TIPS FOR PROVIDERS ON NEGOTIATING MANAGED CARE CONTRACTS TO IMPROVE ACCESS TO MENTAL HEALTH AND ADDICTION CARE

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ABOUT NATIONAL COUNCIL:

The National Council for Behavioral Health is the unifying voice of America's mental health and addictions treatment organizations. Together with over 2,800 member organizations, serving 10 million adults, children and families living with mental illnesses and addictions, the National Council is committed to all Americans having access to comprehensive, high-quality care that affords every opportunity for recovery. The National Council was instrumental in bringing Mental Health First Aid to the USA and more than 700,000 individuals have been trained. In 2014, the National Council merged with the State Associations of Addiction Services (SAAS). To learn more about the National Council, visit www.TheNationalCouncil.org.

ABOUT PSYCH-APPEAL:

Founded by a practicing attorney with a background in mental health, Psych-Appeal is uniquely qualified to help patients, clinicians, and treatment facilities navigate the complex process of challenging insurance company denials. Our extensive knowledge of both mental health care and the law provides clients with a distinct advantage when facing unjust claims denials. Psych-Appeal affiliates with the country's leading law firms as well as with the Parity Implementation Coalition, the Saks Institute for Mental Health Law, Policy, and Ethics, and Patrick J. Kennedy to curb discrimination against mental illness and to expand access to meaningful treatment.

To help reach the full intent of federal mental health parity and addiction equity laws, providers can seek specific language in their contracts with managed care organizations (MCOs) to help them act on behalf of their clients, obtain relevant claims data, and have access to plan documents, including clinical criteria used by plans to make medical necessity decisions. This toolkit provides specific, contractual language and justifications for its inclusion in provider contracts with MCOs. While all of the provisions outlined are important to ensure adequate protection for providers and consumers, if all of them cannot be inserted, the inclusion of any of them will better enable providers to assist patients to access medically appropriate care. Ultimately, if a provider is unable to secure the specific terms listed in their contracts, they should become familiar with them. Under some state and federal laws, the provisions may be invoked even if they are not specifically listed in the contract.

Key Terms
(subject to provider-MCO customization)

Claims file = MCO case management, utilization review, and appeals notes

Electronic access = Email and/or web-based portals

Member = Patient, claimant, or enrollee

MCO = Managed care organization or managed behavioral healthcare organization

Provider = Individual, group, or facility providing clinical services

BACKGROUND AND NEED

The potential confusion regarding the Mental Health Parity and Addiction Equity compliance requirements for MCOs in the Medicaid sector, as well as the often complicated medical necessity determination and appeal procedures may jeopardize an individual's ability to obtain medically necessary care. To maximize efficiency and minimize risks to patients, providers, and payors alike, mental health and addiction claims and appeals processes should be streamlined to the greatest extent possible. This goal has been made possible by the Affordable Care Act ("ACA"), which as of 2010 subjected all non-grandfathered commercial health plans to uniform claims and appeals rules.[1] Recently, the United States Department of Health and Human Services also finalized uniform Medicaid claims and appeals rules, which largely mirror the commercial sector's.[2]

It is imperative that mental health and addiction providers make use of new safeguards to advocate on behalf of their vulnerable patients to ensure patients receive timely and appropriate care.[3] With respect to claims and appeals of denied mental health and addiction care, the following internal claims and appeals processes should be considered by providers negotiating contracts with MCOs that administer both commercial and Medicaid plans.[4] The analysis and recommendations contained herein are solely for educational purposes, and as such, do not constitute legal advice. Ultimately, whether and how providers incorporate the following considerations into their managed care contracts should be decided in consultation with qualified legal counsel.[5]

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1. See 42 U.S.C. §300gg-19(a)(2) and 80 Fed. Reg. 72192, 72217 (Nov. 18, 2015) ("Before the enactment of the Affordable Care Act, health plan sponsors and issuers were not uniformly required to implement claims and appeals processes. For example, ERISA covered group health plan sponsors were required to implement internal claims and appeal processes that complied with the DOL claims procedure regulation, while group health plans that were not covered by ERISA, such as plans sponsored by State and local governments were not. Health insurance issuers offering coverage in the individual insurance market were required to comply with various applicable State internal appeals laws but were not required to comply with the DOL claims procedure regulation... These uneven protections created an appearance of unfairness, increased cost for issuers and plans operating in multiple States, and may have led to confusion among consumers about their rights. Congress enacted PHS Act section 2719 to ensure that plans and issuers implemented more uniform internal and external claims and appeals processes and to set a minimum standard of consumer protections that are available to participants, beneficiaries, and enrollees.")

2. See 42 U.S.C. §1396u–2(b)(4) and 81 Fed. Reg. 27498, 27509 (May 6, 2016)("Aligning with the requirements of MA [Medicare Advantage] and the private market will promote administrative simplicity... We believe it is beneficial to create a national approach that aligns with other health care coverage options and will allow enrollees to transition across public and private health care programs with similar requirements. This consistency will aid enrollees in understanding the benefits of the appeal process and how to effectively utilize it regardless of which type of coverage they have.")

3. This discussion exclusively centers on adverse benefit determinations due to medical necessity and mental health and addiction parity violations. As a general rule, the right to appeal only arises after an "adverse benefit determination" is issued by an MCO. While the term has similar meanings with respect to commercial and managed Medicaid plans, there are some subtle differences. Providers should review 29 C.F.R. §2560.503-1(m)(4), applicable to grandfathered ERISA plans, 29 C.F.R. §2590.715-2719(a)(2)(i), applicable to non-grandfathered ERISA and commercial plans, and 42 C.F.R. §438.400(b), applicable to managed Medicaid plans.

4. It is beyond the scope of this discussion to offer recommendations regarding external appeals (by Independent Review Organizations), since external appeals are neither always nor exclusively handled by MCOs contracted with providers.

5. Provider collaboration with qualified counsel is especially recommended since changes to laws and regulations could significantly alter the analysis and recommendations contained herein.

1. STANDING

(A) Discussion

Without standing, providers lack legal authority to act on behalf of their patients with respect to claims and appeals. While some jurisdictions and managed care contracts afford separate appeal rights to patients and providers, some do not. Fortunately, federal law already recognizes providers as de facto authorized representatives for urgent claims and appeals with respect to ERISA and non-grandfathered commercial health plans.[6] Recently enacted Medicaid regulations, which are inherently more stringent than their private market counterparts, vest states with discretion to permit providers to act as authorized representatives, subject to written patient consent.[7] Therefore, in the absence of robust, separate appeals rights from their patients', and to the degree permitted by federal and/or state law, providers should use managed care contracts to solidify their authorized representative status. Even providers with independent appeals rights may nonetheless wish to incorporate specific elements from the proposed contract terms appearing throughout this paper into their MCO agreements. In doing so, both providers and MCOs can be better equipped to respond to advocacy concerns brought on behalf vulnerable patients struggling with mental health and addiction disorders.

Provider Standing to Appeal Adverse Benefit Determinations
(absent independent appeal rights)

	PLAN TYPE	
Appeal Type	ERISA/ Non-randfathered	Managed Medicaid/CHIP
Urgent	✔	✔ if allowed by state law and patient consents in writing
Non-Urgent	✔ if allowed by state law and patient consents in writing	✔ if allowed by state law and patient consents in writing

(B) Proposed contract terms

1. ***With respect to all ERISA and non-grandfathered commercial health plans administered by MCO, Provider shall be Member's authorized representative for all urgent claims and appeals. Consistent with 29 C.F.R. §2560.503-1 and applicable state law, MCO shall not require Provider to obtain Member consent to act as Member's authorized representative for claims and appeals deemed "urgent" by Provider.***[8]

6. See 29 C.F.R. §2560.503-1(b)(4), which has been incorporated by reference into 42 U.S.C. 300gg-19, 29 C.F.R. §2590.715-2719, and 45 C.F.R. §147.136. ("[A] plan may establish reasonable procedures for determining whether an individual has been authorized to act on behalf of a claimant, provided that, ***in the case of a claim involving urgent care… a health care professional… with knowledge of a claimant's medical condition shall be permitted to act as the authorized representative of the claimant.")***

7. See 42 C.F.R. § 438.420(c)(2)("If State law permits ***and*** with the written consent of the enrollee, a provider or an authorized representative may request an appeal or file a grievance, or request a State fair hearing, on behalf of an enrollee. When the term "enrollee" is used throughout subpart F of this part, it includes providers and authorized representatives consistent with this paragraph, with the exception that providers cannot request continuation of benefits as specified in § 438.420(b)(5).")

8. Note that 29 C.F.R. §2560.503-1(m) permits providers to deem the following as "urgent," and with respect thereto, act as authorized representatives: Any claim that (a) could seriously jeopardize the life or health of the patient or (b) the ability of the patient to regain maximum function or (c) would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

With respect to fully-insured, non-grandfathered ERISA and commercial health plans, state law may broaden the definition of "urgent," thereby expanding de facto provider standing with respect to claims and appeals. State law may not reduce the definition of "urgent" below the federal floor for ERISA and non-grandfathered commercial health plans.

2. ***With respect to all ERISA and non-grandfathered commercial health plans administered by MCO, MCO shall permit Provider to act as Member's authorized representative for non-urgent claims and appeals of adverse benefit determinations, as permitted by state law and pursuant to written Member consent.***[9]

3. ***With respect to all Medicaid plans administered by MCO, MCO shall permit Provider to act as Member's authorized representative for appeals of adverse benefit determinations, as permitted by state law and pursuant to written Member consent.***[10]

2. ACCESS TO PLAN DOCUMENTS

(A) Discussion

Since all health plans are required to base their decisions, at least in part, on plan terms (and applicable law), MCOs must have ready access to this information. Federal regulations already require that all fully-insured health plan documents be made available online.[11] The provision below ensures that providers have the same access to plan documents as their patients. While federal regulations do not currently require plan sponsors to make self-funded health plan documents electronically available, such documents must nonetheless be furnished and MCOs administering self-funded health plans should have little difficulty producing them. It should be noted that neither a verbal verification of benefits nor access to a Summary of Benefits and Coverage (SBC) can adequately substitute for the information contained in governing plan documents.

(B) Proposed contract terms

MCO shall provide electronic access to the Member's complete health plan documents (generally referred to as either the Certificate of Coverage or Summary Plan Description) along with all amendments and riders, as applicable to Member's individual or group health plan, within 24 hours of a verbal or written request by Provider. MCO shall not obstruct or delay access to this information by requiring Member consent.[12]

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9. **Tip:** In states permitting providers to act as authorized representatives, providers should consider utilizing authorized representative forms which: (1) reference the applicable state law(s) allowing them to act as such and (2) verify patient consent that providers: (a) may appeal adverse benefit determinations and (b) receive protected health information, including claims files (discussed in 4: Access to claims data, below).

10. **Tip:** Same as footnote 9, with the exception that providers acting as authorized representatives with patient consent cannot request continuation of benefits pending appeals since patients may ultimately be held liable for payment of continued benefits pending unsuccessful appeals. See 42 C.F.R. §438.402(c)(1)(ii). Only patients and their (non-provider) authorized representatives may request continuation of benefits pending appeals. Therefore, providers may wish to implement "continuation of benefits" procedures (i.e., forms) for direct execution by patients and/or their authorized representatives when requests for continuation of benefits pending appeals are warranted. See 42 C.F.R. §438.420(b)(5).

11. See 80 Fed. Reg. 34292, 34298 (June 16, 2015)(amending, in relevant part, 45 C.F.R. §147.200, 29(a)(2)(i)(J) and 29 C.F.R. § 2590.715–2715(a)(2)(i)(J))("Accordingly, these final regulations provide that issuers must also include an Internet web address where a copy of the ***actual individual coverage policy or group certificate of coverage*** can be reviewed and obtained. The Departments note that these final regulations require these documents to be easily available to individuals, plan sponsors, and participants and beneficiaries shopping for coverage prior to submitting an application for coverage. For the group market only, because the actual "certificate of coverage" is not available until after the plan sponsor has negotiated the terms of coverage with the issuer, an issuer is permitted to satisfy this requirement with respect to plan sponsors that are shopping for coverage by posting a sample group certificate of coverage for each applicable product. After the actual certificate of coverage is executed, it must be easily available to plan sponsors and participants and beneficiaries via an Internet web address.")

Also, with respect to Medicaid plans, see 42 C.F.R. §438.10(g)(1)("Each MCO, PIHP, PAHP and PCCM entity must provide each enrollee an enrollee handbook, within a reasonable time after receiving notice of the beneficiary's enrollment, which serves a similar function as the summary of benefits and coverage described in 45 CFR 147.200(a).")

12. Because these documents do not contain any Protected Health Information ("PHI"), there is no compelling justification for MCOs to require providers to either be authorized representatives or obtain patient consent to receive them.

3. ACCESS TO CLINICAL CRITERIA

(A) Discussion

It is imperative that providers have ready access to all clinical criteria pursuant to which MCOs purport to evaluate services for medical necessity, both initially and on appeal of adverse benefit determinations.[13] Federal regulations clearly require that clinical standards used by MCOs to adjudicate claims and appeals must be disclosed – even if they are proprietary.[14] Many national MCOs now post their clinical criteria on periodically updated websites, although local MCOs and some national MCOs applying third party (i.e., Milliman, InterQual) clinical criteria often withhold their guidelines unless release is requested following an adverse benefit determinations.[15]

(B) Proposed contract terms

Upon execution of this Provider-MCO managed care contract, MCO shall immediately make all its relevant medical necessity criteria electronically accessible to Provider. MCO shall have a continuing obligation to electronically produce any new, revised, or updated clinical criteria to Provider within 7 calendar days of adopting such criteria. Medical necessity criteria shall include all proprietary standards developed by third parties and applied by MCO.

13. Whether providers should accept or reject medical necessity criteria developed and/or adopted by MCOs (as distinguished, for example, from medical necessity criteria established by state laws or non-profit medical specialty associations) is a separate matter. Clearly, providers must maintain clinical standards that allow them to ethically and professionally discharge their duties and should be wary of MCO clinical criteria that improperly restrict access to medically necessary care.

14. See FAQs about Affordable Care Act Implementation (Part XXIX) and Mental Health Parity Implementation (Q12), issued on October 23, 2015, at https://www.dol.gov/ebsa/faqs/faq-aca29.html. ("The criteria for making medical necessity determinations, as well as any processes, strategies, evidentiary standards, or other factors used in developing the underlying NQTL and in applying it, must be disclosed with respect to both MH/SUD benefits and medical/surgical benefits, regardless of any assertions as to the proprietary nature or commercial value of the information.")

Also see 42 C.F.R. §438.404(b)(2) with respect to Medicaid plans, which requires that each denial notice provide "[t]he reasons for the adverse benefit determination, including the right of the enrollee to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and any processes, strategies, or evidentiary standards used in setting coverage limits.")

15. The fact that clinical criteria developed by (private sector) third parties are not publicly posted does raise concerns about transparency and intent.

4. ACCESS TO CLAIMS DATA

(A) Discussion

MCOs are often delayed in generating written notices of their denial rationales in urgent matters. Meaningful appeals, however, generally cannot be initiated in the absence of detailed denial rationales, which are often immediately posted by MCOs to their databases. Even when MCOs generate written denials within required time frames, such denials are often devoid of the specificity contained in their electronic health records. Additionally, the information stored in their electronic health records can also shed light on questionable conduct that would not otherwise be revealed by denial letters alone. Moreover, providers may need access to historical clinical data maintained by MCOs (potentially with longer-term patient familiarity), particularly when treating patients in urgent cases, for the first time, or with limited access to reliable clinical history. Since federal law provides patients with the right to review their claims files when appealing adverse benefit determinations, authorized representatives (such as providers) should be allowed to exercise the same right.[16]

(B) Proposed contract terms

1. ***With respect to all ERISA and non-grandfathered commercial health plan appeals of adverse benefit determinations deemed "urgent" by Provider, MCO shall electronically transmit Member's complete claims file (including all case management, utilization review, and appeals notes) to Provider within 24 hours of a written request. MCO shall not obstruct or delay access to this information by requiring Member consent for its release.***[17]

2. ***Subject to Provider acting as an authorized representative pursuant to state law and written Member consent to Provider acting as Member's authorized representative, MCO shall electronically transmit Member's complete claims file (including all case management, utilization review, and appeals notes) to Provider within 24 hours of a written request with respect to any appeal of an adverse benefit determination deemed "urgent" by Provider.***[18]

3. ***For all claims and appeals not deemed "urgent" by Provider, MCO shall make Member's complete claims file electronically accessible to Provider within (TBD) calendar days of written request, subject to written verification that Provider is acting as Member's authorized representative.***[19]

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16. See 42 U.S.C. §300gg-19(a)(1)(C)("A group health plan and a health insurance issuer offering group or individual health insurance coverage shall implement an effective appeals process for appeals of coverage determinations and claims, under which the plan or issuer shall, at a minimum—***allow an enrollee to review their file***, to present evidence and testimony ***as part of the appeals process***, and to receive continued coverage pending the outcome of the appeals process.")

Also see 42 C.F.R. §438.406(b)("An MCO's, PIHP's or PAHP's process for handling enrollee grievances and appeals of adverse benefit determinations must… (5) Provide the enrollee and his or her representative the enrollee's case file, including medical records, other documents and records, and any new or additional evidence considered, relied upon, or generated by the MCO, PIHP or PAHP (or at the direction of the MCO, PIHP or PAHP) in connection with the appeal of the adverse benefit determination. This information must be provided free of charge and ***sufficiently in advance of the resolution timeframe for appeals*** as specified in § 438.408(b) and (c).")

Also see 81 Fed. Reg. 27498, 27515("Nothing in § 438.406(b)(5) would prohibit an authorized representative from requesting the same information and documentation specified at (b)(5), as long as the state recognizes and permits such legally authorized representative to do so.")

17. Because MCOs may nonetheless require providers acting as authorized representatives to execute their own authorizations for release of patient claims files, providers should ensure that they have ready access to the particular authorization forms required by MCOs.

18. In the Medicaid context, the definition of "urgent" is slightly different than in the ERISA/commercial sector. See 42 C.F.R. §438.410(a)(1)("Each MCO, PIHP, and PAHP must establish and maintain an expedited review process for appeals, when the MCO, PIHP, or PAHP determines (for a request from the enrollee) or the provider indicates (in making the request on the enrollee's behalf or supporting the enrollee's request) that taking the time for a standard resolution could [1] seriously jeopardize the [a] enrollee's life, [b] physical or [c] mental health, or [2] ability to [a] attain, [b] maintain, or [c] regain maximum function.")

19. In the non-urgent context, the timing for provider access to claims files should be negotiated with MCOs based on several factors, including whether the providing is appealing in its own right (as permitted by some jurisdictions/contracts, in which case the time to appeal adverse benefit determinations may be significantly shorter than when appealing as an authorized representative). Providers should allow themselves sufficient time to receive and review MCO claims files prior to appealing. ERISA and non-grandfathered commercial health plans must provide patients and their authorized representatives at least 180 days in which to appeal initial adverse benefit determinations. Managed Medicaid plans must provide patients and their authorized representatives 60 days in which to appeal initial adverse benefit determinations.

5. DENIALS IMPLICATING MENTAL HEALTH AND ADDICTION PARITY

(A) Discussion

Adverse benefit determinations predicated on mental health or addiction parity violations (i.e., non/quantitative treatment limitations) should give rise to the same appeals recourse as adverse benefit determinations based on medical necessity. In fact, a medical necessity denial could be intertwined with a mental health or addiction parity violation.[20] Therefore, in cases in which mental health or addiction parity violations[21] are suspected, it is imperative that providers have prompt access to mental health and addiction parity analyses that health plans are required to undertake to achieve and maintain compliance.[22] If a health plan has not undertaken a parity analysis relevant to a provider's request for information, then the MCO should respond accordingly.

(B) Proposed contract terms

1. ***MCO shall be responsible for maintaining all mental health and addiction parity analyses for its administered health plans.***

2. ***With respect to all ERISA and non-grandfathered commercial health plan claims and appeals deemed "urgent" by Provider, MCO shall electronically transmit all requested mental health and addiction parity analyses within 24 hours of written request by Provider. MCO shall not obstruct or delay access to this information by requiring Member consent.***

3. ***Subject to Provider acting as an authorized representative pursuant to state law and written Member consent to Provider acting as Member's authorized representative, MCO shall electronically transmit all requested mental health and addiction parity analyses within 24 hours of written request by Provider with respect to any appeal of an adverse benefit determination deemed "urgent" by Provider.***

4. ***With respect to all claims and appeals not deemed "urgent" by Provider, MCO shall electronically transmit all requested mental health and addiction parity analyses within (TBD) calendar days of written request by Provider, subject to written verification that Provider is acting as Member's authorized representative.***[23]

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20. See "Warning Signs- Plan or Policy Non-Quantitative Treatment Limitations (NQTLs) that Require Additional Analysis to Determine Mental Health Parity Compliance" at https://www.dol.gov/ebsa/pdf/warning-signs-plan-or-policy-nqtls-that-require-additional-analysis-to-determine-mhpaea-compliance.pdf.

21. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 prohibits health plans from imposing treatment limitations, including non-quantitative treatment limitations, ***only*** or ***incomparably/more stringently*** on mental health and substance use disorder benefits. With respect to ERISA and ERISA-exempt large group plans, respectively, see 42 U.S.C. §300gg-26, 29 U.S.C. §1185(a), and their implementing regulations at 78 Fed. Reg. 68240 (Nov. 13, 2013). With respect to non-grandfathered individual and small group commercial plans, see 45 C.F.R. §156.115(a)(3). With respect to managed Medicaid plans, see 42 C.F.R. §457.496.

22. See FAQs about Affordable Care Act Implementation (Part 31), Mental Health Parity and Addiction Equity Act of 2008, Disclosure, issued on April 20, 2016, at https://www.dol.gov/ebsa/faqs/faq-aca31.html. ("The DOL claims procedure regulations, as well as the internal claims and appeals and external review requirement under section 2719 of the PHS Act, which apply to non-grandfathered group health plans and issuers of non-grandfathered group or individual health insurance coverage, set forth rules regarding claims and appeals, including the right of claimants (or their authorized representative) upon appeal of an adverse benefit determination (or a final internal adverse benefit determination) to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. ***This includes documents with comparative information on medical necessity criteria for both medical/surgical benefits and MH/SUD benefits, as well as the processes, strategies, evidentiary standards, and other factors used to apply an NQTL with respect to medical/surgical benefits and MH/SUD benefits under the plan.*** Additionally, employers and issuers sometimes contract with Managed Behavioral Health Organizations (MBHO) or similar entities to provide or administer MH/SUD benefits under the plan or coverage. The preamble to the MHPAEA final regulations clarifies that the coverage as a whole must still comply with the applicable provisions of MHPAEA, and the responsibility for compliance rests with the group health plan and/or the health insurance issuer, depending on whether the coverage is insured or self-insured. ***This means that the plan or issuer will need to provide sufficient information in terms of plan structure and benefits to the MBHO to ensure that the MH/SUD benefits are coordinated with the medical/surgical benefits for purposes of compliance with the requirements of MHPAEA.***")

Also, see 42 C.F.R. 438.404(b)(2), which requires adverse benefit determinations by MCOs administering Medicaid plans to provide "[t]he reasons for the adverse benefit determination, ***including the right of the enrollee to be provided*** upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the enrollee's adverse benefit determination. Such information includes medical necessity criteria, and ***any processes, strategies, or evidentiary standards used in setting coverage limits.***"

23. See footnote 19.