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Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

September 7, 2021

Kathleen Birrane
Commissioner
Maryland Insurance Administration
200 St. Paul Place
Baltimore, MD 21202

Submitted electronically via: mhpaea.mia@maryland.gov.

RE: Kaiser Permanente Comments on Mental Health Parity Draft Template Forms and Instructions

Dear Commissioner Birrane:

Thank you for the opportunity to comment on the mental health parity draft template forms and instructions. Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for approximately 775,000 members. In Maryland, we deliver care to over 450,000 members.

The Mental Health Parity and Addiction Equity Act (MHPAEA) helps ensure equity in coverage for mental health and substance use disorder patients. Kaiser Permanente strongly supports this important goal. However, MHPAEA does not address other challenges related to behavioral health services, such as rising health care costs, health outcomes and workforce shortages. We are focused on addressing those issues in addition to ensuring all our patients receive high quality, affordable health care.

In December 2020, Congress passed the Consolidated Appropriations Act of 2021(CAA). The Tri-agencies (The Departments of Labor (DOL), Health and Human Services (HHS), and the Treasury (IRS) provided additional MHPAEA guidance and codified the Self Compliance Toolkit, requiring a non-quantitative treatment limitation (NQTL) comparative analysis be made available to both federal and state regulators (as well as to participants, beneficiaries and enrollees of ERISA-covered plans) upon request. The guidance indicates federal regulators intend to focus their enforcement efforts on specific NQTLs, including reimbursement rates.[2] New regulations are required by 2022, which will be informed by public comment. The Toolkit must be updated every two years with input from stakeholders.

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

[2] https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf

We suggest Maryland rely on these tools, either now or in the future, for MHPAEA compliance reporting to avoid creating duplicative or contradictory reporting requirements. Aligning with the federal requirements will reduce the administrative burden on reporting entities, foster more consistent reporting at the state and federal levels, and avoid health care cost increases from additional administrative expenses.

We offer the following comments on Data Supplement 3 (Provider Credentialing):

- The provider credentialing data supplement asks for mean and median number of days from first submission of an application to the later of the effective date or date of contract execution. In our experience, the time to execution of a contract can be affected by the responsiveness of the provider or facility, regardless of provider or facility type. Furthermore, if the sample size of providers or facilities in each category is small, any differences observed in this metric may not be statistically significant or may be skewed by outliers. For these reasons we recommend that the MIA use caution in interpreting a disparity as a violation.

- The provider credentialing data supplement also asks for the percentage of providers that submitted an initial application or request for application and were notified that the carrier would not proceed with the application. There are legitimate reasons to explain why a carrier would not proceed with an application, and we think it would help to add a field that allows a carrier to describe reasons that applications were rejected.

We offer the following comments on Data Supplement 4 (Reimbursement Rates):

- MHPAEA requires the underlying processes and strategies used to apply an NQTL to mental health and substance use disorder benefits must be comparable to those used to apply the NQTL to medical/surgical benefits in the same benefit classification. However, MHPAEA does not require provider reimbursement rates be equal between behavioral health and medical/surgical providers and acknowledges that reimbursement levels for providers are determined based on multiple factors, such as market dynamics, training, and geographic location. Different rates by themselves are not sufficient to indicate non-compliance with MHPAEA. For these reasons we recommend that the MIA use caution in interpreting a disparity as a violation.

- In addition to pending regulations and guidance related to MHPAEA, the Tri-agencies are in the process of implementing federal transparency requirements, which would include provider rate information. The final regulations mandated health plans to make detailed pricing information available to the public by January 1, 2022 on negotiated rates for all covered services for in-network providers, historical payments to out-of-network providers, and drug costs. The CAA also requires reporting on plan medical costs. We ask the MIA to postpone consideration of a new data supplement on reimbursement rates until outstanding questions related to implementation of the federal transparency requirements are clarified. This will avoid duplicative reporting requirements.

- The reimbursement rates data supplement asks carriers to provide weighted average amounts for certain CPT codes; however, this narrowly-focused approach ignores a major root cause of behavioral health access challenges, which is a national shortage of behavioral health providers. It also ignores health plan offerings beyond traditional office visits. Kaiser Permanente has a multi-faceted approach to addressing mental health and substance use disorders, including digital apps, classes, coaching, and a variety of telehealth offerings developed to respond to the growing need for behavioral health services during the COVID-19 pandemic.

Access to mental health and substance use disorder services is a critical issue and we look forward to working with you to provide the most useful information to address these challenges.

Thank you for the opportunity to comment. Please feel free to contact Allison Taylor at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,

Allison Taylor
Director of Government Relations
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.