



STATE OF NEVADA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF HEALTH CARE FINANCING AND POLICY

FINAL REPORT
MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA) OF 2008

OCTOBER 2, 2017

1. INTRODUCTION

As required by the Mental Health Parity and Addiction Equity Act of 2008, the Division of Health Care Financing and Policy (DHCFP) has reviewed the four benefit packages offered to Nevada Medicaid recipients to ensure a compliance review was conducted by October 2, 2017. This final report provides an overview of the steps the DHCFP has taken to ensure parity across both Medical/Surgical (M/S) and Mental Health and Substance Use Disorders (MH/SUD) services.

In order to complete a compliance review, the DHCFP dedicated staff resources to this effort across all impacted programs. In addition, Nevada was one of only 20 States to be awarded participation in the SAMHSA sponsored Medicaid and CHIP Parity Policy Academy (MPPA) which was held on March 23 and 24, 2017 in Rockville, MD. The DHCFP gained knowledge regarding the requirements of the MHPAEA Act as well as an approved Parity Compliance Tool specifically designed for Nevada Medicaid and Children's Health Insurance Premium (CHIP). In addition, the DHCFP was afforded the support of a coach, Suzanne Fields, who provided guidance and support through September 6, 2017.

2. PROJECT DESCRIPTION

The DHCFP began this project by identifying the primary focus, the tools needed to review parity by October 2, 2017, as well as the compliance factors used to demonstrate parity in Nevada. This project ensured Nevada's compliance with MHPAEA within the required timeframes. The DHCFP reviewed four benefit packages for both Fee for Service (FFS) and Managed Care Organizations (MCOs) that included authorization processes, recipient access, provider access, and facility access. While it was not required to review FFS for parity, several services have been carved out of the MCO packages resulting in the DHCFP completing a comprehensive review of FFS packages to demonstrate parity. Topics addressed included:

- Parity Requirements
- Determining parity
- Defining Mental Health (MH) and Substance Use Disorder (SUD) Benefits
- Defining Benefit Packages
- Defining Classifications
- Mapping Benefits to Classifications
- Analysis of Financial Requirements (FRs)
- Analysis of Quantitative Treatment Limitations (QTLs)
- Analysis of Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)
- Identifying and Analyzing Non-Quantitative Treatment Limitations (NQTLs)
- Requirements for Medicaid Alternative Benefit Plans (ABPs)
- Requirements for the CHIP
- Compliance with Availability of Information Requirements

It is important to highlight that the State of Nevada's Department of Health and Human Resources (DHHS) and appropriate divisions under DHHS have adopted, or are in the final process of meeting all CMS parity requirements to ensure all recipients receive quality integrated care across their lifespan. This includes parity compliance for all beneficiaries who:

1. Receive only Medicaid (FFS) state plan services;

2. Move from Title XXI to Title XIX benefit packages; or
3. Are enrolled in FFS or in an MCO.

2.a. Communications Plan

MHPAEA compliance analysis was a top priority for the DHCFP, the DHHS and the State of Nevada. To perform a successful analysis, effective communication with all internal and external stakeholders was essential. Communication conducted throughout this project was based on the basic principle that the team must ensure parity compliance and will provide responsive and timely solutions to any identified parity deficiencies. The DHCFP will also champion the effort for ongoing communication to the public of outcomes in parity monitoring and compliance.

Communications conducted by the DHCFP included:

- Kickoff Meeting - Introduction of MHPAEA and how the DHCFP planned on reviewing current practices and policies for compliancy.
- Core Team Meetings - Weekly meetings with core team members to review the ongoing MHPAEA project.
- Technical Design Meetings - Incorporated into the core team meetings. Included detailed discussion of information to include on the DHCFP public facing website.
- Monthly Project Status Meetings - Bi-weekly meetings with Project Sponsors. Included status updates.
- Project Status Reports - Bi-weekly e-mailed correspondence to Project Sponsors, core team and internal stakeholders. Included status of the project milestones including activities, progress, costs and issues.
- Tribal Notification-Letter sent to all 27 Tribes in Nevada that explained the intent of MHPAEA, what the DCHFP would be doing to meet compliance with the regulations, and if there would be an impact to the tribes. The letter also gives tribal leadership the opportunity to request consultation to discuss the impact in more detail. MHPAEA was a topic on the agenda for Tribal Consultation and updates where provided to the tribes throughout the planning.
- Technical Assistance Calls - members of the DHCFP core team were actively involved in technical assistance calls with the team coach throughout the project period.
- Peer Learning Session Calls - members of the DHCFP core team participated in the peer learning session calls throughout the project period.

2.b. Milestones

The DHCFP included a Milestone Schedule in the original Project Summary which included major changes and communication to maintain the deadlines set forth by the Centers for Medicare and Medicaid Services (CMS) for MHPAEA. The projects identified in the milestones chart included:

- Identification of benefit packages within MCO and FFS.
- Defined the MCO and FFS benefit classifications that included inpatient, outpatient, prescription drugs, and emergency care Compliance Review.

- MCO and FFS review of identified NQTLs that include prior authorization, recipient access, provider access, and facility access.
- Tribal Notification Letter.
- Completed MHPAEA Report.
- Public Facing Website implementation and continuous update.
- Implementation of MHPAEA Parity Compliance Review & Monitoring Plan.
- Submission of the Completed Analysis and Report to Internal Stakeholders.
- Submission of the Complete Compliance Review Report to CMS.
- Ensure on-going Compliance, Monitoring and Reviewing.

3. ANALYSIS APPROACH

1. To prepare for the parity analysis, the DHCFP began by identifying the four benefit packages which would be reviewed. These benefit packages included FFS, MCO, CHIP, and the ABP.
2. Managed Care is delivered through three separate health plans with specific carve outs that are included within the FFS population.
3. CHIP expansion has been identified as being compliant with Early Periodic Screening, Diagnostic, and Treatment.
4. The DHCFP reviewed each benefit package to determine who would be responsible for the parity analysis, either the DHCFP or the MCO.
5. The DHCFP determined which services were covered under M/S or MH/SUD benefits. (Appendix A)
6. The DHCFP identified the four benefit classifications (inpatient, outpatient, prescription drugs, and emergency care) and listed out the services in the appropriate field of either M/S or MH/SUD for each classification.
7. Based on clarification and guidance from the CMS MHPAEA Toolkit and our SAMHSA coach, Nevada does not have any Quantitative Treatment Limits (QTL), all services are offered through a Non-Quantitative Treatment Limit (NQTL) approach.
8. NQTL Analysis was conducted which is explained in more detail in 3.b section of this report.
9. The DHCFP assessed the compliance with requirements regarding availability of information which is explained in more detail in 3.d section of this report.
10. The DHCFP created a public facing webpage located on our website <http://dhcfnv.gov> which includes general MHPAEA information, the State's approach to parity, and the final results of our parity analysis.
11. The DHCFP has identified two (2) areas that require remediation for parity compliance. Details are provided in section 3.c of this report.

3.a QTLs, FRs and AL/ADLs

The DHCFP conducted a full review of our benefit packages and services and have determined that Nevada does not have any QTLs, FRs or Aggregate AL/ADLs.

3.b NQTL Analysis

Nevada Medicaid includes the four benefits packs that were previously identified. Apart from FFS, MCO's includes the same benefit package that is offered to the Medicaid population for the two urban areas of Nevada. The DHCFP contracts with three MCOs: Amerigroup, Health Plan of Nevada and Silver Summit Health Plan. There are no subcontractors within the MCOs, the MCOs are fully responsible for all benefits. Optum, a subcontractor under Quality Improvement Organization (QIO), DXC is the benefit manager for FFS pharmacy. Both the DHCFP and the MCOs were provided an NQTL analysis/review tool for each benefit classification suggested in the MHPAEA toolkit including: inpatient, outpatient, prescription drugs and emergency care. The NQTL analysis was divided into two groups, comparability and stringency. The DHCFP and the MCOs reviewed current practices and policies to ensure completion of this tool which would provide the basis for the NQTL summary.

The DHCFP in conjunction with the three contracted MCOs completed the NQTL analysis through the month of July 2017. Throughout the project both group and individual technical assistance was offered to each of the MCOs to assist with understanding of the review process. The purpose of this analysis was to identify current practices and policy and to finalize the analysis with a summary. The summary included four questions which depending on the answer, could result in a parity compliance issue. The four questions are as follows:

1. Is the justification for the NQTL based on reasonable standards of practice?
2. Is the NQTL comparable for MH/SUD benefits and M/S benefits?
3. Is the NQTL for MH/SUD more or less stringent than the NQTL for M/S? If more stringent clarify.
4. If you have identified that the NQTL is not comparable and/or is more stringent, describe your plan to ensure compliance with MHPAEA by October 2, 2017.

3.c NQTL Findings

Based on the analyses provided, there were no identified parity issues presented by the MCOs. The DHCFP, however, did find two areas which required remediation.

During the Authorization Process NQTL review, Crisis Intervention was a service identified as not demonstrating parity. Current policy restricts this service to four (4) hours per day for up to a five (5) day period (one occurrence). A single occurrence may not exceed five (5) days. The DHCFP found, through data analysis, that current practices did not match policy in that providers were able to extend authorization for Crisis Intervention which exceeded the policy limits making this service an NQTL, not a QTL. However, per MHPAEA guidance, policy and practices must both demonstrate parity compliance. The DHCFP has since submitted an amendment to our policy to reflect the National Standards allowing the implementation of soft limits by allowing the providers to extend services per authorization for any recipient that meets the medical necessary criteria. Policy has been updated to allow override capability to be allowed as follows: Service Limitations-Recipients may receive a maximum of four (4)

hours per day over a three (3) day period (one occurrence) without prior authorization. Recipients may receive a maximum of three (3) occurrences over a 90-day period without prior authorization.

During the Recipient Access NQTL review, the DHCFP identified that prior authorization may be requested for an additional assessment and therapy services for a Level III and above only. This policy excluded the additional assessment access to those individuals who met a Level I or Level II causing an access issue for recipients. Policy has since been amended to reflect that an additional assessment may be requested for all Levels, not excluding any Levels.

The DHCFP has an internal review process prior to policy changes being presented to the public. These policy amendments were sent through our internal review process and are scheduled to be read in and accepted during our Public Hearing on November 16, 2017. The DHCFP understands that these changes surpass the CMS deadline for parity compliance of October 2, 2017; however, notification was provided to CMS on September 29, 2017 and receipt was acknowledged.

Appendix B includes the complete NQTL analysis for the DHCFP, Amerigroup, Health Plan of Nevada and Silver Summit Health Plan. Within this analysis includes the definition for the four benefit packages. The DHCFP completed a full review of each NQTL submitted and has included the NQTL summary findings for each benefit package, each MCO and the DHCFP.

3.d Availability of Information

1. The DHCFP provides a Notice of Decisions (NOD) to recipients and providers when a negative action is taken. This includes a denial, termination or reduction of services. The NOD includes information informing the recipient and/or provider of the request that was made, the outcome and the supporting Medicaid Services Manual (MSM) section. Criteria for medical necessity is located within the supporting MSM and is available to recipients and/or providers upon request with the respective MCO or FFS fair hearings unit. The MSM is also available publicly through the DHCFP website. Additional information pertinent to Medicaid providers is located on Nevada Medicaid's Fiscal Agent website www.medicaid.nv.gov. Providers can be given education regarding the access and utilization of this website. All provider requirements for a service are located within the provider tab on medicaid.nv.gov, ensuring that information is available for providers. Information is available equally for both MH/SUD and M/S.
2. The DHCFP's three MCOs follow the same process as the DHCFP with the allowance and provisions of fair hearings for services that are denied for the provider or recipient
3. Additionally, both providers and recipients are entitled to adequate and timely notice of state agency action and an opportunity to review those decisions when a service or services are denied, reduced, suspended or terminated. A Medicaid provider can submit a grievance and is allowed an opportunity for hearing on an adverse decision made by the DHCFP. Medicaid providers must exhaust internal grievance processes available through the Fiscal Agent, Health Plan, or third-party Health Plan Administrator prior to a DHCFP Fair Hearing. Medicaid recipients receive a Fair Hearing request form and instructions with a NOD. A NOD is sent

whenever an adverse action is taken by the DHCFP. The recipient may submit a Fair Hearing request to the DHCFP within 90 calendar days from the date of the NOD. A hearing preparation meeting is scheduled to provide an explanation of the action taken at which time a provider or recipient can either accept the action taken or request a formal hearing. The HPM is not mandatory and does not impact the scheduling of a Fair Hearing. All Fair Hearings are scheduled through the Department of Administration (DOA) and are controlled by the DOA Hearing Officer. At this time, both testimony and evidence is provided by the DHCFP or Health Plan that supports the action on the NOD. For a recipient Fair Hearing, a decision must be made within 90 calendar days of the request and must notify all parties of the decision made. For a provider Fair Hearing, a decision must be made within 30 calendar days following the Fair Hearing. The decision made by the Hearing Officer is final, but does have the right to be appealed in writing to the District Court in Carson City by filing a petition for judicial review within 30 days after receiving the final decision. Hearings requests are available equally for both MH/SUD and M/S. Additional details regarding the DHCFP and the MCO's hearing process are located in the NQTL analyses in Appendix B.

4. FINAL FINDINGS

After careful review and consideration of current policy and practices, and a full NQTL review of all four benefit packages, the DHCFP has found parity compliance within the services offered to Nevada Medicaid recipients in relation to MH/SUD and M/S. Additionally, upon acceptance of the two identified areas requiring remediation, which is scheduled for November 16, 2017, the DHCFP will be in full compliance with the MHPAEA. The DCHFPs compliance and continuous review plan will developed based on the findings within each of the NQTLs and QTLs to ensure that parity is maintained. Periodic review of quality measures will occur. As policy changes occur a thorough review of the proposed changes will be completed for each of the NQTLs. This review will occur for both MCO and FFS benefit packages.