EQUAL INSURANCE COVERAGE OF SUBSTANCE USE AND MENTAL HEALTH DISORDERS

PARITY AT 10

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April 23, 2019

Robert R. Neall
Secretary
Maryland Department of Health
201 W. Preston Street
Baltimore, Maryland 21201

Dear Secretary Neall:

I am writing on behalf of the Maryland Parity Coalition to request an opportunity to meet to discuss the Maryland Department of Health's (MDH) final report to the Centers for Medicare & Medicaid Services on the Maryland Medicaid program's compliance with the Mental Health Parity and Addiction Equity Act (Parity Act). The Legal Action Center is a law and policy organization that fights discrimination against individuals with histories of substance use disorders, criminal justice histories and HIV/AIDS and works to adopt sound policies to expand access to health services for these individuals. In Maryland, we have worked with our partners to expand treatment in both public and private insurance through compliance with the Parity Act, and have formed the Maryland Parity Coalition has part of the multi-state Parity at 10 Campaign to improve enforcement of federal and state parity laws.

The March 28, 2019 parity compliance report identifies one program requirement – implementation of data collection requirements for mental health and substance use disorder (MH/SUD) services – that violates the Parity Act. It also concludes that no other non-quantitative treatment limitation (NQTL) violates the Act as written or in operation. MDH has examined the following NQTLs for compliance: medical necessity criteria, utilization management – covering both prior authorization (PA) and continuing care (CC) requirements, retrospective review, outlier management and reimbursement rate setting. Based on our review of the report, MDH has not provided sufficient information to reach its conclusion for any NQTL, and, most significantly, it has not conducted a complete parity analysis of the Medicaid program's utilization management or reimbursement standards to ensure compliance "as written" or "in operation."

I. Overview

We have identified the following specific analytical gaps, which are described in greater detail below.

- Medical Necessity Criteria: there is insufficient information about the MNC used for MH benefits; no evidence, such as denial rates and overturn rates, or analysis is presented to demonstrate that the medical necessity criteria as implemented (in operation) are comparable to and applied no more stringently for MH/SUD than for medical/surgical benefits.

- Utilization Management (PA and CC):
    - Inpatient Services: no evidence to demonstrate that PA or CC is not implemented more stringently for MH/SUD benefits.
    - Outpatient – Office Visits: Based on information from Type 50 programs, outpatient service for SUD are subject to PA and CC, and OMHCs are also subject to PA and CC for outpatient MH services and must request authorization for diagnostic evaluations.
    - Other Outpatient Visits and Services: no information is provided about the factors and evidentiary standard used to impose PA or CC for MH/SUD benefits; the list of SUD services that are subject to PA or CC appears to be incomplete, and insufficient information is provided about the specific medical/surgical services that are subject to PA or CC; utilization review data for MH/SUD and med/surg services have been not provided, but are needed to assess whether PA or CC are implemented more stringently for MH/SUD benefits.

- Retrospective Review: no information is provided regarding retroactive review of med/surg benefits, which precludes an assessment of compliance and suggests that this NQTL is not comparable for MH benefits; conclusion that retrospective review is not subject to a parity analysis because med/surg services are paid under a fee-for-service basis during the retroactive period is not correct legally.

- Outlier Management: explanation suggests that outlier management, as written, is not comparable for MH/SUD outpatient visits and outpatient other services because all MH/SUD services are subject to OM as opposed the MCOs data analytics system that verifies the receipt of med/surg services; no evidence is presented to assess the stringency with which OM is applied for any MH/SUD classification.

- Pharmacy Benefits: no information is provided about the factors and evidentiary standards used to impose UM for any prescription drug; the process information and regulatory standards do not establish that UM is comparable as written and in operation.

- Reimbursement Rate Setting: no conclusion is provided on parity compliance; no information is provided regarding the rate setting standards for MH/SUD benefits, precluding a comparative analysis of comparability or stringency as written; no comparative analysis is provided for rate setting "in operation."

II. Discussion

MDH states that it has adopted a parity analysis that is consistent with CMS's guidance outlined in the Parity Compliance Toolkit (see MDH Report at 6), but we have identified significant gaps in MDH's analysis based on the federal guidance. The CMS Toolkit identifies the two-part NQTL analysis that MDH is required to perform:

- Evaluate the *comparability* of the processes, strategies, evidentiary standards, and other factors (in writing and in operation) used in applying the NQTL to MH/SUD benefits and M/S benefits
- Evaluate the *stringency* with which the processes, strategies, evidentiary standards and other factors (in writing and in operation) are applied to MH/SUD benefits and M/S benefits.

CMS Toolkit at 34. MDH's report touches on some, but not all, of these elements for each NQTL, and the description for each NQTL is so generalized that no conclusions of compliance can be confirmed for MH/SUD benefits as compared to any one MCO (or one set of benchmark NQTL standards). We have the following overarching concerns.

A. MCO Standard Used As the Benchmark for Analysis

As a preliminary matter, MDH has neither identified the specific MCO standard that is being used as the comparator for any NQTL nor has it provided a specific analysis for each of the nine MCO plans, each of which may adopt and implement NQTL standards differently for its members. With nine MCO plans, MDH is required to conduct a separate NQTL analysis for each MCO to assess comparability and stringency for the ASO's MH/SUD standards. 42 C.F.R. § 438.920(b). To the extent MDH seeks to develop a single benchmark comparator for MH/SUD services across all MCOs, which is not contemplated under the regulations, it would be required to identify the MCO med/surg standard that is the least restrictive for each NQTL, and then use that standard as the comparator for the processes, strategies, evidentiary standards and other factors for imposing and applying the NQTL to MH/SUD benefits. There is no indication from the report that MDH has approached the NQTL analysis in either way. Instead, MDH's description of each NQTL (as well as the identification of processes, factors and strategies) for med/surg benefits is a generalized summary of all nine MCO standards.

For example, the medical necessity criteria for medical/surgical benefits is described as:

> The…MCOs reported relying on federal requirements, state-developed medical necessity criteria, as well as nationally-recognized, evidence-based clinical decision making criteria. Standards applied include…Interqual, and Milliman Care Guidelines (MCG), as well as plan specific policies and guidelines."

MDH Report at 12. One has no idea which set of med/surg standards MDH has used as the benchmark for its comparability and stringency analyses; e.g. Interqual, MCG, or plan specific policies and guidelines.

For the outpatient all other services sub-classification, the report does not identify any of the strategies, factors or evidentiary standards for imposing utilization management; identifying the underlying purpose of UM (to ensure MNC are met and treatment is provided in the least restrictive setting) does not provide the relevant information. For med/surg services, the report states:

> The factors considered when establishing which M/S services must have a Utilization Management process include possible over and under-utilization of services, experimental status of procedures, industry trends, guidelines and regulations, practice variations, preference driven care, diagnosis, geographic regional variations, and historical evidence that services are being denied or inappropriately requested.

MDH Report at 15. This is a description of factors for all MCOs, and it is unclear which have been used to reach the conclusion that "MCO requirements in this area are more restrictive than those used by the ASO." MDH Report at 17.

Finally, the description of inpatient Outlier Management requirements and processes states that "factors the MCOs reported monitoring include over or under-utilization of services, cost, length of stay, quality of care and readmission rates." MDH Report at 15. Since this is a summary of factors from all MCOs, one has no idea which specific factors are to be used as the comparator to test the adoption and implementation of outlier management for inpatient MH services. This is important because the four factors identified for imposing outlier management on MH inpatient services – average length of stay, readmission rates, and rate of administrative and medical necessity denials – (see MDH report at 15) could very well ***be more stringent*** than the least restrictive set of standards adopted for med/surg benefits. *The very same problem exists for each NQTL.*

A separate analysis of each MCO's NQTL standards is needed to determine whether beneficiaries receive parity compliant MH/SUD benefits. At a minimum, MDH must identify the singular set of med/surg standards it is using to analyze each NQTL. Without such information, the specific process, factors and evidentiary standards used to trigger the application of a factor for med/surg benefits cannot be established and then tested against those elements for MH/SUD benefits and the comparability and stringency of implementation (in operation) cannot be tested.

B. Information Not Included in MDH's Report

As noted above, MDH has provided a "high" level comparison of NQTL standards for MH/SUD and med/surg benefits, generally setting out some of the med/surg benefits subject to each NQTL and the general parameters of the ASO and MCOs implementation process, i.e. practitioner(s) who makes care decisions; administrative process for obtaining a care decision; the amount of time the ASO or MCOs have to make care decisions; the purpose of retrospective review and outlier management. The CMS toolkit requires far greater detail and information to assess compliance.

The following information outlined in the CMS toolkit for NQTL analysis has not been provided by MDH. In some cases, the lack of information precludes an assessment of the accuracy of MDH's conclusion of parity compliance and, in other cases, the information provided contradicts MDH's conclusion.

- <u>Medical Necessity Criteria and Application</u>
    - MNC for mental health benefits in any classification and no description of the MNC for pharmacy benefits.
    - The process, strategies, evidentiary standards and other factors used to **develop or select** the MNC (CMS toolkit at 45).
    - The written and in operation processes, strategies, evidentiary standards and other factors **applied during a medical necessity review**.
    - Identification "of how frequency of review is determined and potential results following such a review." (CMS toolkit at 45 and 53).
    - The amount of discretion allowed in making medical necessity decisions (CMS toolkit at 53).
    - The level of performance required to demonstrate medical necessity; e.g. how many questions or pages in a form, time period allowed to provide supporting documentation. (CMS toolkit at 53).

- Utilization Management (Prior Authorization and Continuing Care Review)

    - The list of SUD benefits that are subject to UM in the outpatient other items and services subclassification– ambulatory detox and intensive outpatient – appears to be incomplete. Partial hospitalization and opioid maintenance therapy[1] are also subject to UM.
    - A complete list of med/surg services subject to UM has not been provided. Specifically, the list of "select outpatient and specialty care provided outside the PCP's scope of practice" must be provided to assess comparability and stringency. Additionally, this statement would suggest that no specialist services, apart from high-tech radiology and genetic testing, are subject to UM. Under these circumstances, it is highly unlikely that "MCO requirements in this area are more restrictive than those used by the ASO" (MHD Report at 17), because virtually all MH and SUD services in this subclassification are subject to UM.
    - The factors and evidentiary standards "applied in writing and in operation when assigning prior authorization to these and other outpatient services…." (CMS toolkit at 47). The report provides no information about factors and evidentiary standards used to impose PA for MH and SUD benefits and provides no information about the evidentiary standards that trigger the use of the factors listed to assign PA to med/surg benefits. (MDH Report at 18).
    - "The factors…that determine the services selected for concurrent review [and the] evidentiary standards [that] support their use." (CMS toolkit at 48).
    - "Average denial rates and overturn rates for concurrent review in each classification." (CMS toolkit at 48).
    - "For each classification, [an] estimate [of] the average frequency of concurrent review across services…." (CMS toolkit at 49).
    - The "outcome measures/standards [used] to indicate over or under application of [UM]." (CMS toolkit at 53).

- Outlier Management (OM)

    - The application of OM in the outpatient visits and other outpatient services appears to be more restrictive for MH/SUD than for med/surg benefits because all MH/SUD benefits are subject to this requirement compared to an undefined number/scope of med/surg benefits. No criteria are provided for the selection of med/surg services to be reviewed under OM.
    - The process and strategies for developing the data analytics used to identify outliers for MH/SUD and med/surg benefits are not identified for any classification, precluding an analysis of comparability and stringency as written and in operation.
    - The frequency of OM and evidence supporting this selected frequency is not identified for any applicable classification for MH/SUD and med/surg benefits, precluding an assessment of comparability and stringency as written and in operation. (CMS toolkit at 53). (The regulatory standard for med/surg benefits of "at least annually" is not sufficient.)

[1] Beacon's Provider Alert, dated March 20, 2019, states that Type 32 providers are required to "complete authorization for on-going therapeutic and MAT treatment."

- Data related to the outcome of OM is not identified for any applicable classification, precluding an assessment of the comparability and stringency of the consequences for MH/SUD and med/surg providers when the OM criteria are not met. (CMS toolkit at 53). The general description of outcome – education and audit – is not sufficient.

- Pharmacy Benefit

  - The list of MH, SUD and med/surg medications that are subject to UM.
  - The strategies, factors and evidentiary standards for imposing UM for both MH/SUD benefits and med/surg benefits and an assessment of comparability and stringency as written and in operation. (CMS toolkit at 47).
  - The frequency of UM for MH, SUD and med/surg medications. (CMS toolkit at 49).
  - "Average denial rates and overturn rates for concurrent review…." (CMS toolkit at 48).
  - The "outcome measures/standards [used] to indicate over or under application of [UM]." (CMS toolkit at 53).

C. Additional Concerns

1. Retrospective Review

MDH asserts that retrospective review for MH inpatient services is not subject to the Parity Act because an individual's med/surg benefits are covered on a fee-for-service basis outside the MCO benefit package during retroactive coverage periods. MDH's explanation raises several factual questions, and the conclusion is not supported by the law. MDH's description of this NQTL indicates that the participant may have paid directly for those services as opposed to the Public Behavioral Health System through state-only funds. (MDH Report at 15). In such cases, the application of retrospective review would directly affect the beneficiary who, upon an eligibility determination, should be reimbursed for those services on the same basis as a beneficiary who receives med/surg services. Additionally, without more information as to whether the provider of such services bears any responsibility for the cost of services during the retroactive period, it is unclear whether the standards for provider reimbursement – an NQTL – are implicated in the retrospective review process.

As a legal matter, the financing system for services during the retroactive period does not remove this NQTL from parity scrutiny. For CHIP recipients and persons in the expansion population (ABP enrollees), the financing system is irrelevant for application of the Parity Act; the benefits for all enrollees, whether financed through fee-for-service or an MCO, are subject to the Parity Act. And for adults who are found eligible for traditional Medicaid retroactively, the source of funding for the retroactive period does not ***convert*** Maryland's Medicaid financing and delivery system to a fee-for-service system. These members are certified generally as of the first day of the earliest month of the retroactive period in which coverable medical expenses were incurred. COMAR 10.09.24.11(C)(2) and (4). Accordingly, the ASO's use of retrospective review is subject to the Parity Act.

Based on MDH's description of this NQTL, neither the state nor the MCOs conduct retrospective review for medical services provided during a retroactive period. Accordingly, retrospective review for MH benefits is a more restrictive treatment limitation than the standards for med/surg inpatient benefits and cannot be applied.

2. Reimbursement Rates

MDH recognizes that reimbursement rates are subject to the Parity Act,[2] but has not conducted an analysis of parity compliance. It has identified one factor on which med/surg benefits are benchmarked – Medicare rates – without addressing the "percentage of that standard [that] is applied to [med/surg] outpatient professionals [by licensure]" (CMS toolkit at 51). The report does not identify the factors upon which MH/SUD reimbursement rates are set. One can only conclude that the current process for setting reimbursement rates for MH/SUD benefits does not comply with federal law.

Although MDH has stated that it is currently reviewing the rate setting process for MH/SUD benefits, it is our understanding that MDH has suspended that review. We, therefore, request an update on the status of the cost of service analysis and steps being taken to adopt a parity-compliant reimbursement system for MH/SUD benefits.

III. Conclusion

MDH has taken important steps to expand MH and SUD services in the Medicaid program, but its Parity Act analysis does not support a conclusion that the program delivers mental health and substance use disorder benefits in compliance with federal law. While the above deficiencies must be addressed to ensure a complete analysis, we are most concerned about the disparate application of utilization management and reimbursement rate setting. Both NQTLs significantly affect patient access to care, and the utilization management requirements increase administrative burden on programs that are desperately seeking to address Maryland's opioid and suicide epidemics.

We request an opportunity to meet with you to discuss our concerns and learn MDH's plans to provide a complete parity compliance analysis and ensure future compliance.

Sincerely,

Ellen M. Weber, JD
Vice President for Health Initiatives
Legal Action Center

Cc: Kirsten Beronio
Juliet Kuhn

[2] The Legal Action Center has previously addressed, by letter dated October 9, 2018, MDH's position in its Preliminary Parity Act Report that reimbursement rates are not subject to the Parity Act.