent and elective services in the M/S versus MH/SUDs. It is not clear if they are the same and how criteria were applied. At times, the matter of "danger to self or others," which is a criterion for involuntary commitment in most states, was used as a criterion for admission - there is no clear analogue in M/S services.
      ii. **Omitted services -** in some cases, carriers omitted certain treatments (e.g., residential substance use care) from their lists of covered services. This could be an example of a parity violation.

C. **Section 3 - Health Services Management:**
   a. **Possible Best Practices**
      i. Overall, carriers did a noteworthy job of reporting denial rates for certain services. When rates for M/S services were reported alongside those for MH/SUDs services, it appears that there are no apparent parity violations in many cases. These were some of the most specific data reported in response to the OIC questionnaire.
      ii. In many cases Utilization Review and Medical Necessity policies appeared to be comparable for M/S and MH/SUDs services. One carrier demonstrated that utilization reviews for crisis stabilization care and withdrawal management/detox occur every three days, which is the same interval as the neonatal intensive care unit (NICU).

For inpatient psychiatry, SUDs and M/S, that carrier's review is the same - every 5 days.

iii. Carriers usually reported using widely accepted utilization management guidelines. For mental health and M/S care, InterQual guidelines were often used. The criteria establish by ASAM were most often used for SUDs.

iv. A number of carriers reported covering Psychiatric collaborative care management CPT codes (99492, 99493 and 99494) and chronic care management CPT codes (99490, 99487 and 99489)

b. **Possible Concerns**

i. **Questionable Numbers -** When numbers were provided for figures like inpatient hospitalization denial rates, the overall counts seemed unlikely at times. Some appeared to be high, while others appeared to be low given the size of the population covered. It was often not clear what the actual 'denominator' was for 'numerators' / numbers of events reported (e.g., in-network versus out of network service requests / denials). This raises questions whether data had been omitted or whether Medicaid data had erroneously been included with commercial carrier data.

ii. **Committee membership -** at times, there was no list of names on the broader medical policy committee, so we could not determine whether MH/SUDs professionals were part of the medical policy group (as opposed to a MH/SUDs policy sub-committee). When separate committees are used to manage policies for MH/SUD vs. M/S, it is difficult to assess comparability.

iii. **Appeals and Denials -** While data on denials were provided in some sections for a variety of carriers, appeals data were very rarely included. Since denials can be appealed and reversed, such data would be informative. Denials are not defined equally from plan to plan. Denials for medical necessity reasons are usually what is reported. However, plans can also issue 'administrative' denials and it is not clear if and when these were counted in the numbers provided. Such denials are different from medical necessity denials and often based on the fact that the provider did not provide certain information requested by the plan. In the recent past, NCQA has provided a directive for carriers to better define and report on this.

iv. **Utilization Review (UR)/Medical Necessity (MN) Concerns -** In some cases, there was concern that UR/MN may be more stringent for

MH/SUDs than M/S services. One carrier requires retrospective review for M/S admissions and psychiatric admissions to a general M/S hospital. However, for psychiatric admissions to freestanding psychiatric hospitals, there is a different policy - they require initial and concurrent medical necessity review in an ongoing manner. On other occasions, there was not enough information provided to assess whether utilization review or medical necessity policies were comparable for MH/SUDs and M/S services.

v. **Prior Authorization Concerns -** In some cases, there was concern that prior authorizations were more stringent for MH/SUDs than M/S services. One carrier reported that, for PT/OT/ST, a member can go for 6 visits without a prior authorization. For intensive outpatient care, however, a prior authorization is needed before initiation. For another carrier, PT/OT/ST do not have a prior authorization requirement, while partial hospitalization and intensive outpatient do have that requirement. We note that Washington state law mandates that the first six visits of medically necessary PT/OT/ST services be provided without requiring prior authorization (see RCW 48.43.016). On other occasions, there was not enough information provided to assess whether prior authorization policies were comparable for MH/SUDs and M/S services (e.g., prior authorization forms for each step of the process were not provided).

vi. **Scope of practice -** some carriers alluded to possible scope of practice restrictions that would likely not be consistent with parity legislation. For example, one carrier reported that psychotherapy is generally performed by therapists and not by psychiatrists.

vii. **Non-standard guidelines -** Instead of using standard guidelines for utilization management, some carriers reported using internally developed guidelines for medical necessity reviews of MH/SUD services and technologies. This was not always true for M/S services, which almost always used Milliman Care Guidelines (MCG), Centers for Medicare and Medicaid Services (CMS), or Interqual criteria. In one case, it appeared that M/S UM was based primarily on procedures, while for MH/SUDs it was based on level of care. On other occasions, it was unclear whether guidelines were operationalized comparably for MH/SUDs and M/S services. For at least one carrier, inter-rater reliability was provided for MH/SUDs, but not for M/S.

     viii. **Documentation Requirements -** In some cases, it appeared that documentation requirements were more stringent for MH/SUDs than M/S services.

     ix. **Lack of Operations Data -** This section is perhaps most critical to assess the "clinical" components of parity - in some cases, operations data were incomplete or missing altogether, making the analysis challenging.

D. **Section 4 - Treatment Plans:**
   a. **Possible Best Practices**
      i. Multiple carriers had minimal treatment plan requirements and, when they did, often were flexible about how these could be received (e.g., by telephone, fax, online).
   b. **Possible Concerns**
      i. **Contradictory findings -** In some cases, policies and procedures noted that carriers did not review or require treatment plans for MH/SUDs or M/S services. However, the same carriers also asked for detailed treatment plan information from all providers in the setting of prior authorizations.
      ii. **Treatment Plans and Case Management disparities -** in some cases, M/S services had no policy for written treatment plans, while MH/SUD services had several documents that appeared to be related to treatment planning. The same was true for case management.

E. **Section 5 - Prescription Drugs/Step Therapy/Fail First:**
   a. **Possible Best Practices**
      i. Many carriers reported that, as a result of the opioid epidemic, Suboxone and other Medication-Assisted Treatment (MAT) prescription drugs used to treat opioid use disorders were not subject to prior authorization and/or step therapy requirements.
      ii. Carriers often did a good job of detailing protocols by drug name for each plan. Additionally, details on formulary development processes were provided in a number of cases.
   b. **Possible Concerns**
      i. **Lumping of MH and SUDs Data -** Although the Market Scan requested carriers to report MH and SUDs medication data separately, this was not done in all cases.

ii. **Key Drugs Omitted from Formulary -** Occasionally, important drugs for SUDs, such as Vivitrol, were not on carriers' formularies.

iii. **Formulary Organization -** Some carriers did not sub-categorize medications by category. It would have been helpful if central nervous system (CNS) drugs were separated from the others for the purposes of this parity analysis.

iv. **Medication data were often incomplete -** In a number of cases, mental health and SU medication data were provided, but comparable data were not displayed for M/S care. Even when data were provided, adequate comparisons were often not made. For example, one carrier listed both MH/SUD and M/S drugs that were subject to step therapy, but no comparative analysis was done.

F. **Section 6 - Network Access:**
   a. **Possible Best Practices**
      i. Many carriers reported ongoing efforts to improve MH/SUDs network adequacy and noted that they re-assess their networks regularly.
      ii. Some carriers reported that a national committee periodically reviewed the network adequacy of their plans.
      iii. A number of carriers reported parity with regard to coverage of telehealth services.
   b. **Possible Concerns**
      i. **Questionable Numbers -** Similarly to above, figure denominators often seemed too low or too high (e.g., having 3 total out-of-network claims). In some cases, there was concern that data had been omitted or that Medicaid data had erroneously been included with commercial carrier data. Additionally, similarly to above, data were often missing and/or a crosswalk between MH/SUDs and M/S services was not provided.
      ii. **Higher Out-of-Network Benefit Use for MH/SUDs -** In general, most carriers noted higher out-of-network service use for mental health/SUDs care than for M/S care, a finding that is consistent with a 2019 report by Milliman that is based on a large national claims data analysis <http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf>.

iii. **Differences in Assessment of Network Adequacy -** In many cases, processes for assessing network adequacy were separate for MH/SUDs and M/S services. For example, in one case, panels were used for M/S but not for MH/SUD (i.e., an open network). In other cases, carriers had different policies and procedures for identifying whether they had sufficient in-network providers for MH/SUDs versus M/S, with audits being more comprehensive and frequent for the latter (e.g., assessed monthly for M/S and semi-annually for MH/SUD).

iv. **Acceptance of New Patients -** With few MH/SUDs providers participating in insurance networks, it is very important to know which in-network providers are actually accepting and seeing new patients. Carriers often did not specifically report how they assess whether providers are actually accepting / seeing new patients or how they keep this information up to date on their websites.

v. **Separate or Different Credentialing Processes** – We noted that, for some carriers, processes for provider or facility credentialing differed between MH/SUDs and M/S services. This included different forms/paperwork and more stringent requirements (e.g., MH/SUD providers are asked for W9s and site visits are conducted in some cases). No analysis was provided to demonstrate that it takes a comparable amount of time to be credentialed as a MH/SUDs versus M/S provider.

vi. **Target Ratios Cited but Not Compared -** target ratios were cited for provider types by a number of carriers (i.e., hope to have X number of psychiatrists per Y number of covered lives). However, figures were often not provided for MH/SUDs and M/S providers and comparisons were therefore not possible. Additionally, operations data were not shown, so it was not possible to determine whether carriers were, in fact, in compliance with their stated target ratios.

vii. **Results of internal network adequacy analyses –** several carriers reported that they conduct regular network adequacy analyses, but almost none of them report the results of these analyses, making it difficult to judge if networks are, in fact, adequate.

G. **Section 7 - Delegated Services:**
   a. No noteworthy findings

H. Section 8 - Provider Payment Rates:

    a. **Possible Best Practices**

        i. A number of carriers clearly stated their payment rates and the methodologies for their calculations. These were often based on industry standard Resource-based Relative Value Scales (RBRVS), with few differences noted between MH/SUDs and M/S services.

    b. **Possible Concerns**

        i. **Payment Rate Ranges Not Sub-Classified -** Carriers often reported broad payment ranges, sometimes based upon Medicare allowed levels, but these were not broken down by service or provider type. It would be helpful to see this sub-divided by benefit classification separately MH/SUDs and M/S.

        ii. **Differences in Rate Setting** – Reviewers noted some inconsistencies in the factors considered by carriers in rate setting for M/S providers and MH/SUD providers. Additionally, some carriers reported differences in the frequency of rate updating for M/S versus MH/SUD services. Finally, processes for determining out-of-network rates differed across the types of services.

I. Section 9 - Out of Network Services:

    a. **Possible Best Practices**

        i. Some carriers did a nice job presenting this data quantitatively, making it possible to make a determination of parity.

    b. **Possible Concerns**

        i. **Questionable Numbers -** Similarly to above, figure denominators often seemed too low or too high (e.g., having 3 total out-of-network claims). There was concern that data had been omitted or that data from individuals covered in managed Medicaid products had been included with commercial carrier data. Additionally, similarly to above, data were often missing and/or a crosswalk between MH/SUDs and M/S services was not provided.

        ii. **Higher Out-of-Network Benefit Use for MH/SUDs -** In general, most carriers noted higher out-of-network service use for mental health/SUDs care than for M/S care, a finding that is consistent with a 2019 report by Milliman that is based on a large national claims data analysis <http://assets.milliman.com/ektron/Addiction_and_mental_health_v s_physical_health_Widening_disparities_in_network_use_and_provi

der_reimbursement.pdf>. The observed differences were up to two to three times higher for MH/SUD than for M/S services. For some carriers, out-of-network use rates were 50% or higher for some MH/SUD services. Additionally, in some cases more M/S inpatient claims were approved than those for mental health/SUDs.

    iii. **Out-of-network Benefit Determination -** For some carriers, consultant psychiatrists and psychologists were used for benefit determination for out-of-network services, an approach that could be perceived as subjective (based on available information in Market Scan).

J. **Section 10 - Geography, Facility or Provider Type:**
    a. **Possible Best Practices**
        i. Many carriers cited no geographic restrictions.
    b. **Possible Concerns**
        i. Certain MH/SUD services were required to be received at a particular provider facility type and it was not clear whether there were similar restrictions for M/S services.

K. **Section 11 - Coverage of MAT prescription drugs:**
    a. Many carriers reported that, as a result of the opioid epidemic, Suboxone and other Medication-Assisted Treatment (MAT) prescription drugs used to treat opioid use disorders were not subject to prior authorization and/or step therapy requirements.

L. **Section 12 - Coverage for Alternative Pain Treatment:**
    a. No noteworthy findings

3. Additional Recommendations for Future Analysis

We would like to make a number of recommendations for the second Market Scan that the Washington State OIC plans to conduct as a part of this project. The overall comments described above in **Section 1** could largely be addressed by the inclusion of specific, targeted questions to all of the carriers. These questions would guide the carriers in conducting analyses that they may not have considered in the past - analyses that would get at the core aspects of parity that are most salient to consumers.

Firstly, we believe that the second Market Scan from the OIC should try to improve the quality of information/data on the following clinically relevant areas/topics:

1. **Numeric Data** → we believe that it would be very helpful to know the total number of patients enrolled in each plan for each carrier (the denominators for many of the calculated rates). It would also be helpful for carriers to confirm that the numbers they provided for approvals/denials and in- versus out-of-network claims were accurate and fully inclusive of all data. These numbers are some of the most important data gathered from the Market Scan and provide some of the greatest insight into parity.

2. **Committee Membership** → Many of the carriers reported membership on their policy/procedure committees, while others made this less clear. It would be helpful to have more information on the specific credentials and backgrounds of overall medical committee and behavioral health sub-committee members.

3. **Crosswalks** → For the domains of prior authorization, utilization review and medical necessity, few carriers actually provided a detailed comparison between MH/SUDs and M/S services. It is not sufficient for carriers to present their policies and procedures for each type of service separately and report that they are "not more or less stringent." This analysis should be quantitatively conducted by the carriers themselves and be clearly presented to the OIC. Section three of the Model Data Request Form (MDRF; described below) provides some guidance for how these questions could be asked more precisely.

4. **Utilization management clinical guidelines** → Some carriers did not do an adequate job of reporting which guidelines they used. For carriers who use their own guidelines, it would be very helpful for us to know more about how those guidelines were created and specifically how they are no more stringent than M/S guidelines.

5. **Treatment plans** → It would be helpful if carriers would provide the actual forms required for providers to fill out for MH/SUDs and M/S services. We either did not receive many of these, or it was not entirely clear which forms specifically were treatment plans.

6. **Prescription drug presentation** → It would be helpful if all carriers presented MH, SUDs and M/S drugs separately. In many cases, MH/SUDs drugs were grouped

together, making comparisons challenging. Additionally, it would be helpful if all central nervous system (CNS) drugs were separated from the rest.

Additionally, we recommended that the OIC improve response data on NQTLs by utilizing components of two existing frameworks - the Model Data Request Form (MDRF) and the Six-Step Parity Compliance Guide for NQTLs.

The Model Data Request Form (MDRF)
The MDRF is a series of questions developed by the National Alliance of Healthcare Purchasers that have already been answered by a number of commercial carriers in Washington State in response to requests from major employer purchasers. It includes structured questions targeting NQTLs that are intended to allow employers to (a) better understand the experience of their employees when seeking to access MH/SUD treatment as compared to M/S treatment, (b) assess the adequacy and accuracy of their TPA's MH/SUD provider networks, and (c) request improvements as deemed necessary.

More information on the MDRF is available online: <http://www.mhtari.org/Model_Data_Request_Form.pdf>. Additionally, real-world examples to help with the use of the MDRF are available here: <http://www.mhtari.org/Best_Practice_Examples_NQTL_Compliance.pdf>.

The Six-Step Parity Compliance Guide for NQTLs
This guide, which was published before the Federal Departments of Labor (DOL) and Health and Human Services (HHS) released the MHPAEA self-compliance tool in 2018 < https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/publications/compliance-assistance-guide-appendix-a-mhpaea.pdf>, provides a roadmap with six key steps to assist carriers with their internal NQTL assessments. It was developed collaboratively by the American Psychiatric Association (APA), the Kennedy Forum and the Parity Implementation Coalition. More information about the six-step parity compliance guide for NQTLs can be found here: < https://www.apna.org/files/six_step_issue_brief.pdf>.

Recently, Milliman published a white paper on NQTLs with regard to MH/SUDs and outlined some best practices for evaluation. This report is available at: <http://assets.milliman.com/ektron/NQTL_Guidelines_White_Paper_10-07-19.pdf>. In the following, we suggest several priority NQTLs for analysis in the upcoming Market Scan. These NQTLs would effectively highlight whether plans have complied with the Federal regulations:

1. **Pre-Authorization for Inpatient Classification** - this NQTL encompasses any form of review or criteria that must occur before inpatient care is authorized, including but not limited to medical necessity, level of care, treatment plans, and fail first.

a. **RECOMMENDATION** - **The Six-Step Parity Compliance Guide for NQTLs** - carriers should measure both Out-of-Network (OON) disparities and denial rate disparities as part of the in-operation analysis of the Pre-Authorization NQTL. Services included in inpatient classification should be the same as those reported by the carrier in the first Market Scan submission. If OON disparities are greater than ten percentage points, the carriers should offer an explanation as to how the in-operation processes that led to this disparity are comparable and applied no more stringently and provide a corrective action plan if the carrier determined that the in operation processes were not comparable and/or were applied more stringently.

2. **Concurrent Review Policies for Inpatient and Outpatient Classifications** - this is the mostly frequently used NQTL by carriers for both inpatient and outpatient services. Parity with regard to concurrent review should extend to outlier services, which is defined as those beyond the typical treatment ranges or costs. One common example of an outlier service concurrent review in the MH/SUD field is psychotherapy visits. In some cases, carriers elect to define psychotherapy as an outlier service after 12 visits, subjecting it to concurrent review after that point in treatment. Concurrent review policies (with and without outlier service regulations) must be analyzed and disclosed so that all the steps used in writing and in operation are no more stringent for MH/SUD than comparable M/S services.

    a. **RECOMMENDATION - The Six-Step Parity Compliance Guide for NQTLs -** Plans should be required to measure both OON and denial rate disparities as part of this NQTL analysis. If OON disparities are greater than ten percentage points, the carriers should offer an explanation as to how the in-operation processes that led to this disparity are comparable and applied no more stringently and provide a corrective action plan if the carrier determined that the in operation processes were not comparable and/or were applied more stringently.

3. **Experimental vs. Non-Experimental Treatments** - Although experimental treatments are relatively rare in the MH/SUD field, coverage disparities can prevent patients from receiving potentially beneficial treatments. This has been outlined in a recent FAQ published by the DOL and HHS: < https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-39-final.pdf>. According to the document, "A medical management standard that limits or excludes benefits based on whether a treatment is experimental or investigative is an NQTL under MHPAEA. A plan or

issuer may impose an NQTL on MH/SUD benefits if, under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors used by the plan in applying its NQTL with respect to MH/SUD benefits are comparable to, and applied no more stringently than, those used in applying the NQTL with respect to medical/surgical benefits in the same classification." See pages 5 and 6 of the above FAQ report for details.

    a. **RECOMMENDATION - The Six-Step Parity Compliance Guide for NQTLs -** Plans should be required to measure both OON and denial rate disparities as part of this NQTL analysis. If OON disparities are greater than ten percentage points, the carriers should offer an explanation as to how the in-operation processes that led to this disparity are comparable and applied no more stringently and provide a corrective action plan if the carrier determined that the in operation processes were not comparable and/or were applied more stringently.

4. **Reimbursement Rates** - this is one of the most essential and influential NQTLs. It is critical to ensure that the methods for calculating and applying reimbursements for MH/SUD and M/S services are comparable.

    a. **RECOMMENDATION - The Model Data Request Form (MDRF) -** We recommend using the MDRF pages 4-6 for guidance <http://www.mhtari.org/Model_Data_Request_Form.pdf>. This analysis is limited to E&M codes and therefore mostly outpatient services.

5. **Exclusion of Behavioral Health Services in Any Classification of Benefits -** This NQTL refers to a carrier's decision to not cover specific MH/SUD services, such as eating disorders residential treatment or certain behavioral health lab tests. <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-39-proposed.pdf>. According to the MHPAEA, "treatment limitations imposed on MH/SUD benefits cannot be more restrictive than treatment limitations that apply to medical and surgical benefits. An exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of the definition of "treatment limitations" in the MHPAEA regulations." For example, barring state-level regulations stipulating the contrary, plans may elect to not provide coverage for conditions such as eating disorders. However, once some aspect of treatment for a disorder is covered, then NQTL management must be no more stringent for MH/SUD than M/S services in the same classification.

    a. **RECOMMENDATION - The Six-Step Parity Compliance Guide for NQTLs**

6. **Disclosure Responses -** It is important, as part of an NQTL analysis, to review and analyze carriers' disclosure response policies for consumers and authorized providers. If a carrier receives a request from a consumer or a provider to explain the rationale for a denial, MHPAEA stipulates that the plan must summarize all of the NQTL analyses that were the basis of the denial. See page 11-12 in the following document for more details on disclosure requirements: <https://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf>. Of note, this disclosure requirement may also compel carriers to complete MHPAEA-required internal NTQL parity analyses.

    a. **RECOMMENDATION - The Six-Step Parity Compliance Guide for NQTLs**

7. **Network Directory Accuracy -** Extensive research has shown that many commercial carrier behavioral health networks are actually "ghost networks," meaning that few in-network providers are actually accepting new patients.

    a. **RECOMMENDATION - The Model Data Request Form (MDRF) -** as outlined in the referenced Milliman report, <http://assets.milliman.com/ektron/NQTL_Guidelines_White_Paper_10-07-19.pdf>, the MDRF includes detailed guidance on this NQTL - see page 9 for details: <http://www.mhtari.org/Model_Data_Request_Form.pdf>. If the number of providers who submitted zero claims or submitted claims for 1-4 unique enrollees constitutes more than 10% of the in-network providers during the last month of the most recent six months in 2018, carriers should provide a clear action plan for remediation. Distinct analyses should be included for psychiatrists, psychologists, social workers, SUD providers and others.

8. **Provider Credentialing (Inpatient) -** If MH/SUDs providers are required to proceed through a more time-consuming or intensive credentialing process than M/S providers, then there could be evidence for a parity violation.

    a. **RECOMMENDATION** - **The Six-Step Parity Compliance Guide for NQTLs -** carriers should measure both Out-of-Network (OON) disparities and denial rate disparities as part of the in-operation analysis of the provider credentialing NQTL. Services included in inpatient classification should be the same as those reported by the carrier in the first Market Scan submission.