September 8, 2021

Lisa Larson
Director of Regulatory Affairs
The Maryland Insurance Administration
200 St. Paul Place, Suite 2700
Baltimore, Maryland 21202

Submitted to: InsuranceRegReview.mia@maryland.gov,

Dear Ms. Larson:

Thank you for the opportunity to submit comments on the draft templates that will be used for Parity Act compliance reporting in connection with the proposed regulations – Mental Health Benefits and Substance Use Disorder Benefits – Reports on Nonquantitative Treatment Limitations and Data. The following comments are submitted by the Legal Action Center and the nine (9) undersigned members of the Maryland Parity Coalition, convened by the Center, and supplement our August 13th comment letter.

The following comments identify concerns and recommendations on both the instructions and templates, as appropriate. As noted in our comments on the draft rule, **all templates and instructions must require carrier to separately report their comparative analysis and data points for mental health (MH) and substance use disorder (SUD) benefits rather than collapsing the analyses into a single MH/SUD finding.** The federal regulatory and state statutory foundation for that standard has been provided in our August 13th comments and is incorporated by reference. In short, carriers impose different NQTLs on MH and on SUD benefits, and compliance with regard to one set of benefits does not excuse or diminish a violation for the other set of benefits. In addition, we restate our objection to data collection on anything less than all NQTLs. **At a minimum, the analysis of NQTLs that are included in the Comparative Analysis Report must cover all aspects of the carrier's design features and not be limited to the queries that are posed.**

I. NQTL Comparative Analysis Report, MHPAEA Data Template and Instructions

A. Instructions

We commend the MIA on the development of thorough and detailed instructions for NQTL Compliance Reporting. We are particularly supportive of the detailed description of responses that would fail to satisfy the "complete" report requirement; the list of audits that support the Step 5 "in operation" analysis; and the requirement to explain why data discrepancies in carrier practices do not reflect a Parity Act violation, including steps taken to reduce disparities. We urge you to retain the instructions, as drafted, and address the following three issues.

- First, we urge the MIA to revise the instructions to require separate reporting for MH benefits and SUD benefits for purposes of benefit/service identification, NQTL identification, and the comparative analyses, both as written and in operation.

- Second, as noted in our August 13th draft proposed regulation comments, **we urge the MIA to provide instructions on the process for identifying the five health benefit plans with the highest enrollment and require carriers to provide whatever supportive data are needed to verify compliance in their plan selection.** This will ensure uniform plan selection across carriers.

- Third, the Step 1 instructions correctly require the carrier to explain the methodology for assigning MH, SUD and med/surg benefits to the six classifications and subclassifications, as appropriate. (p. 2). **We recommend that the MIA include a statement requiring carriers to use the same benefit classification assignments for data analysis in the MHPAEA Data Template and Supplemental Data Form for Utilization Management Practices.** While we would expect carriers to apply their benefit assignment "rules" consistently for all analyses, a reminder of that requirement will be helpful.

We also support the proposed Disclosure Requirements and recommend that the MIA address two issues.

- First, we recommend that the MIA require **carriers to disclose the timeframe for providing responses to requests for plan documents on NQTL design and application** (i.e. processes, strategies, evidentiary standards) for both group plans and for purposes of filing an internal coverage or grievance matter. ERISA requires disclosures for group plan information within 30 days of a request and that standard should be used as a benchmark for evaluating carrier performance.

- Second, we know that carriers frequently refuse to disclose all relevant plan documents in response to NQTL disclosure requests and, accordingly, **urge the MIA to require carriers to submit 5 document responses (with identifying information redacted) to demonstrate compliance with this critically important requirement.** While the instructions appropriately identify the requirement to disclose the carrier's "process" "documentation" and "auditing" for plan document disclosure compliance, we are concerned that an explanation alone will not ensure satisfaction of federal Parity Act disclosure requirements. **We also reiterate our recommendation to include the §15-144 statutory disclosure standard in the regulations.**

B. NQTL Comparative Analysis Report

As noted in our August 13th comment letter and August 30th testimony, the NQTL Comparative Analysis Report presents multiple analytical problems because the NAIC template was not designed to be a compliance tool and has not been updated to conform to the Parity Act amendments under the Consolidated Appropriations Act or the DOL Self-Compliance tool. **We urge the MIA to adopt the report format used by the Texas Department of Insurance, the Pennsylvania Department of Insurance and URAC's Parity Manager™ -- all of which require the carrier to list all NQTLs for MH, SUD and med/surg benefits in each classification without arbitrary limitations, such as those posed by the queries.**

To the extent the MIA retains the NAIC form, we recommend the following revisions (in addition to separating out MH and SUD responses) to address two key concerns: (1) benefit classifications that are identified incorrectly as NQTLs; and (2) the inclusion of queries/examples for particular NQTLs that will likely be interpreted as limiting the identification of plan design features that limit the scope or duration of MH and SUD benefits.[1] As described below, the listed queries/examples for some NQLTs are inconsistent with the draft proposed definitions and/or instructions and the Parity Act analysis.

1. Benefit Classifications that are Identified as NQTLs

As noted in our August 13th comments and August 30th testimony, emergency services (item 5) and pharmacy services (item 6) are benefit classifications and should not be identified as NQLTs.[2] Relatedly, the template appropriately identifies Prescription Drug Formulary Design (item 7) as an NQTL, but seeks information on the application of that NQTL in all other benefit classifications, even though it is singularly relevant to the Prescription Drug classification. To remedy these analytical problems, **we recommend that the MIA:**

- **Delete emergency services as a separate NQTL and ensure that carriers are appropriately identifying and conducting comparative analyses on each NQTL that applies to emergency services in the other chart entries, regardless of whether they apply in the other five classifications.**

- **Delete items 6 and 7 and create an entry for the prescription drug classification and require the identification and analysis of all NQTLs for MH, SUD and med/surg medications in this classification. The NQTLs would include formulary design (item 7), which encompasses the "rules" for determining covered prescription drugs and tier placement, and all the medical necessity, utilization and pharmacy management practices, cost control, dosage limitations, therapeutic substitution and fail first and step therapy requirements identified in the Item 7 queries.[3]**

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[1] These queries are taken from the NAIC tool verbatim and do not reflect a proper NQTL analysis.

[2] We note that the Delaware Department of Insurance, which also uses the NAIC template as the framework for its NQTL report (https://insurance.delaware.gov/wp-content/uploads/sites/15/2019/06/NQTL-Guidance-and-Worksheet-FINAL.pdf.), lists emergency services in its template and uses that entry as the classification to address a range of NQTLs – utilization management requirements, professional staffing and other restrictions on hospital services. Additionally, the DE DOI template does not include emergency services as one of the classifications for any other NQTL analysis. While the DE DOI approach addresses the underlying analytical problem inherent in the NAIC template, it is insufficient because it does not provide for a full examination of all NQTLs that apply to the emergency services classification.

For pharmacy services, the DE DOI template uses the entry to identify prior authorization requirements for each formulary tier and does not treat the classification as an NQTL for that entry. But, like the MIA's draft template, it also incorrectly lists Prescription Drug Formulary Design as an NQTL and seeks to apply that NQTL to all classifications.

[3] We note that the Item 7 query regarding the practitioner disciplines involved in the development of the formulary design would be captured as part of the ***"process"*** used for formulary design. That query is not a separate NQTL, but it should be addressed in the "as written" and "in operation" comparative analysis to demonstrate comparability and no more stringent application for MH and SUD medications.

2. Queries Posed for Specific NQTLs that are Inconsistent with Proposed Definitions, Instructions and/or the Parity Act

The instructions appropriately require a carrier, as Step 1 of the comparative analysis, to "provide a description of applicable NQTLs" and the "specific NQTL plan language and procedures." The template, however, suggests restrictions on several NQTLs by posing narrow queries. Additionally, while the instructions provide comprehensive examples of processes and strategies that are used in the design and implementation of NQTLs, the queries focus on selective processes and strategies to the exclusion of others that the carrier may also use. **The queries will likely result in inconsistent interpretations and limited analyses by carriers.**

The following NQTLs contain limiting language that are inconsistent with proposed definitions, instructions or the Parity Act. **We urge the MIA to correct these deficiencies, which can be achieved by eliminating the queries and requiring carriers to list all NQTLs that apply in each benefit classification for MH, SUD and med/surg benefits and conduct a complete comparative analysis consistent with the instructions and federal and state requirements and guidance.**

- Prior Authorization Review (Item 2): The queries incorrectly list "step therapy" and "fail first" as prior authorization; **they are separate NQTLs that must be addressed discretely for each benefit classification for MH, SUD and med/surg benefits.** Additionally, the "requirements for submission of treatment requests or treatment plans" is a process or strategy for conducting a prior authorization review and should be part of the comparative analysis both "as written" and "in operation." The identification of this prior authorization process/strategy, to the exclusion of other processes/strategies, lends confusion to the template and analysis.

- Concurrent Review Process (Item 3): The query regarding frequency and penalties is confusing and, like requirements for treatment plan submission, are processes and strategies for applying this NQTL and must be part of the comparative analysis both "as written" and "in operation." As noted above, these are not the only processes and strategies that must be examined in the comparative analysis. *See above* for a discussion of the inappropriate inclusion of "step therapy" and "fail first" in the prior authorization NQTL, which are also incorrectly listed as queries in the concurrent review NQTL.

- Retrospective Review Process (Item 4): The query identifies timeline and penalties and poses the same concerns identified above for concurrent review.

- Case Management (Item 8): Case management **is not an NQTL but rather a service** that may be available for MH, SUD and/or med/surg benefits depending upon the scope of services standards (a separate NQTL included as item 12). Additionally, the queries related to available and required case management services and eligibility requirements would be addressed as a process, strategy or factor in ***the scope of services*** analysis. **We request the MIA to identify any specific NQTL it seeks to analyze for this item.**

- Process for Assessment of New Technologies (Item 9): The queries relate to processes, strategies and sources of information used in designing and implementing this NQTL. As noted above, the identification of these processes, strategies and sources to the exclusion of others lends confusion to the template and will likely skew the analysis.

- Standards for Provider Credentialing and Contracting (Item 10): The queries focus on a relatively narrow set of NQTLs in the credentialing and contracting context; i.e. the credentialing standard for some but certainly not all MH, SUD and med/surg providers. **To comply with the Parity Act, this NQTL should capture all design features that limit the scope or duration of treatment through the inclusion or exclusion of MH, SUD and med/surg providers and facilities in a carrier's network.** This includes network tier design, all procedural requirements for seeking network credentialing, as demonstrated in the supplemental data for carrier credentialing, practices for opening and closing network admission and incentivizing providers to join networks, and all contracting standards. The full range of credentialing NQTLs must be identified and analyzed for Parity Act compliance.

- Exclusions for Failure to Complete a Course of Treatment (Item 11): As noted in our August 13th comments, carriers that impose this NQTL may use the Uniform Treatment Form Plan to assess completion of a course of treatment. To the extent the form is used for this or any other utilization management NQTL, the carrier must demonstrate that the required information and procedural requirement itself are comparable to and applied no more restrictively than the process for med/surg benefits.

- Restrictions that Limit the Duration or Scope of Benefits for Services (Item 12): As noted in our August 13th comments and hearing remarks, **the proposed definition for "restrictions that limit the duration or scope of benefits" is appropriately comprehensive** and includes NQTLs that go beyond the queries on geographical location of services and facilities that deliver covered services. The definition covers "exclusions of a specific or [sic] type of MH/SUD treatment" and "other [similar] criteria" that limit the scope or duration of benefits. **We urge the MIA to conform Item 12 to the definition and require reporting of all NQTLs that limit the scope or duration of MH and SUD benefits.**

- Restrictions for Provider Specialty (Item 13): Based on the proposed draft definition of "restrictions that limit the duration or scope of benefits," this NQTL could be included in Item 12. We have no objection to a stand-alone NQTL.

- Reimbursement Facilities and Providers (Item 14): As noted in our August 13 comments, this NQTL **would be better described as "reimbursement rate setting" and encompass the full set of plan design features that affect provider reimbursement for MH, SUD and med/surg practitioners and facilities.** This includes, at a minimum, all features listed in the definition of "reimbursement" with the addition of out-of-network reasonable and customary rates, single case agreement payments, and, as the HEAU has recommended, algorithms used for claim review and reimbursement.

We have no comments on the MHPAEA Data Template and recommend that the MIA follow that format for separate reporting of results for MH, SUD and med/surg benefits.

II. Reimbursement Rates – Template and Instructions[4]

[4] Courtney Bergan has helped guide the reimbursement template analysis and prepared Attachment A. Her remarks from the August 30th hearing are incorporated here.

The Parity Coalition commends the MIA for including an assessment of reimbursement rates as part of its parity compliance assessment, yet we are concerned that the template and instructions, as drafted, will fail to capture accurate and complete data.[5] **We urge the MIA to (1) gather more detailed data on Maryland's MH and SUD services to ensure a sufficient analysis; (2) use appropriate benchmarks – including data from 2021 and local Medicare rates – to draw more accurate comparisons; and (3) ensure that the analysis uses appropriate methodologies and is consistent with sound statistical and actuarial practices.**

A. More Detailed Data on Maryland's MH and SUD Services is Necessary to Ensure a Sufficient Analysis.

The MIA's use of the National Alliance of Healthcare Purchaser Coalition's model network adequacy forms for development of these reimbursement rate templates falls short of ensuring a sufficient parity analysis, especially as the form fails to capture an adequate range of codes for MH services or any data on SUD-specific services.

1. Reimbursement Rates for SUD Services

Consistent with our overarching recommendation that the MIA must analyze MH and SUD separately, **we urge the MIA to analyze the reimbursement of a stand-alone SUD-specific service by including codes for opioid treatment programs (OTPs).** While most SUD services are billed using HCPCS H codes, Medicare does not cover most SUD services and does not use these H codes. Medicare has now established a Medicare rate for OTPs,[6] which will allow for reimbursement data collection and analysis for a stand-alone SUD service and a Medicare benchmark comparison. We also believe this service data would be among the most valuable in assessing parity compliance, as testimony provided as part of the MIA's network adequacy regulatory review process revealed that CareFirst offers exceedingly low reimbursement rates for OTPs, which prevents providers from joining its network. To assess issuer reimbursement practices for essential services to address the state's opioid use disorder epidemic, **we recommend that the MIA create a table that reports the weighted average for all OTP claims, consistent with the methodology identified in Table A, and requires a comparison of the carrier rates to the local Medicare Administrative Contractor (MAC) rates for G2067 and G2068; i.e. the percentage above or below the Medicare rate.**

2. Reimbursement Rates for New Patients vs. Established Patients

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[5] We recognize that the reimbursement rate draft instructions and template have been adopted from the National Alliance of Healthcare Purchaser Coalition's model forms. We note that **the purpose of the Purchaser Coalition's evaluation of a TPA's behavioral health provider network is different from the MIA's Parity Act compliance review.** The goal of the former is to compare a narrow slice of reimbursement rates, which, along with other forms, is used to assess network adequacy for behavioral health services and inform health plan purchasing. *See* Model Data Request Form (MDRF) available at http://www.mhtari.org/Model_Data_Request_Form.pdf. In contrast, the MIA's legislative mandate is to evaluate whether the issuer's reimbursement rate setting practices comply with Parity Act's NQTL standards. Additionally, the MDRF is designed for nationwide use, as an employer-sponsored ERISA plans are often implemented across multiple states, while the MIA's interest is limited to Maryland alone.

[6] *See* National rate data at https://www.cms.gov/files/document/cy2021-otp-payment-rates.pdf and local Medicare Administrative Contractor reimbursement rates at https://www.novitas-solutions.com/webcenter/portal/MedicareJL/pagebyid?contentId=00243503.

As noted in the Center's May 14, 2021 letter, a study by the Maryland Health Care Commission of 2017 commercial carrier data from the All Payer Claims Database revealed the greatest disparity in reimbursement for psychiatrists for new patients as opposed to established patients. **We recommend that two E&M codes for new patients be included in Table A and analyzed consistent with the Table A analysis**: 99204 (new patient 45-59 minutes or moderate level medical decision making) and 99205 (new patient 60-74 and high level of medical decision-making). The Texas reimbursement templates includes a new patient code as does the DOL Self-Compliance Tool, App II (Provider Reimbursement Rate Warning Signs).

3. Reimbursement Rates for Children vs. Adults

As part of the state's commitment to ensuring sufficient access to MH and SUD services for children and adolescents, and recognizing that issuers use different rates for patients based on age, **we urge the MIA to separate out claims for patients 0-17 years from those 18 years and older in Table A (**the weighted reimbursement data for PCPs, med/surg specialists and psychiatrists). "Age" is a factor that can be used for the reimbursement NQTL and, based on the paucity of MH and SUD providers for youth, it is important to determine if that factor is applied to med/surg services and MH and SUD services in a comparable and no more stringent manner and to examine claims data for this element.

4. Reimbursement Rates for Facilities vs. Non-Facilities

All claims for MH, SUD and med/surg services – both facility and non-facility – must be included in the analysis to ensure a complete assessment of Parity Act compliance. Outpatient services for MH, SUD and med/surg services are delivered in various settings and bill services differently under the Medicare Physician Fee Schedule (PFS) based on whether they are designated a facility or non-facility service. As demonstrated in Attachment A, the Medicare PFS provides different rates for facility and non-facility services under the PFS and, absent data on facility services, the MIA cannot assess fully whether MH and SUD services are reimbursed disproportionately. The template as drafted would fail to capture any outpatient services that are delivered in hospital-affiliated settings. Furthermore, an additional "facility fee" can be billed in facility settings, and somatic outpatient services may include billing for this fee to a greater extent than MH and SUD services.

We believe it is necessary to collect and analyze data on facility-based claims and distinguish such services from non-facility claims to assess parity compliance and identify reimbursement disparities in the range of settings in which outpatient services are delivered. **We urge the MIA to revise its template to require reporting of claims for facility reimbursement in both Tables A and B.**[7]

B. Medicare Rates from 2021 and Local Medicare Administrative Contractors are More Appropriate Benchmarks.

1. Medicare Rates for 2021

[7] We also encourage the MIA to require reporting of reimbursement for Nurse Practitioners (NPs) for MH, SUD and med/surg using CPT codes 99213 and 99214. NPs have begun to fulfill prescribing responsibilities for patients with MH conditions on an increasing basis, and there is evidence of lower reimbursement for these practitioners than for NPs who work in med/surg settings.

The draft template uses the 2020 national physician fee schedule as opposed to the 2021 local MAC physician fee schedule. The 2021 fee schedule is the operative data and takes into account important rate changes that were implemented after 2020, including important increases for some psychotherapy codes. As demonstrated in Attachment A, the 2021 National Payment Amount for the psychotherapy codes (CPT 90834 and 90837 for non-facility services) is approximately $10 higher than the 2020 codes and, approximately $16 to $20 higher, respectively for the E&M codes (CPT 99213 and 99214 for non-facility services). Use of the 2020 rates could result in the reporting of a smaller reimbursement disparity and skew results in Tables A and B. **We urge the MIA to revise its template to reflect the 2021 PFS rates**.

2. Local Medicare Administrative Contractor Rates

The local Medicare Administrative Contractor (MAC) reimbursement benchmark is a more appropriate comparator for Maryland's issuers, as it accounts for service costs in our region and will allow for a more precise assessment of any rate disparity for MH, SUD and med/surg providers. As demonstrated in Attachment A, the local MAC rates for Baltimore and surrounding counties, DC and Maryland suburbs, and the rest of Maryland are all higher than that National Medicare rate for services billed as facility and non-facility under the PFS. Local rates average 2.5% to 14% greater than national rates for the E&M codes (non-facility) and 2% to 11% greater for the E&M codes (facility). For the psychotherapy codes, local rates for 90834 are 1% to 8% higher (non-facility) and 1% to 10% higher (facility) than national rates and, for 90837, 1% to 8% higher (non-facility) and 1% to 9% (facility). **We note that the DOL Self-Compliance Tool App. II references the Medicare rate for the locality.** The Healthcare Purchaser Coalition form relies on National Medicare rates to achieve nationwide applicability, which is not needed for a Maryland-specific analysis. **We urge the MIA to require CPT code rates to be reported separately for all three localities using the local MAC reimbursement benchmarks.**

C. <u>The MIA Must Ensure that Analyses Use Appropriate Methodologies that are Consistent with Sound Statistical and Actuarial Practices.</u>

We note a lack of clarity about the purpose of the tables, as drafted, and make the following recommendations to ensure that analyses will be valuable with respect to assessing parity compliance and are consistent with sound statistical and actuarial practices.

1. Amendments to Table A

Insofar as the purpose of Table A is to determine whether similarly trained physicians with identical RVUs are reimbursed equally, **we recommend that Row 5 be limited to a compare of reimbursement disparity (if any) between psychiatrists and non-psychiatrist specialists and the addition of a Row 6 to compares the percentage amount (if any) by which reimbursement for PCPs exceeds psychiatrists (both facility and non-facility)**. The Nov. 2019 Milliman report provides a separate comparison of PCP, specialists, and psychiatrists and revealed that reimbursement rates for PCPs and specialists exceeded that of psychiatrists, with

PCPs showing the largest percent difference.[8] Collapsing the rates into a single value could mask important disparities, as the comparison to PCPs reveals the largest percent difference.[9]

We also recommend that the MIA add a Column C to Table A to calculate the plan weighted average allowed amount as a percentage of Medicare for psychiatrists, PCPs and non-psychiatric specialists using CPT codes 99213 and 99214. Although Medicare rates are not subject to the Parity Act, they serve as a benchmark for comparing any disparities between psychiatrists and other med/surg providers. As noted below, this comparison is far more relevant than a comparison of non-psychiatric physicians to psychologists and LCSWs set out in Table B. This data will also update an analysis performed by the Maryland Health Care Commission in 2019 using 2017 data from the All Payers Claims Database (and provided with our Aug. 13th comments) and is consistent with the Milliman study.

2. Amendments to Table B

The purpose of Table B is less clear as it relates to an "in operation" analysis. It calls for a comparison of reimbursement rates for psychologists and clinical social workers as compared to non-psychiatrist physicians, even though those service codes are not comparable in duration of session and a separate CPT code for psychotherapy with an E&M add on is available (i.e. 90833, 90836, or 90838 depending on duration). If the goal is to provide a comparison of a carrier's med/surg reimbursement and the Medicare rate, as noted above, we recommend that Table A require that analysis for psychiatrists. At a minimum, we urge the MIA to remove this analysis for Table B.[10]

To draw a more complete comparison across practitioner types for psychologists and LCSWs, we urge the MIA to follow Texas's parity reimbursement model and include the following codes for occupational therapists and physical therapists: OT – 97166 (new patient moderate complexity), 97167 (new patient high complexity) and 97186 (reevaluation); PT – 97162 (new patient moderate complexity), 97163 (new patient high complexity), and 97164 (reevaluation). **Additionally, Table B should include the column A analysis (plan weighted average allowed amount) for each code and remove the comparison to the Medicare benchmark in columns B and C.**

3. Amendments to the Instructions

We recommend that the instructions require the issuer to identify the number of claims that are included in each analysis, the number of quarters for which claims data are available, and the

[8] *See* Milliman Research Report, ADDICTION AND MENTAL HEALTH VS. PHYSICAL HEALTH: WIDENING DISPARITIES IN NETWORK USE AND PROVIDER REIMBURSEMENT (Nov. 19, 2019) at 15, https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf.

[9] *See* Milliman Research Report, ADDICTION AND MENTAL HEALTH VS. PHYSICAL HEALTH: WIDENING DISPARITIES IN NETWORK USE AND PROVIDER REIMBURSEMENT (Nov. 19, 2019) at 15, https://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf.

[10] We note that a far better comparison of reimbursement rates would be one based on reimbursement per minute for all practitioners that delivery MH and SUD services compared to med/surg practitioners. That provides a common denominator that is missing from the proposed comparison.

range of reimbursement from lowest to highest claim amount. These data points are essential to assess the results based on accepted statistical standards.

We further recommend that the MIA include a requirement in the instructions that the issuer's actuary attest to the statistical validity of the analysis. While the draft proposed regulations, Sec. .05(E), require a corporate officer to attest to the accuracy of the data, review and attestation by an actuary will better ensure that each issuer conducts a consistent analysis and does not manipulate data to reflect a more favorable result.

Finally, the instructions should be revised to note that claims data are for the period of "January 1, 2021 through the latest month in 2021.

II. Supplemental Data Report – Provider Credentialing

We commend the MIA for collecting data on the carrier's practices for processing provider credentialing applications to help evaluate "in operation" compliance. The separate analysis of practitioners and facilities is particularly valuable. We offer several recommendations to clarify the instructions and strengthen the data requested in the template.

First, we recommend that the instructions and template **require the issuer to identify the total number of credentialing applications received, separating out MH and SUD provider applications for both practitioners and facilities.** Distinguishing credentialing practices for *MH facilities, SUD facilities, and med/surg facilities* is particularly important, as members of the Parity Coalition have consistently identified the need to implement a facility credentialing process for MH community-based providers and/or a "deemed" credentialing standard to facilitate continuity of care and satisfy client need without disruptions in reimbursement. Facility credentialing is also a process that may differ between MH and SUD facilities, as opioid treatment programs and other SUD community-based programs are generally credentialed as facilities.

Second, we recommend that the instructions and template require reporting of the total number of applications involved in each discrete response in addition to the percentage. It is important to know the ***number*** of applications being submitted and the manner in which they are processed, as a percentage alone masks important data trends.

Third, we support the MIA's broad definition of "rejected due to a full network" to capture denials that fall outside the applicant's credentialing qualifications. We are concerned, however, that carriers will define that "reason" differently without additional direction. **We recommend that the MIA set out the additional commonly used terms for a "full network" denial and consider adding to the instructions a qualitative standard as a catch-all; i.e. "any rejection for a reason other than failure to meet credentialing qualifications and requirements."**

In addition, we note that all reasons for credentialing denials are factors that should be analyzed in the NQTL template Item 10 (along with evidentiary standards for the application of each factor to ensure that MH and SUD providers are being evaluated based on the same criteria as med/surg providers). To assess whether the reason(s) for credentialing denials for MH and SUD providers align with med/surg providers, **we recommend that the MIA require carriers to identify the top three reasons for rejection of MH and SUD practitioners and provide the number and percentage of med/surg applications that are denied for those same reasons.**

Finally, in the template, the facility boxes in the last row (percentage notified that carrier would not proceed with the application) appear blocked off for responses. We believe responses should be provided for facilities.

III. Supplement Data Report – Prior Authorization, Concurrent Review, Retrospective Review and Pharmacy Services

We support the MIA's request for data on the full range of utilization management practices by classification and the inclusion of data on requests for out-of-network services under Ins. § 15-830. The later data will provide important information on adequacy of provider networks. **As with all other templates and analyses, this data must be reported separately for MH benefits and SUD benefits to comply with the Parity Act, and we urge the MIA to revise the template to separate out that benefit data.** We have several additional recommendations for the instructions and template to ensure consistent reporting of data across carriers and user-friendly data.

First, we request that the instructions state that the carrier must place MH, SUD and med/surg services in the same benefit classification for purposes of the utilization management template and the NQTL Comparative Analysis Report. As noted above, while this analytical approach should be the standard practice, it is important to include this instruction to ensure an internally consistent report for all NQTLs and supplemental data.

Second, **we request that the MIA provide a definition for the term "denial" to ensure consistent data collection and reporting across carriers.** Unlike the MHPAEA Data Report, which requires a report of the service denial codes, the instructions for this template do not distinguish between medical necessity, administrative or other coverage denials, including those for experimental/investigative procedures. We recognize that the template frames "denials" as "adverse decisions," indicating an interest in collecting denials based on medical necessity alone. **We believe that the inclusion of a definition of "denial" will ensure uniform reporting and, for data reporting purposes, should also include "administrative" denials; i.e. those that are not based on clinical review. We also urge the MIA to revise the template to include separate data reporting of administrative denials for each level of utilization management (prior authorization, concurrent review and retrospective review, as appropriate).**[11] The administrative denial data should be pulled consistently from the denial codes provided in the MHPAEA Data Report.

Finally, we request that the data template provide the percentage (as well as the number) of approvals, denials, peer-to-peer actions, and grievances for each level of utilization management in each classification. This data will provide a more user-friendly report and facilitate comparisons across MH, SUD and med/surg benefits. We trust that the template can be developed to auto-calculate the percentages as in the MHPAEA Data Report.[12]

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[11] We note that the Purchaser Coalition Model Data Request Form includes a definition for "denials" and requires separate reporting for medical necessity and administrative denials. *See* MDRF at 6-7, http://www.mhtari.org/Model_Data_Request_Form.pdf.

[12] Absent an auto-calculate function, the instructions should provide instructions on the components of the numerator and denominator so ensure consistent calculations. *See* MDRF at 6.

IV. Supplemental Data Report - Prescription Drug Formulary Design

We support the MIA's request for data on the Section 15-831 protections. As noted at the August 30th hearing**, reporting the data separately for MH and SUD prescriptions is critically important.** There is a relatively small number of medications for SUD treatment compared to MH conditions, and a carrier's practice under 15-831 for SUD medication requests may be masked by requests for MH medications. **We also urge the MIA to require carriers to submit their formularies as an attachment to allow for review in connection with this data.**

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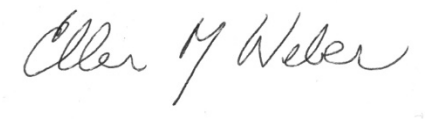
Thank you for considering our views. We look forward to working with the MIA on the promulgation of strong Parity Act compliance reporting regulations and comprehensive templates.

Sincerely,



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National Council on Alcoholism and Drug Dependence-Maryland (NCADD-Maryland)
Western Maryland Area Health Education Center West (AHEC West)
Laura Mitchell, Consumer & Advocate, Montgomery County Council of PTAs, VP of Advocacy; Chair, Substance Use Prevention Committee

Attachment A

Medicare Reimbursement Rates by MD Localities

Locality			Relative Reimbursement of Locality to National Payment Amount (%)		
BALTIMORE_SURR. CNTYS					
HCPCS Codes Psych	**Non-Facility Price**	**Facility Price**	**Non-facility Percentage**		**Facility Percentage**
90833	74.83	$66.42		105.13%	104.58%
90834	108.57	$95.18		105.12%	104.51%
90836	94.61	$83.91		105.10%	104.56%
90837	160.25	$140.75		105.10%	104.50%
90838	125.62	$111.85		105.27%	104.76%
HCPCS Codes E&M			**Average:**	**105.14%**	**104.58%**
99213	99.02	$72.25		107.08%	106.19%
99214	140.3	$106.64		106.94%	106.12%
			Average:	**107.01%**	**106.15%**
DC + MD_VA SUBURBS					
HCPCS Codes Psych	**Non-Facility Price**	**Facility Price**	**Non-facility Percentage**		**Facility Percentage**
90833	$78.56	$69.07		110.37%	108.75%
90834	$113.62	$98.52		110.01%	108.18%
90836	$99.33	$87.25		110.34%	108.72%
90837	$167.71	$145.72		109.99%	108.19%
90838	$131.82	$116.30		110.47%	108.93%
			Average:	**110.24%**	**108.55%**
99213	$106.24	$76.05		114.89%	111.77%
99214	$150.25	$112.30		114.52%	111.75%
			Average:	**114.71%**	**111.76%**
REST OF MARYLAND					
HCPCS Codes Psych	**Non-Facility Price**	**Facility Price**	**Non-facility Percentage**		**Facility Percentage**
90833	$72.51	$64.55		101.87%	101.64%
90834	$105.18	$92.51		101.84%	101.58%
90836	$91.70	$81.57		101.87%	101.64%
90837	$155.27	$136.82		101.83%	101.58%
90838	$121.60	$108.57		101.90%	101.69%
HCPCS Codes E&M			**Average:**	**101.86%**	**101.63%**
99213	$94.82	$69.50		102.54%	102.15%
99214	$134.47	$102.63		102.49%	102.13%
			Average:	**102.52%**	**102.14%**

National Payment Amount		
HCPCS Codes Psych	**Non-Facility Price**	**Facility Price**
90833	$71.18	$63.51
90834	$103.28	$91.07
90836	$90.02	$80.25
90837	$152.48	$134.69
90838	$119.33	$106.77
HCPCS Codes E&M		
99213	$92.47	$68.04
99214	$131.20	$100.49