

New Hampshire Department of Health and Human Services Parity Compliance Report
For
New Hampshire Healthy Families for Calendar Year 2016
(December 31, 2018)

A. Overview:

Background. The Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) requires health insurance carriers to achieve coverage parity for mental health/substance use disorders (MH/SUD) and medical/surgical benefits, especially with regard to financial requirements and treatment limitations. On March 30, 2016, the Centers for Medicare and Medicaid Services (CMS) issued a final rule (“Parity Rule”) to strengthen access to mental health (MH) and substance use disorder (SUD) services for services provided through Medicaid Managed Care Plans, Children’s Health Insurance Plans, and Alternative Benefit Plans, thus aligning such public coverage with the protections already required of private health plans. (Hereinafter MHPAEA and the Parity Rule shall be collectively referred to as the “Parity Law.”) To insure that inappropriate limitations were not being placed on MH/SUD services, the Parity Law required the New Hampshire Department of Health and Human Services (“DHHS” or “Department”) to conduct a parity analysis for Calendar Year 2016 (“CY 2016”) and submit the results of the analysis to CMS not later than October 2, 2017.

As part of the process to ensure its compliance with the October 2, 2017 CMS reporting obligation, on July 3, 2017, DHHS requested the New Hampshire Healthy Families Plan (“Plan”) to conduct an analysis of parity compliance as required by the relevant provisions of the Plan’s Managed Care Contract with DHHS (“Contract”). The July 3, 2017 document, titled “New Hampshire Department of Health and Human Services MCO Mental Health and Substance Use Disorder Parity Analysis” provided guidance about the conduct of the required analysis: “The Plan must conduct an analysis by completing the Excel document entitled “NH DHHS Parity Analysis Tool, July 3, 2017” and by providing narrative responses to questions in the aforementioned July 3, 2017 document.” The Plan was required to provide an analysis of the limitations imposed by the Plan for each Medicaid mental health, substance use disorder, and medical/surgical service provided in the four specified classification categories (Inpatient, Outpatient, Emergency, and Pharmacy) in which the Plan provided services in CY 2016. The required narrative inquiries were designed to elicit information and assurances that the Plan had processes and procedures in place to ensure parity between MH/SUD and Med/Surg services. On September 15, 2017, the Plan submitted the required parity analysis and certification to DHHS, attesting that the comprehensive review of its administrative, clinical, and utilization practices for CY 2016 was complete and that the Plan was in compliance with the relevant provisions of the Parity Law.

Following the DHHS review of the Plan’s September 15, 2017 parity analysis and certification of parity compliance, DHHS submitted its parity compliance report to CMS on October 2, 2017. The October 2, 2017 Compliance Report included a description of the approach and activities undertaken by the Department as part of its parity analysis and concluded that “[T]he NH Medicaid Program, as determined through its Parity Analysis, is in compliance with the Mental Health and Addiction Equity Act.”

In the conclusion section of the October 2, 2017 Compliance Report, DHHS stated that although the DHHS parity analysis had determined that New Hampshire was in compliance with the Parity Law, “its work on ensuring parity between mental health/substance use disorder services and medical/surgical services is far from over” and referenced the NH DHHS Compliance Monitoring Plan included as Appendix D to the October 2, 2017 Compliance Report. Following the submission of the October 2, 2017 Report, DHHS began the implementation of the Compliance Monitoring Plan by requesting additional information and further analysis from the Plan as required by the parity provisions in the Contract between DHHS and the Plan. The Contract requires the Plan to demonstrate how all administrative, clinical, and utilization practices are in compliance with the relevant provisions of the Parity Law. The Plan was also required to provide an analysis of any Quantitative Treatment Limitations and Non-Quantitative Limitations in place for CY 2016 for MH or SUD services in order to demonstrate that any such limitations imposed by the Plan were in compliance with parity requirements using the methodologies outlined in the Parity Rules and relevant CMS guidance documents.

To assist the Plan in meeting its ongoing responsibility to insure parity compliance and accurate reporting, DHHS arranged for support from a national parity expert on October 18, 2017. Following the technical assistance consultation, DHHS requested that the Plan provide additional information on non-quantitative treatment limitations in each classification (inpatient, outpatient, emergency, and pharmacy) using guidance documents provided by DHHS for each classification. During the period from December 1, 2017 to April 15, 2018, the Plan submitted the completed guidance documents in a timely manner to DHHS. DHHS reviewed the completed guidance documents and sent follow-up questions to the Plan, to which the Plan responded.

Purpose of Report. The purpose of this report is twofold. The first purpose is to fulfill the Department’s responsibility to conduct an independent analysis of the material submitted by the Plan in order to validate both the parity analysis conducted by the Plan and the Plan’s conclusion that it was compliant with the requirements of the Parity Law for CY 2016. Based on the Department’s independent review of the materials provided by the Plan, the Department finds that the Plan was compliant with the requirements of the Parity Law for CY 2016.

The second purpose of this report is to identify any areas of concern with regard to ongoing parity implementation and compliance and to make recommendations to the Plan for improvements. DHHS will use its findings to make recommendations for future managed care contract amendments and reprocurement.

Structure of Report. As described above, pursuant to its contractual obligation to demonstrate parity compliance, the Plan provided information and responded to questions from DHHS regarding the Plan’s parity compliance activities/analysis. The information provided by the Plan was organized by the four service categories: Inpatient, Outpatient, Emergency, and Pharmacy.

The iterative process utilized by DHHS and the Plan resulted in the resolution of a significant number of the Department’s parity questions, leaving only a limited number of outstanding issues for discussion and resolution. This report includes only those questions, responses, and recommendations that remain outstanding. Finally, it is noted that the requests for further

information/analysis and the recommendations for future action in this report relate only to the Inpatient and Outpatient Service Classifications. This is because the Plan's parity analysis in the Emergency and Pharmacy Classifications did not give rise to further DHHS inquiries or recommendations to improve parity compliance.

B. Availability and Accessibility of Information

a. Inpatient

1. DHHS Inquiry: The Plan provided the Interqual Adult and Geriatric, and Child and Adolescent Psychiatry Criteria as part of the Plan's submission. DHHS recommends that these criteria be made available to members and providers pursuant to 42 CFR 438.915.

NHFF Response: The criteria are available to members and providers upon request, however, we are contractually prohibited from posting the criteria externally due to the proprietary nature of these materials.

DHHS Response/Recommendation: DHHS recommends that the Plan make it clear in their member handbook and provider manual that these criteria are available to them for review upon request. DHHS encourages the Plan to consider additional language in member communications that clearly defines the process for requesting the criteria.

2. DHHS Inquiry: The Plan's denial letter for services says that the medical necessity criteria are attached, yet the letter also informs the member that the specific criteria can be requested. Please explain. See page 5 of the February 15, 2018 Inpatient Submission.

NHFF Response: The letter includes the specific rationale for the medical necessity decision that applies to the member's particular situation. However, the member and provider have the right to request the policy that outlines the medical necessity criteria in its entirety for a particular level of care. This is referenced in the Member Handbook (page 90) and the Provider Manual (page 45).

DHHS Response/Recommendation: The Plan's response is sufficient. However, given that the specific rationale mentioned in the letter may be brief and/or vague, DHHS recommends that the denial letter explicitly outline the member's right to access the full criteria for the denial and the process for doing so.

3. DHHS Inquiry: How can providers and members access EPC.UM.229? See page 3 of the February 15, 2018 Inpatient Submission.

NHFF Response: Providers and members do not have access to this internal policy that outlines the turnaround times (TAT) for provider notifications. However, this information is also available in the Member Handbook (p. 94) and the Provider Manual (p. 42).

DHHS Response/Recommendation: The Plan’s response is sufficient.

4. DHHS Inquiry: If a member does not meet medical necessity criteria for inpatient behavioral health, who makes the referral for a lower level of care? How does the Plan follow-up with the member? See page 3 of the February 15, 2018 Inpatient Submission.

NHMF Response: If a member does not meet the medical necessity criteria for inpatient behavioral health level of care, the attending physician will refer the member to a lower level of care. The member is also referred to care management for follow up. The care manager will make three attempts to contact the member after discharge from an inpatient facility and will send a follow up letter if the member is unable to be reached telephonically. Once the member is contacted, the care manager will ensure that after care services are in place, identify gaps in services and offer assistance and referrals to close gaps.

DHHS Response/Recommendation: DHHS encourages the Plan to consider what it can do for someone who may not respond to these outreach efforts. DHHS suggests that the Plan monitor those who are not responding to these outreach efforts and identify opportunities for process or quality improvements. DHHS also recommends that the Plan review the denial process to ensure that the attending physician is given the resources and information needed regarding the lower level of care that is approved by the plan and which specific providers the physician is able to refer the member to.

b. Outpatient

5. DHHS Inquiry: On Page 8 of the NHMF February 15, 2018 Outpatient Submission, the Plan states that “local practitioners with professional knowledge or clinical expertise ... have an opportunity to give advice or comment on the adoption of UM criteria and on instructions for applying the criteria.” How do providers learn about these opportunities? Are the comments on UM criteria publically available? If so, how can providers find this information?

NHMF Response: Providers may submit comments via the Provider Advisory Group as well as a number of committees such as the Quality Improvement and Utilization Management Committees. Our Chief Medical Officer ensures that local providers from various specialties participate in these committees. Criteria discussions are reflected in the committee meeting minutes and changes are included in the annual policy updates. As previously stated, criteria are available to members and providers upon request.

DHHS Response/Recommendation: DHHS requests that the Plan provide committee participation information and that opportunities for provider engagement are widely disseminated and not solely through invitation from the Chief Medical Officer.

6. DHHS Inquiry: On Page 9 of the NHMF February 15, 2018 Outpatient Submission, the Plan explains that when “an in network provider is not available, the health plan will grant approval

for an out of network provider option,” How many out of network referrals has the Plan made for its members that have been unable to receive inpatient mental health treatment for more than five (5) days?

NHFF Response: The Plan does not track out of network referrals for inpatient mental health, instead out of network admissions are being tracked. The Plan does not hold back members for inpatient admissions. Our utilization management staff reviews for medical necessity criteria as soon as the current clinical information is received. If no in-network options are available, members are referred to out-of-network providers immediately.

DHHS Response/Recommendation: DHHS recommends that the Plan consider tracking out of network referrals to ensure that individuals being referred to OON providers actually receive access to care through that referral.

7. DHHS Inquiry: Does the Plan track out of network referrals for inpatient mental health?

NHFF Response: The Plan does not track the out of network referrals for inpatient mental health. The Plan does track out of network admissions.

DHHS Response/Recommendation: See DHHS Response to Inquiry #6 above.

C. Network Adequacy

8. DHHS Inquiry: Does the Plan feel that its network of inpatient behavioral health providers is adequate? What does the Plan do to increase its network of inpatient behavioral health providers? See Pages 7-8 of December 15, 2017 Inpatient Submission.

NHFF Response: The Plan meets network adequacy for BH voluntary admissions. In order to increase our network of inpatient behavioral health providers we monitor all network adequacy requirements, including BH, on a monthly basis to determine if gaps exist in our network. We also monitor, as needed, all terminations to determine if they create a network gap. If a gap is identified, we review available providers and outreach to obtain an agreement for participation. We also monitor our existing providers to determine if they are adding new services, and work to ensure those services are included within their existing agreement.

DHHS Response/Recommendation: The Plan’s Response is sufficient.

D. Criteria for Reviewers

9. DHHS Inquiry: Does the Plan think Utilization Management staff would benefit from having SUD expertise? See pages 8-9 of the December 15, 2017 Outpatient Submission and pages 2-3 of the December 15, 2017 Inpatient Submission.

NHFF Response: Yes, New Hampshire Healthy Families encourages its clinical staff to keep current on behavioral health issues, particularly SUD. Staff are granted 3 educational days a year to attend training. New Hampshire Healthy Families also offers on-line classes available through the company's training website. Additionally, the plan has an SUD director who is available to staff to provide education and training as needed.

DHHS Response/Recommendation: The Plan's Response is sufficient.

E. InterQual

10. DHHS Inquiry: Explain and provide supporting documentation to explain why InterQual is appropriate to determine medical necessity for inpatient behavioral health? See page 2 of the February 15, 2018 Inpatient Submission.

NHFF Response: InterQual is a nationally recognized medical necessity criteria set that is used by numerous managed care organizations and hospitals across the country to determine medical necessity criteria for both M/S and BH/SUD. These criteria draw upon the expertise of leading professionals in the field as well as substantive review of literature including the latest developments in different medical and behavioral health specialties. See attached document that explains the InterQual criteria development process.

DHHS Response/Recommendation: The Plan's Response is sufficient.

F. Higher PA Denial Rates for Mental Health Treatment

11. DHHS Inquiry: When the Plan denies an individual inpatient behavioral health treatment, how does the care management staff follow up with the individual? See page 4 of the February 15, 2018 Inpatient Submission.

NHFF Response: When the plan denies coverage for an inpatient behavioral health treatment, the impacted member is referred to care management. Once the member is discharged from an inpatient facility, a care manager will make three phone calls on different days and different times to increase the likelihood of reaching the member. If the care manager is unable to reach the member, a follow up letter will be sent. If a member is considered high risk, a Member Connections Representative will conduct a home visit to ensure that follow up care has been established and assist with care management engagement.

DHHS Response/Recommendation: DHHS seeks clarification as follows: Will the care management staff conduct this follow-up even if the member is not enrolled in care management? What happens if care management cannot locate the individual? Is there a number that members can use if they received an inpatient denial and continue to need services?

NHFF Further Response: Yes, follow up will be conducted even if the member is not enrolled in care management. If the care manager cannot locate the individual over the phone, a follow

up letter will be sent. If a member is considered high risk, a Member Connections Representative will follow up with a home visit.

Before the member is discharged, a care manager will outreach to the provider to offer assistance with aftercare referrals. The care manager will also provide his/her call back phone number in the event that future assistance is needed. Additionally, the denial letter includes a phone number to the Appeals Department if there are questions about the denial. Calls are subsequently routed from the Appeals Department to Care Management as appropriate.

DHHS Response/Recommendation: See DHHS Response/Recommendation to Question # 4 above.

12. DHHS Inquiry: How does the Plan propose to reduce the inpatient behavioral health PA denials? DHHS finds that the PA denials for behavioral health is statistically different from the PA denials for medical/surgical. The Plan explained that this difference occurs because behavioral health treatment is complex, is a sub-specialty of medicine, and has fewer claim codes compared to medical/surgical. DHHS does not understand why these differences cause higher PA denials.

NHMF Response: The Plan has determined that the process of development and application of medical necessity criteria is no more stringent for BH/SUD than M/S. The Plan does not expect the outcomes of the medical necessity review to be comparable between BH/SUD and M/S as the medical necessity criteria are applied to different disease states. For example, we would not expect the denial rates for an orthopedic surgery to be the same as the denial rates for neurosurgery.

As per the CMS Parity compliance toolkit: "...it is not required that the result of applying an NQTL to MH/SUD and M/S benefits for the NQTL to be permissible. Instead, compliance depends on parity of the processes, strategies, evidentiary standards and other factors used to apply the NQTL (in writing and in operation). Among other things, there should not be arbitrary or discriminatory differences in how a state or MCO/PIHP/PAHP applies NQTLs to M/S benefits as compared with MH/SUD benefits."

DHHS Response/Recommendation: Based on the discussion with the Plan and this response, DHHS agrees that the denial rates are not a parity violation. However, DHHS recommends that the Plan consider a comprehensive review of the processes in place for PA processes for behavioral health to ensure that the processes themselves are compliant with parity. CMS guidance recommends exploring processes when variances in numbers exist.

b. Outpatient

13. DHHS Inquiry: Provide further clarification as to why there are strategically higher rates of PA denials for behavioral health than medical/surgical. What does the Plan recommend in order to reduce the PA denial rate for behavior health?

NHHS Response: All outpatient utilization management decisions are based on application of evidence based, nationally recognized medical necessity criteria. This practice is consistent with New Hampshire regulation and our contractual obligation to the State of New Hampshire. New Hampshire Healthy Families will continue to monitor staff inter-rater reliability scores and internal processes across the utilization management organization to ensure that utilization management processes continue to be applied consistently for BH/SUD and M/S services.

DHHS Response/Recommendation: See response to #12 above. Where denials are the result of missing information from providers and/or limited detail in the PA request, DHHS recommends providing additional opportunities for provider education about the PA process and the details needed to ensure approvals are not delayed due to missing information.

G. Miscellaneous Questions:

a. Inpatient

14. DHHS Inquiry: Can the Plan confirm that residential SUD treatment was included in the answers supplied for the inpatient SUD responses?

NHHS Reply: Yes

DHHS Response/Recommendation: The Plan's response is sufficient.

15. DHHS Inquiry: On page 3 of the February 15, 2018 Inpatient Submission, the Plan explains that there is no PA for emergency admissions, however "the Plan requests notification within 24 hours of admission to allow utilization managers to provide post stabilization continued stay review and assistance with discharge planning." What happens if, after "notification," the Plan disagrees with the inpatient placement? How does the Plan in these instances follow-up with providers and members?

NHHS Response: In the instances when a member is admitted to a routine inpatient level of care following an emergency admission, we would follow the standard utilization management process as follows:

Clinical information to substantiate appropriateness of continued stay is collected over the phone, reviewed against medical necessity criteria and an authorization is granted if the medical necessity criteria are met. If the criteria are not met, the case is sent for medical director review. If the review results in a denial, the utilization manager will contact the provider to offer assistance in scheduling a timely appointment for the member at a lower level of care. Once the member is discharged from an in-patient facility, the case management staff will immediately initiate the outreach to the member via the phone. The staff will make up to three attempts within 7 days. If the care manager is unable to reach the member, a follow up letter is sent to the member and a Member Connections visit to the member's home is scheduled if the member is determined high risk.

DHHS Response/Recommendation: DHHS suggests working with the providers to ensure that members are connected to case management staff prior to discharge. This may reduce the risk of losing the member to contact. DHHS suggests utilizing the discharge plan for the member to facilitate this outreach and requests a copy of this form for review. DHHS also suggests that the plan expand the details provided in the member handbook about the case management program and opportunities for members to connect with case management in instances where they are discharged to lower levels of care due to UM processes.

16. DHHS Inquiry: If a utilization manager refers a potential medical necessity issue to a peer reviewer, what is the turnaround time for the peer reviewer to make and communicate its decision upon receiving the referral?

NHMF Response: If a utilization manager refers a potential medical necessity to a peer reviewer, the peer reviewer has 24 hours from the time the referral is made to outreach to the attending physician, complete the review, and communicate results to the utilization manager who made the original referral.

DHHS Response/Recommendation: DHHS recommends that the Plan add this information about turnaround time and processes for emergent or non-emergent peer reviews to the member and provider handbooks.

b. Outpatient

17. DHHS Inquiry: On page 4 of the February 15, 2018 Outpatient Submission, the Plan states that there are no prior authorizations for outpatient SUD treatment, yet there were 27 authorized services in the table. What is the reasoning behind this?

NHMF Response: Prior authorization is not required for outpatient SUD; however, Notification is required for certain SUD services. Notification is requested to ensure the timeliness and accuracy of claims payment. This process is different from prior authorization process in that the plan does not collect clinical information for outpatient SUD and therefore, medical necessity criteria are not applied to these requests.

DHHS Response/Recommendation: DHHS suggests making the difference in processes and impacts between prior authorization and notification clear in the provider handbook.

18. DHHS Inquiry: On page 9 of the February 15, 2018 Outpatient Submission, the Plan explains that when NHMF receives a request for an out-of-network outpatient service that the Plan will redirect the member to an equivalent network option within the geo access area if one is available. If this occurs, how does the Plan contact the provider and the member?

NHHS Response: When New Hampshire Healthy Families receives a request for an out-of-network outpatient service, the utilization manager will outreach to the member and the provider, collect clinical information and provide a list of in network providers available in the geo access

area. The utilization manager will also offer assistance to the member in scheduling the outpatient appointment with one of the contracted providers on the list.

If no in-network options are available in the in the geo access area, the staff will outreach to the out-of-network provider to initiate a process of single case agreement to allow the provider to be reimbursed for their services to this particular member at an in-network rate.

DHHS Response/Recommendation: The Plan's response is sufficient.