The League of Life and Health Insurers of Maryland

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For information, contact:
Matthew Celentano, Executive Director

September 9, 2021

Lisa Larson
Regulations Manager
Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Re: Mental Health Parity Regulations

Dear Ms. Larson:

On behalf of the League of Life and Health Insurers of Maryland, Inc. (League), thank you for the opportunity to provide comments on the appropriateness of the proposed supporting documents for Draft COMAR 31.10.51. The League is the state trade association representing life and health insurance companies in Maryland.

The League appreciates the work the Maryland Insurance Administration (MIA) has done on this issue from the 2020 Session to date and the collaborative process throughout. The League would like to thank the MIA for its consideration of the comments made throughout the 2020 Session and corresponding workgroups including the industry. While the process has addressed some of the questions and concerns we raised, the discussion still leaves a number of concerns for League members.

The League suggest the MIA look to narrow the proposed forms to the Department of Labor (DOL) tool for the four categories: Utilization Review; Formulary Exceptions; Provider Credentialing; and Reimbursement Rates. This would be a narrow addition to the reporting required the NAIC Tool, per the uncodified language in HB 455. While we appreciate the templates offered by the MIA, we believe it is an incorrect assumption that the forms follow the DOL tool, and the data supplements certainly go further. The result of this extension creates multiple challenges for carriers and will ultimately lead to consumer confusion and less innovation for expanded services in Maryland.

As you are well aware, the Federal landscape has dramatically shifted in recent months due to the passage of the CAA. Carriers are still receiving guidance regarding the nature and depth of documents are required to support an NQTL analysis and having a divergent approach could have harmful results. The DOL is **currently** undergoing a significant number of audits that will culminate in a Congressional report

and findings of non-compliance. The DOL has committed to releasing guidance which will address the same issues covered in the data supplement templates such as documenting information for the in-operation analyses. Ultimately, a patchwork of reporting templates across states will have no benefit to regulators and will present undue challenges in compliance for carriers across the country. Carriers would rather the MIA choose the DOL tool as proposed as consistency is preferred, especially as other states are beginning to have similar conversations. Carriers also believe that if a state goes further than the DOL tool it will shift resources away for added compliance that might have been used for innovation to improve behavioral health outcomes for consumers.

We have repeatedly heard from stakeholders that we cannot wait for action from the Federal government, but the reality is that the Federal authorities have sped up their communication in recent months and we do not believe it to be accurate to say we cannot wait for the Federal government to catch up –the CAA passage raised the bar for federal parity requirements such that they now follow state laws that included step-wise NQTL requirements like in Connecticut or New Jersey.

An example of the deviation we are grappling with is in data supplemental #1. We have failed to find any portion of the form from the end of page 1 under the banner of prior authorization anywhere in the DOL tool. . In addition, The Maryland proposed data supplement 3 focuses on the average length of time to negotiate a provider contract, which is not an explicit basis for parity comparison in the DOL Toolkit (in fact, it is not even mentioned as a possible metric).

In terms of outcome measures for credentialing, there may be other salient data points besides the granular and limited ones set forth in the Maryland supplement. For example, it may make sense for plans that use NCQA credentialing methodologies for both medical/surgical and MH/SUD providers to audit those processes to ensure that reviewers are using the same checklists. The metrics chosen by Maryland, however, are influenced by factors that are unrelated to NQTLs and go beyond DOL Toolkit. For example, providers may stall contract negotiations. Further, it is not clear that the length of provider contract negotiations has an appreciable impact on access to benefits or network adequacy. Additionally, the length of time to negotiate contracts is not a data point that most plans currently track, and it will be burdensome to capture (i.e. there are no consistent standards for plans to track and assess the length of negotiations). League members also raised concerns related to credentialing that there was not a proper definition of a facility, and without one, the date could be suspect and might not be an end workflow management system that could be utilized to truly capture the information requested and reporting upon. A few members also requested clarity on whether dental would be considered in-scope for "health" care services and "health" care benefit plans. Members believe no and that the regulations are limited to medical and behavioral, but are having difficulty confirming with a lack of definition.

With regard to Data Supplement 4 (Reimbursement Rates), the DOL Toolkit includes an Appendix II (p 38) which discusses how data should be collected to compare reimbursement rates for MH/SUD providers against medical/surgical providers for warning sign purposes. While the Maryland proposed data supplement 4 does include the elements contained in the Appendix II, it goes further than the DOL Toolkit in a patently incongruent manner. The DOL Toolkit states: "**This is not the only framework for analyzing provider reimbursement rates, and it is not determinative of compliance**. This framework utilizes Medicare reimbursement rates as its benchmark for comparison. If a plan's or issuer's comparison of reimbursement rates indicates that the reimbursement rate is lower for MH/SUD providers, either as compared to medical/surgical providers or as **compared to an external benchmark, such as Medicare**, the plan or issuer should consider further review to ensure that the processes, strategies, evidentiary standards, and other factors used with respect to provider reimbursement for MH/SUD benefits are

comparable to, and applied no more stringently than, those used with respect to provider reimbursement for medical/surgical benefits."

The Maryland proposed data supplement 4 constrains a payer to use Medicare as the external benchmark and removes all flexibility contained in MHPAEA for how a plan may demonstrate compliance with the NQTL. Whereas the DOL Toolkit allows for a myriad of ways to compare reimbursement rates, the Maryland approach seems to be narrowly focused on only one prescribed way of doing the analysis. In addition, the Maryland approach breaks down provider types in a more granular fashion than what is required in the DOL Toolkit. For example, Maryland sets forth four required provider categories: Primary Care Physicians; Non-psychiatrist Medical/Surgical Specialist Physicians; Psychiatrists; and, Non-psychiatrist Behavioral Health Professionals. The DOL Toolkit, however, only focuses on two such categories: MD specialists and non-MD specialists.

It is important to remember that MHPAEA requires that the underlying processes and strategies used to apply an NQTL to mental health and substance use disorder benefits, such as reimbursement rates, must be comparable to those used to apply the NQTL to medical/surgical benefits in the same benefit classification. 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, including: market dynamics, supply and demand, education and training, geographic location, etc. Different rates are not by themselves determinative of non-compliance to MHPAEA.

Thank you, again, for the opportunity to provide this feedback on the mental health parity regulations and proposed supporting documents. Should you have any questions, please do not hesitate to contact me.

Sincerely,

Matthew Celentano
Executive Director
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Additional League Member Template Comments

NQTL Analysis Report Template Form

- For each NQTL, it appears that the carrier would need to indicate in step "b" if the NQTL applies to each benefit classification. Would the carrier need to put an "X" in the each Classifications and Sub-Classifications box to indicate that the NQTL applies to each benefit classification?
- For each NQTL, does the MIA want the carrier to address each benefit classification under steps 2-7?
- It would be helpful to see an example of how to fill out the template.
- Credentialing and Contracting - These are two separate processes. To combine them is very confusing. The title of this NQTL should be limited to Provider Credentialing as Contracting is a separate process. We would propose changing this section to "Credentialing and Admission Standards"
- Failure to Complete a Course of Treatment – Could the MIA provide an example for this definition? This seems to be a different definition than what other state regulators have outlined. The definition used by other states requires the completion of a course of treatment in order for a subsequent course of treatment to be covered. An example is that a member would need to complete (either successful or not successful) a diet program for bariatric surgery being covered.

MHPAEA Data Report Template Form

- The Data requested in this document appears to duplicate the data requested in the Data Supplement 1 document.
- We recommend combining mental health (MH) and substance use disorder (SUD) be combined as Medical and Surgical (M/S) are combined. Other states have agreed to combine MH/SUD.
- We recommend limiting "Reasons for Denials" to top 5 reasons. Other states have focused on the top five reasons as there may be many reasons for denial.
- We recommend specifying that the claims data be claim lines reported because a claim could contain 1 line or 20 lines. Many states have agreed that reporting claims by line is more appropriate because if we need to report "denials" and some claim lines are denied and others are approved, it is challenging to know if the claim is denied or approved.
- We recommend specifying that Prior Authorization Information be clinical (adverse determination) denials and not include administrative denials

- The MIA should consider updating the report to include IP Concurrent Review and Retro Review total case count and denial and appeal data, and remove the data Supplement 1 because this the data reported in the Supplement 1 overlaps with this template.

Data Supplement 1 (Utilization Review)

- Supplement #1 and the Data Report Template seem to overlap. The Supplement #1 combines MH/SUD and the Data Report Template separates MH and SUD. We would recommend using the combined MH/SUD.
- We recommend starting with the Data Report Template and not the Supplement #1 requirement because the Supplement #1 document seems to go beyond the DOL requirements with asking for an age band breakdown, peer review information and GAP requests.
- If the MIA is asking a carrier to request NQTL and outcomes data for the top five large group plans, top five small group plans, and five individual plans, the data (case counts) will be so small that the data will not be statistically sufficient. Breaking down the data by age group not only goes beyond the DOL requirements, but also, the case counts will be so small that the data will be meaningless.
- Obtaining the GAP case counts for Medical/Surgical counts will require significant IT work. The result is that actual reporting in 2022 could be very difficult. This, along with a number of the other proposed reporting requirements, if enacted, will require significant IT work including programming and testing which takes time. Together, these changes will be unduly burdensome if reporting is required for these items in 2022. Tying the appeals to the prior authorization denials will be challenging because of the lag time of the appeals. An appeal can be received 180 days after the denial date of a prior authorization or concurrent review denial. Also, second level appeals and external appeals can be received after the first level appeal decision which draws out the lag time required for reporting purposes. We recommend reporting all prior authorization cases and concurrent review cases for the calendar year either based on receipt date or determination date. We also recommend reporting appeals for the same timeframe (e.g., calendar year) to avoid the lag time required for reporting data. Reporting this information for each of the top five plans may not provide sufficient case counts.
- We would need to perform significant IT work to report peer-to-peer reviews. See comment #4 to Data Supplement 1. Please note that providers have the option to request a peer-to-peer for prior authorization and concurrent review denials. Providers do not always request a peer-to-peer and the carriers do not have control over whether the providers request a peer to peer.
- We would need to do significant IT work to report appeals related to prior authorization vs. concurrent review for M/S. Currently, our systems are not able to report this information separately. See comment #4 to Data Supplement 1.
- Use of "Inpatient" vs. "Other Inpatient" goes beyond the DOL requirements. Med/Surg would need to know how to classify "Other Inpatient" as this is not a valid benefit classification under MHPAEA as this has not been defined by the Department of Labor.
- Reporting grievances by age category goes beyond MHPAEA. Also, the case counts will be so small that the data may not be meaningful.

Pharmacy

- We are compelled to note that breaking the data out by age group is not a MHPAEA requirement. Also, breaking down the data into very refined categories will result in case counts that will be so small – it is difficult to do any type of meaningful comparison.

- Reporting on peer-to-peer interactions goes beyond MHPAEA requirements. In addition, we should note that the carrier does not have any control over whether the provider chooses to request a peer to peer discussion.
- There are no retrospective reviews for Rx; the data will be "0".
- The appeal record for the Prescription Drug section does not require that the appeal be "tied" to the prior authorization data – which makes sense. This approach should be used for the non-pharmacy reporting (above).

Data Supplement 3 (Provider Credentialing)

- Credentialing is separate and distinct process from provider contracting. We can report credentialing information and data and separately report contracting information and data. Reporting on the timeframe that covers both credentialing and contracting would require an IT enhancement. So, the "mean (or median) number of days from the first submission of an application to the later of the effective date or date of execution of a contract" will require an IT enhancement. See comment #4 to Data Supplement 1.
- Percentage of providers that completed the process and executed a contract
    - We suggest the MIA provide guidance on to clarify what constitutes "completed the process" as opposed to the execution of a contract.
- Percentage of providers that submitted an initial application, but withdrew or failed to complete the credentialing process by not responding
    - We suggest the MIA provide guidance to clarify what is meant by initial application e.g., is this intended to capture when an application is first submitted to an organization, subsequently completed and clean, or when an application is completed and submitted to a credentialing committee for review or when received from the Council for Affordable Quality Healthcare, Inc.
- Mean number of days from first submission of an application to the later of the effective date or date of execution of contract, AND
- Percentage of providers that submitted an initial application or request for application that were notified that the carrier would not proceed with the application (the carrier does not have any control over the time that it takes a provider to complete their application
    - We suggest that we report two separate turn-around-timeframes:
      1) the timeframe of when the provider requests to be part of the network to the receipt of a completed application; and
      2) the receipt of a completed/clean application to the decision timeframe.

Data Supplement 4 (Reimbursement Rates)

- The Maryland report compares MH/SUD providers to Primary Care Physicians, PCPs defined as general practice, family practice, internal medicine and pediatric medicine physicians. We agree with family/general practice and internal medicine but not pediatricians because MH/SUD does not set separate rates for behavioral health providers who see pediatric patients.
- The report includes Med/Surg providers defined to include orthopedic surgeons, dermatologists, neurologists etc. We do not agree that these specialties align with the MH/SUD providers.
- The report did not include mid-level providers. We suggest that the MIA consider mid-level providers such as physician assistants/nurse practitioners and psychologists/therapists because all are non-MDs.

- The Maryland report uses Weighted Average in-Network Allowed amounts. Averages can be easily skewed by only a few number highly specialized/ high volume providers with inflated reimbursement rates when compared to the overall provider network. We suggest that "median" is a better representation of a true market rate.
- With the CPT codes that are utilized, the Maryland report utilizes M/S CPT codes 99213 & 99214. This works for M/S. 99214 is not a commonly used code with MD MH/SUD providers. We suggest utilizing the 90792 CPT code, which is an initial evaluation and used by almost all MD MH/SUD providers
- For non-MD's MH/SUD, the Maryland report utilizes CPT codes 90834 & 90837
    - 99213 and 90834 are different types of services. 99213 is an evaluation code and 90834 is a therapy code. We suggest 90791, which is more of an evaluation code and more comparable to 99213.
    - 99214 and 90837 are also different types of services for the same reasons above.

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