Deborah Rivkin
Vice President
Government Affairs – Maryland

CareFirst BlueCross BlueShield
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-528-7054
Fax 410-505-6651

October 29, 2021

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

Sent via email: mhpaea.mia@maryland.gov

RE: Comments on Revised Draft of Proposed Supporting Documents for COMAR 31.10.51 ***Mental Health Benefits and Substance Use Disorder Benefits – Reports on Nonquantitative Treatment Limitations and Data***

Dear Ms. Larson:

On October 26, 2021, the MIA announced that it had posted revisions to its August 24, 2021 draft reports and instructions required to be submitted by carriers to the MIA pursuant to SB0334/HB0455 of 2020, codified at § 15-144 of the Insurance Article. The MIA also posted specific questions for stakeholder consideration. CareFirst offers the following comments on the data supplements, the revised documents, and questions.

DATA SUPPLEMENTS – CONCERNS AND RECOMMENDATIONS

Although no changes have been made to date, CareFirst reiterates its strong concerns with the proposed Data Supplements. The Data Supplement templates contain prescriptive data points that go beyond state and federal Mental Health Parity and Addiction Equity Act (MHPAEA) requirements and include information that is not necessary or relevant to a parity analysis.

- **As we previously commented, neither federal nor state law prescribes *specific data* that carriers must analyze to determine compliance of a plan's non-quantitative treatment limitations (NQTLs) in operation.** Rather, federal and state law allow for carriers to use their discretion in the use of the quantitative data points that they employ in their internal audits of in operation compliance. As stated in our September 7, 2021, letter:

    - *Federal guidance on MHPAEA compliance does not prescribe specific data points required to be used in a carrier's "in operation" compliance audits. Federal guidance suggests that carriers follow the U.S. Department of Labor, Self-Compliance Tool (DOL Tool)[1] as a template for conducting an adequate*

comparative analysis. While the DOL Tool does include in its "compliance tips" looking at certain data when conducting a comparative analysis, nothing in the DOL Tool requires that the data be collected in a specific way in order to complete the comparative analysis. Furthermore, even where the DOL Tool does provide a specific template for analyzing data (reimbursement rates), it acknowledges that this is just one way a plan may assess its methodology and states "[t]his is not the only framework for analyzing provider reimbursement rates[.]"

- *Md. Ins. § 15-144(e) outlines the specific elements of the NQTL in operation analysis required by § 15-144(d)(1). Section 15-144(e)(4) expressly requires carriers to submit the "results of audits" performed on the NQTLs but does not require that carriers collect and report specific data prescribed by the MIA as required for these audits as part of the NQTL Analysis Report.*

- MHPAEA does not contemplate nor strive to compare NQTLs among carriers; rather, it is designed to evaluate how each individual carrier administers its own plans' medical/surgical and mental health and substance use disorder benefits. NQTLs vary across products and carriers, meaning that prescribing a specific data set for all carriers and plans to rely on to determine compliance will not result in useful information. Even if the MIA wanted to compare carriers to each other, because of NQTL variance, a data submission that is uniform among carriers will not result in a true "apples to apples" comparison of how plans conduct their in-operation analyses.

- Data Supplement 1 (Utilization Review) requests data for prior authorization, concurrent review, and retrospective review broken out by age groups (0-12, 13-17, adult). **Age groups are not MHPAEA classifications**. The comparative analysis for parity compliance is done within the classifications as established by federal law and **no subclassifications other than those specifically permitted in the regulation shall be used**.[1] Nothing in the state or federal parity laws support collecting data broken down in this manner and this data will not be useful for determining if there are parity issues.

- **Data Supplement 1 (Utilization Review) requests data concerning carrier compliance with § 15-830(d) of the Insurance Article, a law which is not referenced in <u>SB0334</u>/<u>HB0455</u>.** We question the appropriateness of asking for this data as part of a report that arises from § 15-144, which does not contemplate § 15-830(d)'s network adequacy requirements and data. If the MIA is interested in collecting specific data about network access for specific age groups to identify network gaps or gaps in available providers within Maryland, we suggest that such work be done via a survey or workgroup rather than through this MHPAEA Report.

RECOMMENDATION: Prescriptive Data Supplements 1-4 should be deleted in their entirety. In appreciation of the Commissioner's position that certain data elements in addition to the specific items included in the data report are necessary in order to verify a carrier's in operation audit compliance, CareFirst notes that Step 5 of the NQTL Analysis Report requires carriers to report

[1] 45 C.F.R. § 146.136(c)(2)(ii).

on the methodology and results of audits conducted to determine NQTL compliance in operation. The MIA could add to the Step 5 requirement that a carrier must disclose the specific data underlying the carrier-specific audits it conducts so that the MIA may verify the audits. This approach will provide the MIA with the information necessary to determine if there are any red flags with how an NQTL is operating.

OTHER COMMENTS

CareFirst appreciates the changes made to the MIA's regulations to reflect our previous recommendations on the draft proposed regulations. We offer the following additional comments on the proposed changes to the instructions.

DEFINITIONS

(1) "Facility" means a person, other than an individual, that provides health care services. "Facility" includes entities that bill for a bundled set of services that include services provided by staff employed by the facility. Examples of facilities include hospitals, outpatient radiology centers, and residential treatment centers.

This is broader than any definition of "health care facility" in the Insurance Article or the Health General Article. For example, the definition in the Insurance Article (15-10B-01) is:

(g) Health care facility. -- "Health care facility" means:

(1) a hospital as defined in § 19-301 of the Health - General Article;

(2) a related institution as defined in § 19-301 of the Health - General Article;

(3) an ambulatory surgical facility or center which is any entity or part thereof that operates primarily for the purpose of providing surgical services to patients not requiring hospitalization and seeks reimbursement from third party payors as an ambulatory surgical facility or center;

(4) a facility that is organized primarily to help in the rehabilitation of disabled individuals;

(5) a home health agency as defined in § 19-401 of the Health - General Article;

(6) a hospice as defined in § 19-901 of the Health - General Article;

(7) a facility that provides radiological or other diagnostic imagery services;

(8) a medical laboratory as defined in § 17-201 of the Health - General Article; or

(9) an alcohol abuse and drug abuse treatment program as defined in § 8-403 of the Health - General Article.

What is the basis for the broader definition used in this draft?

(2) "Reimbursement rates" means the formulae to calculate the dollar allowed amounts under a value-based or other alternative payment arrangement, dollar amounts, or fee schedules payable for a service or set of services.

The draft definition is better suited for the term "reimbursement rate methodology." "Reimbursement rates" are the actual level of reimbursement the provider receives (i.e., the dollar amount), not the "formulae to calculate the dollar allowed amount."

COMMISSIONER'S QUESTIONS

In the MIA's hearing notice, the Commissioner asked for stakeholders to provide comments on two additional issues:

(1) Whether the data supplements should be required at the same time as the report required by § 15-144 of the Insurance Article, at a later date, or as a separate data call.

RESPONSE: As noted above, CareFirst recommends replacing the data supplements in their entirety with enhanced reporting under Step 5 of the Analysis Report. Enhanced Step 5 data could be submitted at the time the report is due.

(2) The cost of compliance with specific data elements requested in the data supplements and whether these costs are in addition to the costs of compliance with the MHPAEA reporting requirements of 42 U.S.C. § 300gg-26(a)(8), in particular for health plans that use the Self-Compliance Tool published by the Department of Labor, including the appendices to the Self-Compliance Tool.

RESPONSE: Insofar as the Data Supplements ask for data that is outside the scope of MHPAEA altogether (see comments above concerning Data Supplement 1), the cost of putting together these supplements is entirely additional to the cost of federal MHPAEA reporting requirements, including for plans that use the DOL Tool.

As to information in the Data Supplements that is also contemplated by the DOL Tool, it is still possible that a carrier's internal audit would contain different data analyses currently. Neither federal law nor the DOL Tool itself *require* that a carrier audit its plans' "in operation" compliance by using the data points suggested in the DOL Tool.[2] Therefore, any data which is requested in the Data Supplements that carriers do not currently audit, regardless of its inclusion in the DOL Tool, will generate additional compliance costs. Further, for carriers that *do* follow all the tips in the DOL tool, we note that the tool contains an entirely different template for reimbursement analysis then the one that the MIA has chosen to use for its report.

[2] *See* FAQs about Mental Health and Substance Use Disorder Parity Implementation and the Consolidated Appropriations Act, 2021 Part 45 (April 2, 2021), available at https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-45.pdf ("plans and issuers that have carefully applied the guidance in the Self-Compliance Tool should be in a strong position to comply with the Appropriation Act's requirement to submit comparative analyses upon request."); *See also* 2020 MHPAEA Self-Compliance Tool, pg 26 and 38 available at https://www.dol.gov/sites/dolgov/files/EBSA/laws-andregulations/laws/mental-health-parity/self-compliance-tool.pdf ("These are examples of methods/analyses substantiating that factors, evidentiary standards, and processes are comparable…. [a]ccordingly, the following framework for comparison may assist plans and issuers in identifying information they might consider when comparing reimbursement rates for certain MH/SUD and medical/surgical services based on Current Procedural Terminology (CPT) codes. This is not the only framework for analyzing provider reimbursement rates, and it is not determinative of compliance.").

We thank you for this opportunity to provide additional comments, and we look forward to continuing this important conversation.

Sincerely,

Deborah R. Rivkin