

Presentation for November 23, 2020 Maryland Insurance Administration National Meeting

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Background and Experience

For over the past 10 years, Dr. Harbin's and Ms. Middlebrook's experience with parity compliance includes:

- Co-authors of The "Six-Step" Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements
- Informing the DOL/HHS regulatory and sub-regulatory process with submissions of FAQs, Best Practice Examples and numerous presentations on NQTL implementation and enforcement
- Provided input to Clear Health Quality Institute (CHQI) on Parity Accreditation Guidelines (now owned by URAC)
- Conducting audits of WA State health plan responses to Second Market Scan on parity compliance
- Participated in working group sessions with national health plans per HHS/ASPE to reach consensus on disclosure requirements under MHPAEA, ERISA Section 104 and Claims Procedures, Internal Claims & Appeals, External Review Processes requirements
- Panelists on Parity/NQTL compliance for NAIC Summer 2020 National Meeting
- Participated in working groups with health plans on NQTL medical management protocols
- Co-chair and Consultant for the Parity Implementation Coalition
- Dr. Harbin has been a Parity Consultant to the American Psychiatric Association and the Kennedy Forum.
- Ms. Middlebrook was Managing Editor of the Kennedy Forum Parity Resource Guide for Addiction & Mental Health Consumers, Providers and Advocates.
- Dr. Harbin was a panelist for the 2020 DOL Parity Compliance Listening Session.
- Ms. Middlebrook was a presenter at the White House Mental Health and Substance Use Disorder Parity Task Force stakeholder listening session.

Challenges with NQTL Compliance

Challenges with NQTL compliance on the part of plans are being seen in both federal and state regulatory audits (and by employers) including, but not limited to:

- Lack of, or failure to provide, ***quantitative evidentiary standards that necessarily define many factors*** utilized in designing NQTLs, also referred to as “thresholds” that trigger the application of an NQTL;
- Lack of, or failure to provide, the ***comparative analyses*** between MH/SUD and medical/surgical benefits demonstrating comparability and no more stringency, both “in writing” and “in operation”, with respect to the design and application of the NQTL;
- Especially for “in operation” comparability and no more stringency analyses, lack of, or failure to provide, ***outcomes measures data*** evidencing either compliance or a Warning Sign warranting further investigation into NQTL compliance;
- When reviews of market data or trends are conducted, including for reimbursement rates, failure to provide the ***market data*** or how the plan’s own actions, including reimbursement rates, ***compare to such market data***;
- Failure to respond in a complaint manner to ***disclosure requests***, as set forth in **FAQs About Affordable Care Act Implementation Part 31, Mental Health Parity Implementation, etc.**, issued April 20, 2016 at Q9, <http://www.dol.gov/sites/dolgov/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-31.pdf>

Challenges with NQTL Compliance (cont'd)

Challenges on the part of regulatory agencies are also being seen, including, but not limited to:

- Many regulators do not specify in their market scans *what analyses* and *results* from those analyses are required.
- Many regulators do not identify a *specific methodology and definitions* for *measuring disparate outcomes* such as reimbursement rates, out-of-network use and denial rates, etc.
- In addition, some regulators may not *specify* that it is required that the NQTL analyses be consistent with the *DOL/HHS MHPAEA Self-Compliance Tool* (e.g., quantitative evidentiary standards that define factors must be provided, outcomes measures disparities are a necessary part of the “in operation” compliance analyses and must be conducted and provided, etc.).

When regulators (or employers) request comparative data on disparate outcomes without providing a specific methodology and definitions for these measures and analyses, such requests are highly unlikely to yield useful data.

The Steps Required for NQTL Compliance Analysis

2020 MHPAEA Self-Compliance Tool

DOL/HHS has adopted a multi-step parity compliance guide for NQTLs in the 2020 MHPAEA Self-Compliance Tool that is consistent with The “Six Step” Parity Compliance Guide for Non-Quantitative Treatment Limitation (NQTL) Requirements, the key elements of which include:

Step 1. Identify the NQTL, including all services the NQTL applies to in each benefit classification;

Step 2. Identifying the factors considered by the plan in designing each NQTL;

Step 3. Defining each factor according to the source and ***any evidentiary standard, including quantitative measures that trigger the application of the NQTL;***

Step 4. Comparative analyses between MH/SUD vs. medical/surgical benefits, ***for each NQTL, both as written and in operation***, demonstrating that the NQTL was developed and applied comparably and no more stringently. Such analysis ***necessarily includes outcomes data*** such as ***denial rates, reimbursement rates and out-of-network utilization***. ***Disparities*** in this data between MH/SUD vs. medical surgical are a **WARNING SIGN** or **RED FLAG**, indicating that further investigation into the comparability and stringency in application of NQTL processes, strategies, evidentiary standards and other factors is warranted.

See **2020 DOL/HHS MHPAEA Self-Compliance Tool**: <https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/mental-health-parity/self-compliance-tool.pdf>

2020 MHPAEA Self-Compliance Tool (cont'd)

Evidentiary Standards that Define Factors

- The **MHPAEA Final Rules**, Example 2 under the NQTL rule, demonstrates that plan information required as part of the NQTL analysis includes the quantitative evidentiary standard that defines the factor: A plan applies concurrent review where there are “high levels of variation in length of stay (*as measured by a coefficient of variation exceeding 0.8*).” (Emphasis added).
- The Self-Compliance Tool directs: “[A]lso identify any threshold at which each factor will implicate the NQTL.” “Examples of how factors identified based on evidentiary standards may be defined to set applicable thresholds for NQTLs include, but are not limited to, the following:
- Excessive utilization as a factor to design the NQTL when utilization is *two standard deviations above average utilization per episode of care*.
- Recent medical cost escalation may be considered as a factor based on internal claims data showing that medical cost for certain services increased *10 percent or more per year for two years*.” (Emphasis added).

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2020 MHPAEA Self-Compliance Tool

Evidentiary Standards that Define Factors (cont'd)

- “Lack of adherence to quality standards may be considered as a factor when deviation from generally accepted national quality standards for a specific disease category occurs more than 30 percent of the time based on clinical chart reviews.
- High level of variation in length of stay may be considered as a factor when claims data shows that 25 percent of patients stayed longer than the median length of stay for acute hospital episodes of care.
- High variability in cost per episode may be considered as a factor when episodes of outpatient care are two standard deviations higher in total cost than the average cost per episode 20 percent of the time in a 12-month period.
- Lack of clinical efficacy may be considered as a factor when more than 50 percent of outpatient episodes of care for specific diseases are not based on evidence based interventions (as defined by nationally accepted best practices) in a 12-month sample of claims data.”

(Emphasis added).

2020 MHPAEA Self-Compliance Tool (cont'd)

Examples of Warning Signs for Reimbursement Rates

The Self-compliance Tool provides specific examples of **WARNING SIGNS** “related to provider reimbursements that may be indicative of noncompliance and warrant further review”:

“1. Inequitable reimbursement rates established via a comparison to Medicare: A plan or issuer generally pays at or near Medicare reimbursement rates for MH/SUD benefits, while paying much more than Medicare reimbursement rates for medical/surgical benefits. For assistance comparing a plan or coverage’s reimbursement schedule to Medicare, see the PROVIDER REIMBURSEMENT RATE WARNING SIGNS in Appendix II.

2. Lesser reimbursement for MH/SUD physicians for the same evaluation and management (E&M) codes: A plan or issuer reimburses psychiatrists, on average, less than medical/surgical physicians for the same E&M codes.

3. Consideration of different sets of factors to establish reimbursement rates: A plan or issuer generally considers market dynamics, supply and demand, and geographic location to set reimbursement rates for medical/surgical benefits, but considers only quality measures and treatment outcomes in setting reimbursement rates for MH/SUD benefits.” p. 21

(Emphasis added).

2020 MHPAEA Self-Compliance Tool (cont'd)

Examples of Outcomes Data Necessary for Operational Analysis

- The Self-Compliance Tool also provides guidance on the need for outcomes data to conduct a complete NQTL operational comparability analysis:
- “Determine *average denial rates and appeal overturn rates* for concurrent review and assess the parity between these rates for MH/SUD benefits and medical/ surgical benefits.” p.13
- “For the period of coverage under review, plans and issuers should be prepared to *provide a record of all claims (MH/SUD and medical/surgical) submitted and the number of those denied within each classification of benefits.*” p. 20
- “NOTE: While outcomes are NOT determinative of compliance, *rates of denials may be reviewed as a warning sign, or indicator of a potential operational parity noncompliance.*” p. 17

(Emphasis added).

Additional Resources: Best Practice Examples with Regulatory Guidance Embedded; Milliman White Paper on NQTL Analyses

- The *Best Practice Examples with Regulatory Guidance Embedded*, [http://www.mhtari.org/Best Practice Examples NQTL Compliance.pdf](http://www.mhtari.org/Best_Practice_Examples_NQTL_Compliance.pdf) provide detailed narrative guidance on how to conduct a complete and compliant NQTL analyses for NQTLs such as preauthorization and concurrent review, reimbursement rates, exclusions from or limitations on benefits and plan disclosure.
- The Milliman White Paper entitled *Nonquantitative treatment limitation analyses to assess MHPAEA compliance*, [http://www.mhtari.org/NQTL Guidelines White Paper 10-07-19.pdf](http://www.mhtari.org/NQTL_Guidelines_White_Paper_10-07-19.pdf) provides guidance through the Six-Steps process, including quantitative, claim data driven comparability analyses to ascertain disparities between NQTLs applied to MH/SUD and medical/surgical benefits.

The Model Data Definitions and Methodology form (MDDM)

- The Model Data Definitions and Methodology form (“MDDM”), <http://www.mhtari.org/model-data-definitions-method.pdf> contains *specific, detailed instructions and definitions* developed to elicit targeted, *consistent and reliable responses* from plans on *quantitative measures for determining outcomes disparities* related to network adequacy and other NQTLs.
- The source document for the MDDM is the Model Data Request Form (MDRF), which was tested and retested by multiple national experts including Milliman and has been recognized and endorsed by URAC’s Parity Accreditation Standards as a best practice.
- The MDDM requests data that measures:
 - 1) Disparities in Out-of-Network Use for MH/SUD vs. medical/surgical
 - 2) Disparities in Reimbursement Rates for MH/SUD vs. medical/surgical providers
 - 3) Disparities in Denial Rates for MH/SUD vs. medical/surgical services
 - 4) Network Provider Directory Accuracy and Participation
- *Absent specific definitions and methodology for analysis incorporated in the MDDM, plans are simply not able to test or report disparities in outcomes in a consistent, reliable or meaningful manner.*
- Washington State OIC has utilized the MDDM as part of its Second Market Scan audit of health plan parity compliance.