

**Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equality Act of
2008 (MHPAEA) Report for the Centers for Medicare & Medicaid Services**

Submitted by
Maryland Department of Health

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Executive Summary

This report presents the Maryland Department of Health’s (MDH’s) final analysis of state’s Medicaid and Children’s Health Insurance Program’s (CHIP) compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA) and the Affordable Care Act. MHPAEA requires parity in the treatment limitations and financial requirements for mental health and substance use disorder (MH/SUD) benefits, as compared to medical/surgical (M/S) benefits, provided to enrollees of Medicaid managed care organizations (MCOs) and coverage provided by Medicaid alternative benefit plans (ABPs) and Children’s Health Insurance Programs (CHIP). This report is submitted as a supplement to MDH’s preliminary report submitted on August 22, 2018.¹

States were required to analyze parity compliance based on the following variables:

- **Aggregate Lifetime and Annual Dollar Limits (AL/ADLs)**—Dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis are not applied to MH/SUD benefits unless a limit is applied to at least one-third of M/S benefits.
- **Financial Requirements (FRs)**—Payment by beneficiaries for services received including copayments, coinsurance, and deductibles applied to a classification of MH/SUD benefits may be no more restrictive than the financial requirements applied to M/S benefits in the same classification.
- **Quantitative Treatment Limitations (QTLs)**—Limits on the scope or duration of a benefit that are expressed numerically such as day or visit limits applied to a classification of MH/SUD benefits may not be more restrictive than the QTLs applied to M/S benefits in the same classification.
- **Non-Quantitative Treatment Limitations (NQTLs)**—Limits on the scope or duration of benefits that cannot be expressed numerically, such as prior authorization, network admission standards, or data collection requirement, which otherwise limit the scope or duration of benefits applied to MH/SUD benefits such that they are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to apply NQTLs to M/S benefits.

Following its initial assessment, MDH determined that AL/ADLs, FRs, and QTLs are not applicable to the State’s parity analysis. Therefore, MDH made the decision to focus its analysis on NQTLs. MDH conducted the parity analysis of NQTLs by surveying benefit information from the State’s nine MCOs, the behavioral health administrative services organization (ASO), and CHIP.

In its preliminary analysis, MDH identified one NQTL of particular concern—Data Collection Requirements. To remedy this potential issue, MDH commenced a stakeholder process in September 2018 to determine the best pathway to ensure the continued completeness and utility of the data collection system while minimizing the risk of violating MHPAEA. MDH will use these forums to solicit input from the provider community and the broader public. MDH intends

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https://mmcp.health.maryland.gov/Documents/Parity/Maryland%20Prelim%20Parity%20Analysis_FINAL_8.22.18.pdf

to align any changes to the data collection process with the planned re-procurement of the ASO contract in 2019.

In this final report, MDH did not identify any additional NQTLs of concern. However, stakeholders have raised concerns regarding MDH's process for setting rates for MH/SUD services. MDH is currently engaged in an independent study of the rate setting process. MDH intends to submit the report to the General Assembly in the coming months.

I. Introduction

On March 30, 2016, the Centers for Medicare & Medicaid Services (CMS) issued a final rule addressing the requirements for Medicaid and Children's Health Insurance Programs (CHIPs) compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equality Act of 2008 (MHPAEA) and the Affordable Care Act.²

MHPAEA requires parity in the treatment limitations and financial requirements for mental health and substance use disorder (MH/SUD) benefits, as compared to medical/surgical (M/S) benefits, provided to enrollees of Medicaid managed care organizations (MCOs) and coverage provided by Medicaid alternative benefit plans (ABPs) and Children's Health Insurance Programs (CHIPs). States must provide each MCO enrollee with benefits that are in compliance with parity, regardless of whether MH/SUD services are provided by the MCO or are carved out of the MCO benefit package. Parity requirements do not apply to MH or SUD benefits for beneficiaries who receive only Medicaid non-ABP fee-for-service (FFS) state plan services. This report is meant to meet the analysis and reporting requirements of MHPAEA.

States were asked to look at their benefit and utilization management practices and policies to ensure compliance with the following general requirements:

- **Aggregate lifetime and annual dollar limits (AL/ADLs)**—Dollar limits on the total amount of a specified benefit over a lifetime or on an annual basis are not applied to MH/SUD benefits unless a limit is applied to at least one-third of M/S benefits.
- **Financial Requirements (FRs)**—Payment by beneficiaries for services received including copayments, coinsurance, and deductibles applied to a classification of MH/SUD benefits may be no more restrictive than the financial requirements applied to M/S benefits in the same classification.
- **Quantitative Treatment Limitations (QTLs)**—Limits on the scope or duration of a benefit that are expressed numerically such as day or visit limits applied to a classification of MH/SUD benefits may not be more restrictive than the QTLs applied to M/S benefits in the same classification.
- **Non-Quantitative Treatment Limitations (NQTLs)**—Limits on the scope or duration of benefits that cannot be expressed numerically, such as prior authorization, network admission standards, or data collection requirement, which otherwise limit the scope or duration of benefits are applied to MH/SUD benefits such that they are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to apply NQTLs to M/S benefits.

² <https://www.gpo.gov/fdsys/pkg/FR-2016-03-30/pdf/2016-06876.pdf>

The rule required Maryland Department of Health (MDH) to submit documentation of compliance with the parity requirements to CMS no later than October 2, 2017. Maryland has been in constant contact with CMS as it has developed its parity analysis and has sought and received technical assistance from CMS contractors on several occasions. This report presents MDH’s final parity analysis

Maryland’s preliminary report identified one NQTL of particular concern—Data Collection Requirements. MDH commenced a stakeholder process in September 2018 to determine the best pathway to ensure the continued completeness and utility of the data collection system while minimizing risk of violating MHPAEA.

The parity analysis is a joint effort between the Maryland Department of Health’s Health Care Financing, which administers the Maryland Medicaid Program, and the Behavioral Health Administration.

II. Methodology

A. Compliance Process

MDH adopted an approach to parity analysis consistent with CMS guidance as outlined in the CMS parity toolkit, “*Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children’s Health Insurance Programs*” and included the following steps:³

1. Identifying all benefit packages to which parity applies.
2. For each benefit package, determining whether the State or an MCO is responsible for the parity analysis.
3. Determining which covered benefits are MH/SUD benefits and which are M/S benefits.
4. Defining the four benefit classifications (inpatient, outpatient, prescription drugs, and emergency care) and determining into which benefit classification MH/SUD and M/S benefits fall.
5. Determining whether AL/ADL apply to MH/SUD benefits, and if they do, whether assessing for compliance with applicable parity requirements.
6. Determining whether any FRs or QTLs apply to MH/SUD benefits and testing the applicable FRs or QTLs for compliance with parity.
7. Identifying and analyzing NQTLs that apply to MH/SUD benefits, and testing the applicable NQTLs for compliance with parity.

III. Medicaid/CHIP Delivery System and Benefits Package

³ Parity Compliance Toolkit Applying Mental Health and Substance Use Disorder Parity Requirements to Medicaid and Children’s Health Insurance Programs, <https://www.medicaid.gov/medicaid/benefits/downloads/bhs/parity-toolkit.pdf>.

A. Medicaid/CHIP Delivery System

MDH is responsible for all Medicaid funded services in the state. The vast majority of participants receive services through the HealthChoice Program. HealthChoice—Maryland’s statewide mandatory Medicaid managed care program—was implemented in 1997 under authority of Section 1115 of the Social Security Act. As of January 2019, 1,379,965 Marylanders are enrolled in Medicaid. Approximately 86 percent of the State’s Medicaid population is enrolled in the HealthChoice Program. Participants in the HealthChoice Program include children enrolled in the Maryland Children’s Health Program (MCHP), Maryland’s Children’s Health Insurance Program (CHIP). Maryland elected to expand services to adults under the age 65 up to 138% of the federal poverty level under the Affordable Care Act in 2014. These individuals are also covered under HealthChoice. HealthChoice participants choose one of the nine (9) participating managed care organizations (MCOs).

Maryland currently operates a bifurcated care delivery system for M/S and MH/SUD benefits. MCOs are responsible for delivering all Medicaid covered services *except* for inpatient, emergency, and specialty outpatient MH/SUD services,⁴ which are delivered on a fee-for-services basis through an Administrative Services Organization (ASO) model. Beacon Health Options currently operates the ASO. MH/SUD prescription services are managed by MDH on a fee-for-service (FFS) basis. Long-term services and supports, including services for individuals with intellectual and developmental disabilities, HIV/AIDS medications, and dental services are also carved out from the MCO contracts. As such, MDH has the responsibility of performing the parity analysis for benefits and to identify and address any areas on non-compliance across all delivery systems.

The groups of Medicaid-eligible individuals who enroll in HealthChoice MCOs include the following:

- Families with low income that have children;
- Families that receive Temporary Assistance for Needy Families (TANF);
- Children younger than 19 years who are eligible for MCHP;
- Children in foster care and individuals up to age 26 who were previously enrolled in foster care;
- Adults under age 65 with income up to 138 percent of the federal poverty level (FPL);
- Women with income up to 264 percent of the FPL who are pregnant or less than 60 days postpartum; and
- Individuals receiving Supplemental Security Income (SSI) who are under 65 and not eligible for Medicare.

Not all Maryland Medicaid beneficiaries are enrolled in HealthChoice MCOs. These participants receive care on a FFS basis. Groups that are not eligible for MCO enrollment include the following:

- Medicare beneficiaries;
- Individuals aged 65 years and older;⁵

⁴ Note, MH/SUD services delivered by the participant’s primary care provider are the responsibility of the MCO.

⁵ Individuals aged 65 and older can be enrolled in a HealthChoice MCO if covered as a parent or caretaker.

- Individuals in a “spend-down” eligibility group who are only eligible for Medicaid for a limited period of time;
- Individuals who require more than 90 days of long-term care services and are subsequently disenrolled from HealthChoice;
- Individuals who are continuously enrolled in an institution for mental disease for more than 30 days;
- Individuals who reside in an intermediate care facility for intellectual disabilities; and
- Individuals enrolled in the Model Waiver or the Employed Individuals with Disabilities program. Additional populations covered under the HealthChoice waiver—but not enrolled in HealthChoice MCOs—include individuals in the Family Planning and REM programs.

B. Benefits Package

For purposes of the parity analysis and administration of MH/SUD services, MDH defines behavioral health conditions as those conditions listed in ICD-10CM, Chapter 5, “Mental, Behavioral Health, and Neurodevelopmental Disorders.” The conditions listed in Chapter 5: subchapter 1, “Mental disorders due to known physiological conditions” (F01 to F09), subchapter 8, “Intellectual disabilities” (F70 to F79), and subchapter 9, “Pervasive and specific developmental disorders” (F80 to F89) are excluded. Details regarding specialty behavioral health services administered by the ASO can be found in COMAR 10.09.70.02.⁶

M/S conditions definitions are consistent with the M/S conditions listed in ICD-10-CM, Chapters 1-4, Chapters 5-subchapter 1, 8, and 9, and Chapters 6-20.

1. MCO Administered Benefits⁷

MCOs must cover MH/SUD services delivered by the participant’s primary care provider. The MCO benefit package also includes, but is not limited to, the following M/S services:

- Inpatient and outpatient hospital care;
- Physician care;
- Federally qualified health center (FQHC) or other clinic services;
- Laboratory and X-ray services;
- Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services for children;
- Prescription drugs, with the exception of mental health and HIV/AIDS drugs;
- Durable medical equipment and disposable medical supplies;
- Home health care;
- Vision services;
- Dialysis;
- The first 90 days of long-term care services; and
- Somatic services related to gender identity disorder, including gender reassignment surgery.

⁶ <http://www.dsd.state.md.us/comar/comarhtml/10/10.09.70.02.htm>.

⁷ For individuals who are not eligible for HealthChoice, these services are provided on a FFS basis by MDH.

2. M/S FFS Administered Benefits

The following services are carved out of the MCO benefit package and instead are covered by the Medicaid FFS system:

- Dental care for children, pregnant women, and adults in the REM program;
- Health-related services and targeted case management services provided to children when the services are specified in the child's Individualized Education Plan or Individualized Family Service Plan;
- Therapy services (occupational, physical, speech, and audiology) for children;
- Personal assistance services offered under the Community First Choice program;
- Viral load testing services, genotypic, phenotypic, or other HIV/AIDS drug resistance testing for the treatment of HIV/AIDS;
- HIV/AIDS drugs; and
- Services covered under 1915(c) home and community-based services waivers.

3. MH/SUD Benefits Administered on a FFS Basis by the ASO

MH/SUD benefits administered by the ASO are as follows:

MH Services:

- Inpatient care in psychiatric units of acute general hospitals for all ages;
- Inpatient psychiatric services for individuals under 21 years old in free-standing Institutions for Mental Diseases (IMDs);
- Mental health assessment;
- Individual therapy;
- Group therapy;
- Mental health targeted case management;
- Family psychotherapy and psychoeducation;
- Psychiatric rehabilitation;
- Psychological testing;
- Assertive community treatment;
- Mobile treatment;
- Intensive outpatient program services;
- Partial hospitalization; and
- Laboratory services.

SUD Services:

- Inpatient detoxification in acute general hospitals for individuals of all ages;
- Inpatient detoxification and SUD treatment services for individuals under 21 years old in free-standing IMDs, which in Maryland are licensed as Intermediate Care Facilities for Addictions;
- Inpatient detoxification and SUD treatment services for individuals from 21 to 64 years of age who are enrolled in a Medicaid MCO and reside in a non-public IMD for

- ASAM Residential levels 3.1, 3.3, 3.5, 3.7, and 3.7WM (licensed at 3.7D in Maryland);⁸
- Alcohol and/or drug assessment;
 - Individual therapy;
 - Group therapy;
 - Intensive outpatient program services;
 - Partial hospitalization;
 - Ambulatory detoxification;
 - Opioid maintenance therapy for individuals 18 years of age and over; and
 - Laboratory services.

IV. Benefits Classification

For purposes of the parity analysis, MDH adopted the following definitions for each benefits classification:

- **Inpatient:** Any non-emergency service that involves the individual staying overnight at a facility. This includes inpatient MH and SUD treatment and crisis stabilization services occurring in a facility. All covered services or items provided to a beneficiary when a physician has written an order for admission to a facility.
- **Outpatient:**
 - **Outpatient—Office Visits:** Office visits (primary care or specialist) that are provided to a beneficiary in a setting that does not require a physician’s order for admission and do not meet the definition of emergency care.
 - **Outpatient—All Other Items & Services:** All services other than office visits that are provided to a beneficiary in a setting that does not require a physician’s order for admission and do not meet the definition of emergency care.
- **Prescription Drugs:** Covered medications, drugs and associated supplies requiring a prescription, and services delivered by a pharmacist who works in a free-standing pharmacy.
- **Emergency:** All covered services or items delivered in an emergency department (ED) setting or to stabilize an emergency/crisis, other than in an inpatient setting.

V. Final Parity Analysis

MDH’s preliminary parity analysis identified one NQTL of particular concern—Data Collection Requirements.⁹

⁸ Effective July 1, 2017, MDH provides reimbursement for up to two non-consecutive 30-day stays annually for ASAM levels 3.1, 3.3, 3.5, 3.7, and 3.7WM. MDH intends to phase in coverage of ASAM level 3.1 beginning on January 1, 2019 and extend coverage of benefits for dual-eligibles at these levels of care no later than January 1, 2020.

Following its initial assessment, MDH determined that FR, AL/ADLs, and QTLs are not applicable to the State’s parity analysis. Therefore, MDH made the decision to focus its analysis on NQTLs. Under MPHAEA, a state or MCO may not impose an NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the benefit as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to M/S benefits in the classification. MHPAEA regulations generally define an NQTL as any limit on benefits that cannot be expressed numerically, but which otherwise limits the scope or duration of benefits for treatment under a plan or coverage.

MDH conducted the parity analysis of NQTLs by surveying benefit information from the State’s nine MCOs, the behavioral health ASO, and CHIP. MDH sought information on the NQTLs in place through the ASO and MCOs in the following categories: (1) inpatient services, (2) outpatient services (office visits and all other services), (3) prescription drugs, and (4) emergency care.

The final analysis addresses the NQTLs listed in the table below:

Table 1: NQTLs Evaluated in Final Report

NQTL*	Benefit Category				
	Inpatient	Outpatient— Office Visits	Outpatient— All Other Items & Services	Prescription Drugs	Emergency Care
Medical Necessity Criteria	Unified assessment for all benefit categories. Requirements, processes, and evidentiary standards are consistent across all benefit categories.				
Utilization Management	X	N/A	X	X	N/A
Retrospective Review	X	N/A	N/A	N/A	N/A
Outlier Management	X	X	X	X	N/A

**Cells with a designation of N/A indicate that final analysis demonstrates that these standards are not in place on the MH/SUD side; therefore, additional analysis is not required.*

The responses to MDH’s questionnaires for prior authorization (PA) and concurrent review NQTLs from the ASO and the MCOs indicate that the analysis of these NQTLs can be effectively consolidated, as the strategies, evidentiary standards, and processes for each are substantively similar. Accordingly, these individual NQTLs have been grouped and renamed the “Utilization Management” NQTL. Responses for Medical Necessity, Medical Appropriateness,

⁹ A full discussion of this issue can be found in the preliminary report, https://mmcp.health.maryland.gov/Documents/Parity/Maryland%20Prelim%20Parity%20Analysis_FINAL_8.22.18.pdf.

and Practice Guidelines were also substantially similar. These individual NQTLs have been consolidated and renamed the “Medical Necessity” NQTL. The requirements, processes, and evidentiary standards for development of Medical Necessity Criteria are consistent across all benefit categories, so a single assessment regarding parity compliance is presented below.

A. Development of Medical Necessity Criteria

- **Strategy**

The ASO and all nine MCOs utilize medical necessity criteria consistent with state regulatory requirements. Broadly, the medical necessity definition and criteria apply uniformly to the delivery of services by both the ASO and the MCOs across all benefit categories and state regulations are identical for both MH/SUD and M/S services.

MH/SUD Definition	MCO M/S Definition
COMAR 10.09.36.01B	COMAR 10.09.62.01B
(11) "Medically necessary" means that the service or benefit is: (a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition; (b) Consistent with currently accepted standards of good medical practice; (c) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and (d) Not primarily for the convenience of the consumer, family, or provider.	(112) "Medically necessary" means that the service or benefit is: (a) Directly related to diagnostic, preventive, curative, palliative, rehabilitative, or ameliorative treatment of an illness, injury, disability, or health condition; (b) Consistent with current accepted standards of good medical practice; (c) The most cost efficient service that can be provided without sacrificing effectiveness or access to care; and (d) Not primarily for the convenience of the consumer, the consumer's family, or the provider.

- **Requirements, Processes, and Evidentiary Standards**

The ASO and MCOs reported relying on federal requirements, state-developed medical necessity criteria, as well as nationally-recognized, evidence-based clinical decision making criteria. Standards applied include the American Society of Addiction Medicine for SUD services (ASAM), Interqual, and Milliman Care Guidelines (MCG), as well as plan specific policies and guidelines. Both the ASO and MCOs incorporate periodic review of processes and medical necessity criteria by qualified professionals.

- **Recommendations**

MDH identified no parity issues with respect to development of medical necessity criteria. The development of medical necessity criteria applied to MH/SUD benefits are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, or other factors used to establish medical necessity criteria for M/S benefits across all benefits categories.

B. Inpatient Services

Based on its final analysis, MDH identified the following NQTLs for inpatient services required further evaluation to determine if a parity violation exists: Utilization Management, Retrospective Review, and Outlier Management.¹⁰

1. Inpatient Utilization Management

- **Strategy**

The ASO and all nine MCOs utilize Utilization Management strategies for all inpatient services. Non-emergent or elective inpatient admissions are subject to both prior authorization and concurrent review. Services are reviewed for medical necessity to ensure appropriate access to care based on level of need, to assess covered benefits, and to control costs.

- **Requirements and Processes**

Both the ASO and MCOs permit providers to initiate the Utilization Management review processes through a variety of means. The ASO permits providers to initiate Utilization Management review through a provider call, fax, or utilization of a secure provider portal. All MCOs also made multiple options available to providers initiating Utilization Management review processes. All MCOs permit requests to be submitted by phone or fax. The majority of MCOs also made a secure provider portal available.

Both the ASO and MCOs reported timeframes used for conducting prior authorization was up to 14 days for standard requests, and between one hour to seventy-two hours for expedited requests. Extensions of time for up to 14 days were noted as used by the ASO and the MCOs when necessary to obtain additional information to support the authorization. These standards are consistent with state regulatory requirements.¹¹ The ASO indicated concurrent review is conducted on the last covered day. Up to 3 units are authorized on concurrent review. MCOs indicated concurrent reviews are completed on a daily basis, which is more restrictive than the standard used for MH/SUD services.

The ASO has algorithms in place to determine if the submitted clinical information clearly meets medical necessity. Services are automatically authorized if appropriate. For both the ASO and MCOs, Utilization Management reviews and decisions are completed by trained staff. The ASO

¹⁰ The ASO also reported using these NQTLs for IMD services. CMS has advised MDH that IMD services do not fall under the parity rules as they are an expansion service that would not be covered but for the § 1115 waiver authority. As such, provision of IMD services has been excluded from the discussion below.

¹¹ COMAR 10.09.71.04

utilizes a two tier process where an RN, LCPC, LCSW, LCSW-C, LCADC, PhD, PsyD, or LCPC-S conducts an initial review. A secondary review is conducted by a psychiatrist were the initial reviewer cannot reach a decision. Annual reports tracking denial rates, overturned determinations, and appeals as well as an annual inter-rater reliability test are used by many to assess consistency of decision making in the appeals process.

Pursuant to COMAR 10.09.71.04, MCOs must ensure utilization management decisions are made by a health care professional who has appropriate clinical expertise in treating the enrollee's condition or disease; and are not be based solely on diagnosis, type of illness, or condition. MCOs reported using a variety of licensed clinicians to perform reviews including RNs and MDs. Reviews are typically also subject to a two-tier review if the initial reviewer cannot reach a decision. MCOs all monitor consistency of Utilization Management decisions and use a variety of mechanisms, including quarterly or annual reports and annual inter-rater reliability studies.

- **Evidentiary Standards**

The ASO and MCOs reported relying on federal requirements, state-developed medical necessity criteria, as well as nationally-recognized, evidence-based clinical decision making criteria. Standards applied include the American Society of Addiction Medicine for SUD services (ASAM), Interqual, and Milliman Care Guidelines (MCG). Standards are reviewed annually.

- **Recommendations**

MDH identified no parity issues with respect to the application of Utilization Management standards for inpatient services. The processes, strategies, and evidentiary standards used to apply Utilization Management requirements to MH/SUD services were comparable to, and not more stringently applied than, the processes, strategies, and evidentiary standards used to apply Utilization Management requirements to M/S services.

2. Inpatient Retrospective Review

- **Strategy**

A Retrospective Review decision is any review for care or services that have already been received when there has been no notification or request for review during the Utilization Management process or when clinical information was not available at the time services were being rendered.

The ASO uses Retrospective Review for inpatient MH services.¹² In the majority of cases, the ASO grants Retrospective Review of a service when an individual has been determined retroactively eligible for Medicaid services.¹³ The ASO assesses whether the service provided was a Medicaid covered benefit. All applicants for Medicaid coverage can apply for up to three months of retroactive coverage when they apply for benefits. Participants who have paid for

¹² *Id.* At 10.

¹³ The ASO is also responsible for authorization of services through the Public Behavioral Health System outside the Medicaid Program using state-only funds.

medical care or prescription costs out-of-pocket during this three month period can seek reimbursement for these costs if their retroactive coverage is approved. During retroactive coverage periods, an individual's M/S benefits are covered on a FFS basis outside the MCO benefit package.

- **Recommendations**

MDH identified no parity issues with respect to Retrospective Review. The ASO utilizes Retrospective Review primarily for the purpose of determining retroactive Medicaid coverage for services previously paid for by the participant directly or covered through the Public Behavioral Health System (PBHS) using state-only funds. During retroactive coverage periods, an individual's M/S benefits are covered on a FFS basis outside the MCO benefit package; therefore, Retrospective Review is not subject to analysis under parity.

3. Inpatient Outlier Management

- **Strategy**

Both the ASO and MCOs adopt Outlier Management strategies to identify and investigate possible fraud, waste, and abuse (FWA).¹⁴ Identification of variations at a provider level can also be used to improve quality of care delivered to Medicaid participants. The ASO utilizes Outlier Management for inpatient MH.¹⁵ MCOs are required to establish procedures and a system with a dedicated staff to identify and investigate potential fraud, waste, and abuse pursuant to the requirements of COMAR 10.09.68.01.

- **Requirements and Processes**

The ASO monitors Outlier Management through data analytics. As required under its contract, the ASO provides for a random sample of all services rendered by providers after services have been appropriately authorized, in order to determine whether the medical necessity continued and was documented as required throughout the course of treatment/service provision and conduct audits annually. Factors monitored include average length of stay (ALOS), readmission rates, and rates of administrative and medical necessity denials. All ASO providers are granted a minimum authorization span of 3 units at initial review. As an incentive, the ASO grants providers with lower than average ALOS and lower readmission rates with longer authorization spans of 6 units. Outliers may also be contacted by medical, clinical, and/or quality teams for educational purposes and subject to audit.

MCOs also use data analytics to monitor Outlier Management. Pursuant to COMAR 10.09.68.01, MCOs must establish system to verify by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and shall apply such verification processes at least annually. Factors the MCOs reported monitoring include over or under-utilization of services, cost, length of stay, quality of care and readmission rates. Outliers may be subject to outreach for educational purposes or audit.

¹⁴ MCO responsibilities are governed in part by the requirements under COMAR 10.09.68.01.

¹⁵ *Id.* At 10.

- **Evidentiary Standards**

Both the ASO and MCO utilize a variety of standards for purposes of monitoring outliers. These include nationally recognized evidence-based criteria such as through the use of Interqual, internal guidelines based on utilization averages and standard of practice specific to service statewide or nationally, applicable State/Federal laws and guidelines.

- **Recommendations**

Both the ASO and MCOs use data analytics gathered from Outlier Management processes to improve the quality of care provided to participants and trigger educational outreach and audits of providers. As a baseline, the period of authorization for all ASO providers is 3 units. Although the ASO permits longer spans (6 units) for certain well performing providers, this process is intended to incentivize performance by providers and is not used for purposes of outlier management. Additionally, this process does not negatively impact access to care.

For these reasons, the MDH analysis identified no parity issues with respect to Inpatient Outlier Management.

C. Outpatient—Office Visits

Based on its final analysis, MDH identified the following NQTLs required further evaluation to determine if a parity violation exists: Utilization Management and Outlier Management.

1. Outpatient—Office Visits Utilization Management

The ASO does not use Utilization Management strategies for purposes of authorizing outpatient services

As noted in its preliminary report, MDH is working with stakeholders to resolve a parity concerns around separate NQTL, Data Collection, connected to the authorization of outpatient services.

2. Outpatient—Office Visits Outlier Management

- **Strategy**

Both the ASO and MCOs adopt Outlier Management strategies to reduce fraud, waste, and abuse (FWA).

The ASO utilizes Outlier Management for all Outpatient-Office services; however, oversight in this area does not directly impact authorization of care for Medicaid participants. Individual requests for outpatient services are rarely reviewed. Outlier management is generally used for the purpose of reviewing provider billing patterns. Identification of variations at a provider level can be used to improve quality of care delivered to Medicaid participants.

Pursuant to COMAR 10.09.68.01, MCOs must establish system to verify by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and shall apply such verification processes at least annually. Two MCOs also indicated they tie oversight in this area to their Concurrent Review processes. The purpose of Outlier Management is to identify potential over and under utilization of services, abnormal business practices, and potential outliers.

- **Requirements and Processes**

The ASO monitors Outlier Management through data analytics. As required under its contract, the ASO must provide for a random sample of all services rendered by providers after services have been appropriately authorized, in order to determine whether the medical necessity continued and was documented as required throughout the course of treatment/service provision and conduct audits annually. Providers identified as outliers may be contacted by medical, clinical, and/or quality teams for educational purposes and subject to audit.

The MCOs primarily monitor Outlier Management through data analytics; however, some MCOs also accept referrals from outside sources such as providers, caregivers, and local health departments. Pursuant to COMAR 10.09.68.01, MCOs must establish system to verify by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and shall apply such verification processes at least annually. Outliers may be subject to outreach for educational purposes or audit.

- **Evidentiary Standards**

Both the ASO and MCOs engage in Outlier Management primarily for the purpose of reviewing provider billing patterns that fall outside the standard of care. See additional discussion regarding standards used to set Medical Necessity Criteria above.

- **Recommendations**

MDH identified no parity issues with respect to use of Outlier Management for Outpatient—Office Services. The strategy, requirements, processes, and evidentiary standards utilized by the ASO with respect to MH/SUD services are not more restrictive than those used by the MCOs with respect to M/S services.

D. Outpatient—All Other Items & Services

Based on its final analysis, MDH identified the following NQTLs required further evaluation to determine if a parity violation exists: utilization management and outlier management.

1. Outpatient—All Other Items & Services, Utilization Management

- **Strategy**

Utilization Management strategies are used by both the ASO and MCOs. MCO requirements in this area are more restrictive than those used by the ASO.

The ASO utilizes Utilization Management strategies to ensure that an individual meets the medical necessity criteria for a given level of care. Best practice is to treat in the least restrictive setting that meets the individual's clinical needs. For MH/SUD services, adherence to medical necessity criteria assures that the member's needs are being met in the least restrictive environment. When an individual does not meet medical necessity criteria for a particular level of service, it is state policy to offer an alternative level of service for which they do meet criteria so that no individual eligible for the PBHS is turned away from care. The following MH services are subject to Utilization Management strategies: Crisis Residential; Partial Hospitalization (PHP); Intensive Outpatient (IOP); Electroconvulsive therapy (ECT), Psychological Testing, Therapeutic Behavioral Services Psychiatric Rehabilitation Services, Residential Rehabilitation Services, Targeted Case Management; Respite; Occupational Therapy; Mobile Treatment; 1915i Services; and Applied Behavior Analysis (ABA). The following SUD services are subject to Utilization Management strategies: ambulatory detox and intensive outpatient treatment.

MCOs employ Utilization Management strategies to ensure the medical necessity of services and access to appropriate levels of care. In addition, MCOs identified other factors which trigger establishment of these guidelines. These factors considered when establishing which M/S services must have a Utilization Management process include possible over and under-utilization of services, experimental status of procedures, industry trends, guidelines and regulations, practice variations, preference driven care, diagnosis, geographic regional variations, and historical evidence that services were being denied or inappropriately requested. M/S services identified by MCOs subject to Utilization Management strategies include services such as select outpatient and specialty care provided outside of the PCP's scope of practice, high-tech radiology, durable medical equipment, genetic testing, and home health services.

- **Requirements and Processes**

With respect to ASO requirements for MH/SUD services subject to Utilization Management, all requests for authorization are reviewed against medical necessity criteria. Providers may call, fax, or utilize the secure provider portal to submit a request for authorization. The request for authorization is reviewed by a clinical care manager or by an algorithm to determine if the clinical information clearly meets medical necessity criteria. If the information does not clearly meet Medical Necessity Criteria, a care manager reviews the clinical material. If the member would appear to need an alternative level of care based upon the clinical information received, additional information is gathered from the provider asking for further clinical explanation. If there is still concern that the member is receiving a level of care that does not meet the member's needs at this time, the case is reviewed with a psychiatrist who will make the final determination on whether the individual meets medical necessity for that level of care or not. If the psychiatrist believes that the individual does not meet medical necessity criteria for that level of care, an alternative level of care is recommended. The state reviews the utilization patterns and authorization processes on an annual basis.

All MCOs made multiple options available to providers initiating Utilization Management review processes. All MCOs permit requests to be submitted by phone or fax. The majority of MCOs also made a secure provider portal available. Pursuant to COMAR 10.09.71.04, MCOs must ensure utilization management decisions are made by a health care professional who has

appropriate clinical expertise in treating the enrollee's condition or disease; and are not be based solely on diagnosis, type of illness, or condition. MCOs reported using a variety of licensed clinicians to perform reviews including RNs and MDs. Reviews are typically also subject to a two-tier review if the initial reviewer cannot reach a decision. MCOs use different mechanisms to monitor consistency of utilization management decisions, including quarterly or annual reports and annual inter-rater reliability studies.

- **Evidentiary Standards**

The ASO and MCOs reported relying on federal requirements, state-developed medical necessity criteria, as well as nationally-recognized, evidence-based clinical decision making criteria. Standards applied include the American Society of Addiction Medicine for SUD services (ASAM), Interqual, and Milliman Care Guidelines (MCG). Standards are reviewed annually.

- **Recommendations**

MDH identified no parity issues with respect to use of Utilization Management for Outpatient—Other Services. The strategy, requirements, processes, and evidentiary standards utilized by the ASO with respect to MH/SUD services are not more restrictive than those used by the MCOs with respect to M/S services.

2. Outpatient—All Other Items & Services, Outlier Management

Both the ASO and MCOs adopt Outlier Management strategies to reduce fraud, waste, and abuse (FWA). Identification of variations at a provider level can also be used to improve quality of care delivered to Medicaid participants. The ASO utilizes Outlier Management for all services in this category; however, oversight in this area does not directly impact authorization of care for Medicaid participants. Outlier management is generally used for the purpose of utilization review and reviewing provider billing patterns.

Pursuant to COMAR 10.09.68.01, MCOs must establish system to verify by sampling or other methods, whether services that have been represented to have been delivered by network providers were received by enrollees and shall apply such verification processes at least annually. Two MCOs also indicated they tie oversight in this area to their Concurrent Review Processes.

- **Requirements and Processes**

The ASO monitors Outlier Management through data analytics. Providers identified as outliers may be contacted by medical, clinical, and/or quality teams for educational purposes and subject to audit. The MCOs primarily monitor outlier management through data analytics; however, some MCOs also accept referrals from outside sources such as providers, caregivers, and local health departments.

- **Evidentiary Standards**

Both the ASO and MCOs engage in Outlier Management primarily for the purpose of reviewing provider billing patterns that fall outside the standard of care. See additional discussion regarding standards used to set Medical Necessity Criteria above.

- **Recommendations**

MDH identified no parity issues with respect to use of Outlier Management for Outpatient—Office Services.

E. Pharmacy

Maryland, like other states, elects to cover pharmacy services as part of its Medicaid benefit package although it is not required to by CMS. The ASO is not responsible for coverage of MH/SUD pharmacy benefits. Instead, these benefits are managed by the Maryland Medicaid Pharmacy Program on a FFS basis consistent with the criteria set by MDH and the Pharmacy and Therapeutics Committee. Prescription drug coverage under Medicaid MCOs for M/S must be consistent with the amount, duration, and scope as described by Medicaid FFS.^{16, 17} Additionally, MCOs cannot have medical necessity criteria for prescription drugs that are more stringent than Medicaid FFS.¹⁸ Both the Pharmacy Program and the MCOs must comply with Section 1927(k)(2) of the Social Security Act regarding coverage for outpatient drugs.¹⁹

Based on its final analysis, MDH identified the following NQTLs for pharmacy services required further evaluation to determine if a parity violation exists: Utilization Management and Outlier Management.

1. Pharmacy—Utilization Management

- **Strategy**

The Pharmacy and Therapeutics Committee has the discretion to develop a preferred drug list (PDL) within the Medical Assistance Program pursuant to COMAR 10.09.03.12. Drugs not on the PDL are subject to preauthorization. MCOs have the discretion to set their own formularies, PDLs, and prior authorization requirements consistent with the minimum performance standards set by MDH.²⁰ Both the Pharmacy Program and the MCOs must comply with Section 1927(d)(5) of the Social Security Act with respect to establishing Utilization Management requirements.²¹ Both FFS drugs and MCO-covered M/S drugs subject to Utilization Management are reviewed for medical necessity and to control costs.

- **Requirements and Processes**

The Medicaid Pharmacy Program does not use a Pharmacy Benefit Manager (PBM) for its FFS program and instead utilizes a Point of Sale, electronic claims processing system through a vendor, Conduent. The vendor processes claims, provides clinical services, and monitors utilization based upon the Department’s rules and regulations. All nine MCOs engage with Pharmacy Benefit Managers to manage their respective pharmacy benefits. Both Conduent and the MCOs permit providers to initiate the Utilization Management review processes through a

¹⁶ Sections 1902 and 1903 of the Social Security Act.

¹⁷ COMAR 10.09.67.04

¹⁸ *Id. at 16.*

¹⁹ *Id. at 17.*

²⁰ COMAR 10.09.67.04I

²¹ *Id.*

variety of means. The FSS POS permits providers to initiate Utilization Management review through a provider call or fax. All MCOs also made multiple options available to providers initiating Utilization Management review processes. All MCOs permit requests to be submitted by phone or fax. The majority of MCOs also made a secure provider portal available.

- **Evidentiary Standards**

Both the Pharmacy and Therapeutics Committee and the MCOs rely on evidenced-based medicine and clinical practice guidelines as well as FDA guidance when setting Utilization Management standards.

The Pharmacy and Therapeutics Committee develops recommendations for the PDL by considering the clinical efficacy of the drug; cost effectiveness of the drug, including any supplemental rebates from manufacturers; and needs of Program participants, such as the ease of drug therapy administration, rate of compliance with drug therapy instructions, and frequency of prior authorization.

MCOs cited similar standards for the development of Utilization Management requirements, including the clinical efficacy of the drug; cost effectiveness; potential for abuse or misuse and diversion, and frequency of prior authorization.

- **Recommendations**

MDH identified no parity issues with respect to the application of Utilization Management standards for pharmacy services. The processes, strategies, and evidentiary standards used to apply Utilization Management requirements to MH/SUD services were comparable to, and not more stringently applied than, the processes, strategies, and evidentiary standards used to apply Utilization Management requirements to M/S services.

2. Pharmacy—Outlier Management

The Pharmacy Program does not engage in an Outlier Management process. The Drug Utilization Review vendor monitors prescribing patterns solely for educational purposes. Prescribers identified as engaging in unusual prescribing patterns may be contacted by letter. These letters educate the prescriber regarding the typical standard of care for a drug or combination of drugs. This educational outreach does not impact authorization or payment for services. For these reasons, no further analysis for parity purposes is necessary.

VI. Additional Considerations

A. Rate Setting

Stakeholders raised concerns regarding MDH's rate setting process for MH/SUD services. Rates for M/S services are benchmarked against Medicare. Consistent benchmarks for MH/SUD services through Medicare are not available. MDH is currently reviewing the rate setting process for MH/SUD services. Pursuant to the requirements of HB 1329/SB967—Heroin & Opioid Prevention Effort (HOPE) & Treatment Act of 2017 (Chs. 571 and 572 of the Acts of 2017), MDH is conducting an independent cost-driven, rate-setting study to set community provider

rates for community–based behavioral health services that includes a rate analysis and an impact study that considers the actual cost of providing community–based behavioral health services. MDH intends to submit the report to the General Assembly in the coming months.

VII. Next Steps

MDH will continue with the stakeholder process to resolve parity concerns identified with respect to the Data Collection NQTL in its preliminary analysis. MDH intends to align any changes to the data collection process with the planned re-procurement of the ASO contract currently underway. MDH will release its independent rate-setting study in the coming months.