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August 16, 2017

Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

ATTN: Darci Smith, Special Assistant – MHPAEA

Dear Ms. Smith:

Thank you for the opportunity to provide questions for the Maryland Insurance Administration's (MIA) third market conduct survey regarding compliance with the Mental Health Parity and Addiction Equity Act (Parity Act). The Legal Action Center has worked with the Community Behavioral Health Association of Maryland, Mental Health Association of Maryland, Maryland-DC Society of Addiction Medicine, the Maryland Psychiatric Society and the National Council on Alcoholism and Drug Dependence-Maryland to develop the following questions, which I am submitting on behalf of the entire group.

We appreciate that the MIA's third survey will focus on evaluating whether carriers implement their internal process and policies consistently and uniformly for mental health, substance use disorder and medical/surgical benefits. The Parity Act requires that plan design standards, defined as non-quantitative treatment limitations (NQTLs), comply with federal non-discrimination standards both as written and in operation. State insurance departments have discovered significant disparities between policies as written by carriers and in their implementation based upon a close examination of claims and other quantitative data. Our proposed questions, therefore, focus primarily on requests for raw data that will uncover disparities in the application of key NQTLs and lead to an investigation of underlying implementation standards that may violate the Parity Act. In addition, we urge the MIA to direct its review of plan design standards beyond network adequacy, which has been a key focus of the first two market surveys. We have proposed several questions that ascertain potential barriers to network adequacy.

We preface our proposed questions with one general request that applies throughout. The Parity Act requires a carrier to ensure that its benefit coverage complies with federal standards, even when a third-party vendor, such as a managed behavioral health organization, has responsibility for empaneling and managing network providers or applying medical management standards to a carrier's mental health and substance use disorder benefits. We wish to ensure that the MIA gathers data from the carrier's third-party vendor, as applicable, to evaluate all carrier representations of compliance with the Parity Act. Our understanding is that carriers often do not monitor the processes of their managed behavioral health organizations and may not be aware of network, reimbursement rate or medical management standards that are implemented by their third-party vendors.

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A. Facility Contracting

1. Identify the requirements, processes and standards used in the carrier's facility contracting process for mental health, substance use disorder, and medical facilities, and provide documentation, such as audits, to demonstrate the carrier implements these requirements to mental health and substance use disorder facilities in a manner that is comparable to and no more restrictive than the implementation process for facilities that provide medical services.

2. Identify the number of providers that are credentialed and reimbursed as facilities in the carrier's network, designating each mental health, substance use disorder service or medical service facility. For substance use and mental health services, designate the type or level of service (based on ASAM criteria for substance use disorder providers) that may be reimbursed in each setting. For medical services, designate the types of services that may be reimbursed in each setting.

3. For the most recent contracting year, identify the number of mental health providers, ,substance use disorder providers, and medical services providers that began the process of contracting as a facility but did not complete the contracting process or was denied a facility contract.

4. Identify the processes and evidentiary standards used to determine which services a mental health or substance use disorder facility may provide and be reimbursed with a revenue code. Provide documentation to demonstrate that this determination process is comparable and no more restrictive than what is applied to medical facility revenue code determinations.

5. Identify the processes and evidentiary standards used to establish the rate for each revenue code for both mental health and substance use disorder services. Provide documentation to demonstrate that this determination process is comparable and no more restrictive than what is applied to medical facility revenue code determinations.

B. Reimbursement Rates

1. Identify and provide documents that describe the processes, evidentiary standards, or other factors, including geography, recent trends in services, or identified need, used to determine in-network reimbursement rates tied to CPT codes for mental health and substance use disorder services, respectively. This should include any rate setting methodologies, such as those used by the Centers for Medicare & Medicaid Services or other usual and customary rate database, such as the Fair Health Charge Database.

2. Identify and provide documents that describe the processes, evidentiary standards, or other factors, including geography, recent trends in services, or identified need, used to determine in-network reimbursement rates for medical/surgical services tied to CPT codes. This should also include any rate setting methodologies, such as those used by the Centers for Medicare & Medicaid Services or other usual and customary rate database, such as the Fair Health Charge Database.

3. Identify and provide documents that describe the rules the carrier implements for reimbursement of multiple services delivered within a single day for mental health, substance use disorder and medical/surgical benefits, respectively, for in-network, outpatient services. and provide all audits the carrier conducts to assess compliance with its rules.

4. Identify and provide documents that describe the rules the carrier implements to determine the allowable amount for out of network mental health, substance use disorder and medical/surgical services, respectively, for the following classifications and provide all audits the carrier conducts to assess compliance with its rules:
    a. Outpatient
    b. Inpatient
    c. Sub-acute residential services

C. Utilization Management Standards and Application of Standards

1. Identify and provide documents that describe the process the carrier has implemented to evaluate whether the utilization management standards imposed on mental health and substance use disorder services are, in policy and in operation, comparable to and applied no more stringently than the utilization management standards for medical/surgical services and provide all audits the carrier conducts to assess compliance.

    a. To the extent the carrier contracts with a behavioral health management entity, identify the carrier's process for overseeing the contractor's activities to verify Parity Act compliance in policy and in operation.

    b. Identify and provide all documents, algorithms and other evidentiary standards the carrier obtains from the organization or unit that manages its behavioral health services and describe the review process the carrier implements to assess comparability of benefit coverage and utilization management standards, as written and as applied.

    c. Identify and provide all documents that inform enrollees of the utilization management requirements, including all levels of authorization, that will apply to mental health, substance use disorder, and medical benefits and the frequency of review for services in each classification.

2. Authorization of lower levels of care – Inpatient Services

    a. Identify the number and percentage of total requests for inpatient (including residential treatment services) for mental health and for substance use services for which the carrier denied a requested level of care but authorized a different and less intensive/lower level of care.

i. In providing the data, identify both the requested and authorized level of care and separate out the mental health and substance use disorder determinations.

b. Identify the number and percentage of total requests for inpatient medical or surgical services for which the carrier denied a requested level of care but authorized a different and less intensive/lower level of care.

i. In providing the data, identify both the requested and authorized level of care.

3. Authorization of lower levels of care – Outpatient Services

a. Identify the number and percentage of total requests for which the carrier denied a requested level of care for partial hospitalization/day treatment or intensive outpatient treatment for mental health and substance use service, but authorized a different and less intensive/lower level of care.

i. In providing the data, identify both the requested and authorized level of outpatient care and separate out the mental health and substance use disorder determinations.

b. Identify the number and percentage of total requests for outpatient medical or surgical services (primary and specialty services) for which the carrier denied a requested level of care but authorized a different and less intensive/lower level of care.

i. In providing the data, identify both the requested and authorized level of outpatient care, in addition to listing the specific evidentiary standard upon which decisions were made.

c. Identify all rules, algorithms , and evidentiary standards that are used to determine the frequency of concurrent authorization for outpatient services for mental health disorders, for substance use disorders, and for medical/surgical conditions.

4. Process for determinations of length of stay for inpatient/residential treatment

a. Identify all rules, algorithms, and evidentiary standards, that are used to determine the length of stay for inpatient/residential treatment for mental health and substance use disorders and for medical/surgical conditions.

b. Identify all rules, algorithms, and evidentiary standards that are used to determine the frequency of concurrent authorization for mental health and substance use disorders and for medical/surgical conditions.

5. Identify the total number of claims paid and claims denied in 2016 for mental health, substance use disorder and medical/surgical services, respectively, in the following classifications:

a. Outpatient in-network
b. Outpatient out-of-network
c. Inpatient/residential in-network
d. Inpatient/residential out-of-network
e. Prescription Drug

6. For the most recent plan year, provide the following information regarding utilization management requirements for prescription drugs for mental health medications (as a group), substance use disorder medications (as a group), and medications for somatic conditions (as a group), and separated by brand and generic drugs.

    a. Number of prescription orders requested by a pharmacist to fill a prescription (received by any method, including computer, fax or phone)
    b. Number and percentage of prescription orders that required pre-authorization and number and percentage of orders that did not require pre-authorization
    c. Number and percentage of prescription orders that required pre-authorization that were approved and denied
    d. Number and percentage of prescription orders that were dispensed as a different medication than ordered due to carrier authorization, fail first or formulary tiering policies

D. Adverse Decisions and External Review

1. For the most recent plan year with complete data, identify the total number and rate of adverse decisions for requested services for mental health, substance use disorder and medical/surgical services, respectively, in the following classifications:

    a. Outpatient in-network
    b. Outpatient out-of-network
    c. Inpatient/residential in-network
    d. Inpatient/residential out-of-network
    e. Prescription Drug

2. Identify the total number and rate by which the carrier reversed an initial denial of authorization for benefit or services coverage based on a peer-to-peer or Medical Director review for mental health, substance use disorder and medical/surgical services, respectively, in the following classifications:

    i. Outpatient in-network
    ii. Outpatient out-of-network
    iii. Inpatient/residential in-network
    iv. Inpatient/residential out-of-network
    v. Prescription Drug

3. Identify the total number and rate of reversal of adverse decisions on external review for mental health, substance use disorder and medical/surgical services, respectively, in the following classifications:

    i. Outpatient in-network
    ii. Outpatient out-of-network
    iii. Inpatient/residential in-network
    iv. Inpatient/residential out-of-network
    v. Prescription Drug

Thank you for considering our suggestions for the third market conduct survey. Please feel free to contact me at eweber@lac.org if you have any questions.
Sincerely,

Ellen M. Weber
Vice President for Health Initiatives