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| **From:** | Jamie Sexton -MDInsurance- |
| **To:** | EBSA MHPAEA Request for Comments |
| **Cc:** | Mary Moody Kwei -MDInsurance-; David Cooney -MDInsurance-; Kathleen A. Birrane -MDInsurance-; Megan Senior -MDInsurance- |
| **Subject:** | Maryland Insurance Administration Technical Release 2023-01P Comments |
| **Date:** | Tuesday, October 17, 2023 2:51:46 PM |
| **Attachments:** | Maryland Insurance Administration Technical Release 2023-01P Comments.docx |



To Whom IT May Concern:

Attached please find comments respectfully submitted by the Maryland Insurance Administration (MIA) on the U.S. Department of Labor's Proposed Relevant Data Requirements for Nonquantitive Treatment Limitations (NQTLs) Related to Network Composition and Enforcement Safe Harbor for Group Health Plans and Health Insurance Issuers Subject to the Mental Health Parity and Addiction Equity Act, Technical Release 2023-01P.

Please let us know if you have any questions about our responses or require any additional information.

Thank you,

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October 17, 2023

*Submitted electronically to: mhpaea.rfc.ebsa@dol.gov*

**Subject: Maryland Insurance Administration Comments in Response to U.S. Department of Labor Technical Release 2023-01P**

To Whom It May Concern:

The Maryland Insurance Administration (MIA) respectfully submits these comments on the U.S. Department of Labor's Proposed Relevant Data Requirements for Nonquantitive Treatment Limitations (NQTLs) Related to Network Composition and Enforcement Safe Harbor for Group Health Plans and Health Insurance Issuers Subject to the Mental Health Parity and Addiction Equity Act, Technical Release 2023-01P.

Maryland law, § 15-144 of the Insurance Article, requires carriers to file analyses of their compliance with the Mental Health Parity and Addiction Equity Act ("MHPAEA") in 2022 and 2024. The requirements for the plan-level, seven-step analysis are laid out in the statute, and instructions are provided in regulations and on the Maryland Insurance Administration ("MIA") website. In order to obtain a better understanding of compliance issues, and identify areas where more attention is required to a carrier's in-operation analysis, the MIA requires four data supplements. The four data supplements cover utilization review, formulary exceptions, provider credentialing, and reimbursement rates. The MIA notes that network adequacy is not one of the NQTLs subject to reporting requirements, but that Maryland has a separate network adequacy law, which requires annual reports. The MIA strongly supports the use of data collection and reporting to indicate whether an issuer is in compliance with MHPAEA in operation.

**Time and Distance Standards**

*How can the Departments ensure that the data would provide a meaningful representation of whether a plan or issuer is designing and applying NQTLs related to network composition in a manner that places greater restrictions on access to treatment from in-network MH/SUD providers than from in-network M/S providers? Are there other measures, such as wait times, that should be used to determine whether NQTLs related to network composition are designed and applied in compliance with MHPAEA?*

The network adequacy standards adopted in regulation pursuant to § 15-112 of the Insurance Article include time and distance standards and wait times. The MIA notes that specific

instructions are necessary to ensure that issuers are measuring travel time and distance in a meaningful way that is consistent among issuers.

The MIA's experience with wait time standards is that issuers have difficulty in collecting the data from providers, and that it is difficult to define how the wait time should be measured. For example, a patient may call a health care provider to request an appointment, be offered one that day, and decline because of conflicting commitments. Does the issuer measure that as a same-day wait time, or measure the time until the actual appointment that is made by the patient? Would a provider have records of the earliest offered appointment time?

**Reimbursement Rates**

It is important to define "reimbursement rates" as the allowed amounts paid for claims, not simply the fee schedule rates that may apply. This provides data on the providers who are actively participating in the network by seeing patients and submitting claims for payment.

Out-of-network reimbursement amounts may also be meaningful in determining access to care. A patient may not be able to afford care if the out-of-network reimbursement is insufficient.

*How can the Departments ensure that the data would provide a meaningful representation of whether a plan or coverage is designing and applying NQTLs related to network composition in a manner that places greater restrictions on access to treatment from in-network MH/SUD providers than from in-network M/S providers?*

The use of Medicare rates as a benchmark is likely to provide a meaningful representation of whether the issuer is developing reimbursement rates that allow access to treatment. Medicare rates are a standard benchmark for health insurance reimbursement; many health plans use a percentage of Medicare rates as their standard for out-of-network payments.

Use of billed charges as a benchmark is unlikely to provide a meaningful representation of whether reimbursement rates are structured in a way that would restrict access to in-network treatment. Billed charges are not developed in a standard manner, and are not meaningful in themselves. It is not known whether any payor, even a self-pay patient, is ever expected to pay the billed charges. To the extent that billed charges are used in developing reimbursement rates, health care providers have an incentive to inflate the charges, without expectation of receiving that amount in payment.

*Are there different or additional CPT codes than those outlined above (99213, 99214, 90834 and 90837) that would help plans and issuers evaluate their reimbursement rate structures?*

These are the CPT codes that have been used by Maryland.

*Which specific types of MH/SUD and M/S providers should be considered for purposes of the comparative analysis data collection and evaluation requirement on reimbursement rates for NQTLs*

*related to network composition? Which types of M/S providers are the appropriate comparators to which particular types of MH/SUD providers for this purpose?*

Maryland requires data for primary care physicians, non-psychiatrist specialist medical/surgical physicians, psychiatrists, psychologists, and clinical social workers.

*In determining average in-network payments, average billed charges, and average allowed amounts, should the average be calculated as a mean, a median, or a mode?*

Maryland requires use of a weighted average of in-network payments.

*Is the National Medicare Fee Schedule helpful to compare reimbursement rates, and if not, why not?*

Regional Medicare fee schedules are typically used as a benchmark for reimbursement rates.

*How should the evaluation of reimbursement rate data requirements take geographic area into account? How should the Departments define geographic areas? Should the Departments do so in a manner that is consistent with other data elements described in this document?*

Medicare's fee schedules for geographic regions are generally used as benchmarks.

*What data, if any, would be analogous to reimbursement rate data for plans that do not utilize a set schedule of reimbursement rates? If there are no analogous data, would the other relevant data described in this document for NQTLs related to network composition meaningfully reflect whether these plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits?*

The relevant data are the allowed amounts actually used to calculate payment and cost-sharing when a claims are processed. Issuers may have a set fee schedule, but negotiate above that amount in order to bring a provider into the network. If an issuer frequently offers medical/surgical specialists contracts with negotiated higher amounts, but offers MH/SUD providers only the base fee schedules, then it is important to use the amounts that are actually paid.

*Are there ways in which reimbursement rate data are susceptible to manipulation that could create the appearance that plans and issuers are designing and applying NQTLs related to network composition in a manner that does not place greater restrictions on access to MH/SUD benefits as compared to M/S benefits when that is not the case?*

If "reimbursement rate" is defined based on fee schedules, then a health plan could use fee schedules that create the appearance of similar payments based on the benchmarks, but be more willing to increase M/S providers' negotiated reimbursement above the fee schedule amount.

**Additional Comment Solicitation**

*What data currently collected by States (including, but not limited to, those in the Appendix) is particularly useful to demonstrate parity in how plans and issuers establish provider networks and show that NQTLs related to network composition applied to MH/SUD benefits are comparable to, and are applied no more stringently than, such NQTLs applied to M/S benefits, or demonstrate the comparability of plans' and issuers' MH/SUD networks as compared to their M/S networks?*

Maryland collects data regarding provider credentialing. The MIA developed the data request in response to assertions by MH/SUD providers that their applications for credentialing were more likely to be denied or subject to greater delays than applications by M/S providers. The MIA also heard assertions from issuers that MH/SUD providers did not apply to be credentialed and contracted as part of the provider network. The MIA was interested in learning whether MH/SUD providers were in fact more likely to be denied participation in the network, or to drop out of the process, possibly due to obstacles created by the carrier, than M/S providers.

The data required of issuers includes: the mean number of days from the first submission of an application to the later of the effective date or date of execution of the contract; median number of days from the first submission of an application to the later of the effective date or date of execution of the contract; the percentage of providers that submitted an application, but withdrew or failed to respond to requests for additional information; the percentage of providers that completed the process and executed a contract; the percentage of providers that submitted an application, but were rejected due to a full network; and the percentage of providers that submitted an application, but were notified that the issuer would not proceed with the application. These data are requested for M/S and MH/SUD facilities, and for M/S and MH/SUD practitioners. The data request was developed in response to assertions by MH/SUD providers that their applications for credentialing were more likely to be denied or subject to greater delays than applications by M/S providers.

*How should the Departments define "in-network" and "out-of-network" in the context of these data requirements?*

Generally, “in-network” providers are providers who have signed a contract to participate on an issuer’s provider panel and provide services at an agreed-upon fee, and “out-of-network” providers are those that do not have a contract to participate on the issuer’s provider panel. However, there are cases in which a provider enters into a single case agreement with an issuer in order to treat a particular patient. In this situation, the provider agrees to a set fee for one particular patient.

Thank you for the opportunity to comment on the proposed requirements.