PROTECTING CONSUMER ACCESS TO MENTAL HEALTH AND ADDICTION CARE IN MANAGED MEDICAID PLANS

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MENTAL HEALTH FIRST AID
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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.

The potential confusion regarding the Mental Health Parity and Addiction Equity Act compliance requirements for Managed Care Organizations ("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. It is imperative that states negotiating Medicaid contracts with MCOs make use of new safeguards and mental health and addiction parity protections to ensure access to essential services for vulnerable populations.[1] This includes empowering providers to effectively challenge adverse benefit determinations impacting their patients' access to medically necessary care.

Key Terms (subject to State Medicaid Plan-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 health care organization

Provider = Individual, group, or facility providing clinical services

State = Director or department with Medicaid plan oversight

Managed care contracts can help clarify the rights, expectations, and responsibilities of states, MCOs, and patients (and their authorized representatives, including providers). To ensure beneficiaries receive timely and appropriate care, the following safeguards and processes for claims and appeals of denied mental health and addiction care should be considered by states negotiating contracts with MCOs that administer Medicaid plans. The analysis and recommendations contained herein are solely for educational purposes, and as such, do not constitute legal advice. Ultimately, whether and how states incorporate the following considerations into their managed care contracts should be decided in consultation with qualified legal counsel.[2]

1. COMMUNICATIONS

(A) Discussion

Since recently enacted Medicaid regulations require that appeals of adverse benefit determinations must be confirmed in writing (except in urgent circumstances), all MCOs should be prepared to handle written communications with members, providers, and authorized representatives via expeditious methods, including email/web-based portals and fax. MCOs should also be prepared to process all urgent and non-urgent appeals-related inquiries via the same expeditious methods as actual appeals. As discussed in sections 4, 7, and 8, below, appeals-related inquiries can encompass requests for data such as clinical criteria, claims files, and mental health and addiction parity analyses. Appeals-related inquiries are therefore not the same as actual appeals. Rather, appeals-related inquiries enable patients and providers to obtain information so as to submit meaningful appeals. Because appeals-related inquiries may seek data for purposes of either urgent or non-urgent appeals, appeals-related inquiries must be responded to pursuant to urgent and non-urgent timeframes.[4]

1. This discussion is limited to adverse benefit determinations implicating medical necessity, network adequacy, and mental health and addiction parity. As a general rule, the right to appeal only arises after an "adverse benefit determination" is issued by an MCO. See 42 C.F.R. §438.400(b), applicable to managed Medicaid plans.

2. Collaboration with qualified counsel is especially recommended since the analysis contained herein is based on federal requirements, which set a due process floor, and cannot account for state law variations. Additionally, changes to laws and regulations could significantly alter the analysis and recommendations contained herein.

3. *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 . . . (3) Provide that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed ***in writing***, unless the enrollee or the provider requests expedited resolution.")

4. While providers are entitled to designate appeals as "urgent" pursuant to 42 C.F.R. §438.410(a)(1), MCOs are also permitted to override such designations pursuant to 42 C.F.R. §438.410(c). *See* 81 Fed. Reg. 27498, 27519 (May 6, 2016) ("Finally, we decline to add requirements to prohibit managed care plans from overriding the decision of a health care provider in requesting an expedited resolution.") Nonetheless, states should prohibit MCOs from overriding appeals-related inquiries deemed "urgent." Of course, states should also obligate MCOs to track and report all rationales for overriding designations of urgent appeals.

(B) Proposed contract terms

1. ***MCO shall conspicuously display, both on its public website and in all written communications with members and providers, the following contact information:***

   - Email and/or web-based portal for appeals-related inquiries (i.e., urgent and non-urgent requests for patient claims files, mental health and addiction parity analyses) and actual appeals;
   - Fax number for appeals-related inquiries (i.e., urgent and non-urgent requests for patient claims files, mental health and addiction parity analyses) and actual appeals.

2. ***MCO shall provide the State, at a frequency established by the State, with all relevant metrics regarding the:***

   - Availability of its electronic and fax communication systems in any given reporting period; and
   - Turnaround times for processing appeals-related inquiries and actual appeals received through electronic and fax communication systems, categorized (at a minimum) by appeal-related inquiry (i.e., urgent v. non-urgent requests for (a) patient claims files, (b) mental health and addiction parity analyses, etc.) and actual appeal type (i.e. urgent v. non-urgent).

2. STANDING

(A) Discussion

Without standing, providers lack legal authority to act on behalf of their patients with respect to claims and appeals despite generally being the parties best suited to so. While some jurisdictions and managed care contracts afford separate appeal rights to patients and providers (and thereby confer standing), some do not. Though 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,[5] 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.[6] Therefore, in jurisdictions that permit providers to act as authorized representatives, MCOs should be required to support the ability of providers to effectively advocate on behalf of patients by streamlining the use of uniform consent forms.

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

5. *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.*")

6. *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).")

(B) Proposed contract terms

1. ***With respect to all Medicaid plans administered by MCO, MCO shall permit providers to act as authorized representatives for appeals of adverse benefit determinations, as permitted by State law and pursuant to written patient consent.***[7]

2. ***MCO shall be required to accept the following State-approved forms, which shall be conspicuously posted on MCO's public website and made available through other means upon request:***

   - Authorized representative form verifying patient consent to providers: (a) appealing adverse benefit determinations; and (b) receiving protected health information, including claims files, from MCO;
   - Continued benefits-pending-appeals form for execution by patients and/or their non-provider authorized representatives.[8]

3. ACCESS TO PLAN DOCUMENTS

(A) Discussion

Since 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 require MCOs to provide vital documents to their members subsequent to enrollment.[9] The provision below ensures that authorized representatives and providers (even not acting as authorized representatives) have the same access to plan documents as patients. It is important to note 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.[10]

(B) Proposed contract terms

MCO shall conspicuously post complete health plan documents (and, where not contained in the health plan documents, network adequacy standards) on its public website. MCO must also make such documents available within 24 hours by email, fax, or mail (as requested) by patients, authorized representatives, and providers.[11]

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7. In light of the May 6, 2016 Medicaid Final Rule's (*see* 81 Fed. Reg. 27498) silence regarding prior authorization standards for services other than prescription drugs, it is presumed that providers have authority to request *initial* prior authorization of services on behalf of their patients, subject to State law time frames (for urgent and non-urgent *initial* prior authorization requests).

8. *See* 42 C.F.R. §438.402(c)(1)(ii). 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. Only patients and their (non-provider) authorized representatives may request continuation of benefits pending appeals. See 42 C.F.R. §438.420(b)(5). Nonetheless, states may elect to assign the ultimate financial responsibility for benefits paid pending even ultimately unsuccessful appeals to MCOs.

9. *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).")

10. Because 45 C.F.R. §147.200(a)(2)(J) requires a summary of benefits and coverage to include ***"an Internet web address where a copy of the actual individual coverage policy or group certificate of coverage can be reviewed and obtained,"*** and because 42 C.F.R. §438.10(g)(2)(xvi) provides that states may require enrollee handbooks to include "any other content" not enumerated in 42 C.F.R. §438.10, states should require that enrollee handbooks include ***all*** material terms of coverage such as a definition of medical necessity, reference to any specific, State-mandated clinical guidelines that MCOs must apply, and network adequacy and access standards.

11. Because these documents do not contain any Protected Health Information ("PHI"), there is no justification for MCOs to require providers to either be authorized representatives or to obtain patient consent to receive them. *See* 81 Fed. Reg. at 27724. ("There is nothing in § 438.10 that prevents a state from imposing a specific timeline on their managed care plans. Additionally, we believe with the use of electronic communications proposed elsewhere in § 438.10, the distribution of information will occur very quickly, oftentimes on the same day.")

4. ACCESS TO CLINICAL CRITERIA

(A) Discussion

It is imperative that patients, authorized representatives, and providers (even when not acting as authorized representatives) have ready access to all clinical criteria pursuant to which MCOs evaluate services for medical necessity, both initially and on appeal of adverse benefit determinations. Federal regulations clearly require that clinical standards used by MCOs to adjudicate claims and appeals must be disclosed – even if they are proprietary.[12] Many national MCOs now post their clinical criteria on periodically updated public 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 determination.[13]

(B) Proposed contract terms

1. ***If MCO does not conspicuously post all its medical necessity criteria on its public website, it shall make its relevant medical necessity criteria immediately available through email, fax, or mail upon request. MCO shall have a continuing obligation to produce any new, revised, or updated clinical criteria to contracted providers within 7 calendar days of adopting such criteria.***

2. ***States wishing to further mitigate against the risks of MCOs applying proprietary and/or inadequate medical necessity criteria for behavioral health may consider adding:***

   - For all mental health disorders, MCO shall be required to exclusively apply the most recent versions of the Child and Adolescent Level of Care Utilization System ("CALOCUS") and Level of Care Utilization System ("LOCUS");

   - For all substance use disorders, MCO shall be required to exclusively apply the most recent criteria published by the American Society of Addiction Medicine ("ASAM").

12. *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.")

Finally, see 81 Fed Reg. at 27752 (May 6, 2016)("§438.236(c) requires each managed care plan to disseminate practice guidelines to all affected providers, and upon request, to enrollees and potential enrollees. We do not expect managed care plans to disseminate all of their practice guidelines widely (such as through public posting on a Web site), but we do expect that managed care plans make specific practice guidelines available to the applicable network providers (or out-of-network providers to whom the plan refers enrollees for covered services) for which such practice guidelines apply. We believe this is consistent with the general concept of having practice guidelines and assisting health care professionals to apply the best evidence-based practice to clinical care.")

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

5. NETWORK ACCESS

(A) Discussion

To ensure beneficiaries receive medically necessary care in a timely manner, especially when alternative services recommended by MCOs may not be suitable (i.e., because they service a particular adult rather than adolescent population) or unavailable (i.e., due to waiting lists), states should preclude MCOs from: (1) not promptly approving pre-service requests[14] or (2) issuing adverse benefit determinations for ongoing care unless MCOs can confirm actual availability of alternative (pre-approved) services, subject to state-mandated adequacy, timeliness and geographic access standards. For example, if an MCO proposes partial hospitalization in lieu of residential treatment as step-down care from hospital detoxification, then the MCO should be required to identify the exact partial hospitalization program(s) both suitable and available to admit the patient, subject to time and distance parameters set by the State (i.e., immediately in urgent cases, within 15 miles of the patient's home, and with sufficient expertise to treat the identified problem).

(B) Proposed contract terms

1. ***MCO shall approve all pre-service requests, including those that must be offered out-of-network, when it cannot secure either the requested or MCO-recommended services within the adequacy, timeliness, and geographic standards, subject to the prior authorization time frames (for urgent and non-urgent requests) established by the State.***

2. ***MCO shall not issue an adverse benefit determination for ongoing care without also confirming in writing (via email or fax) the actual availability and suitability of the proposed alternative service, subject to the adequacy, timeliness, and geographic access standards established by the State. If the alternative service proposed by MCO does not satisfy the State's adequacy, timeliness, and geographic access standards, MCO shall continue to approve ongoing care, even if such services must be offered out-of-network and at a higher level than recommended by the MCO.***

3. ***MCO shall provide the State, at a frequency set by the State, with all relevant metrics regarding its network adequacy and all approvals of pre-service (urgent and non-urgent) requests and ongoing care (categorized by service type and whether provided in- or out-of-network) due to adequacy, timeliness, and geographic mandates.***

6. NEGOTIATED COVERAGE MODIFICATIONS

(A) Discussion

MCOs routinely encourage providers to accept less than the full amount of requested (prescribed) services. This practice is often referred to as "modifying" requests for coverage and is particularly common when intensive services are requested (i.e., hospitalization, residential treatment, partial hospitalization, intensive outpatient treatment). For example, providers requesting coverage for x units of treatment are often asked to accept y units instead. By engaging in coverage request modifications, MCOs effectively deny the full course of coverage that providers deem to be medically necessary and approve only a fraction of the requested care (at least until a concurrent review, often

14. The May 6, 2016 Medicaid Final Rule does not establish prior authorization time frames for services other than prior authorization requests for prescription drugs. States must therefore establish such time frames commensurate with the requested service type (urgent v. non-urgent).

prematurely conducted when coverage requests are modified). By modifying initial coverage requests, MCOs are able to report lower denial rates, incur reduced administrative costs, and potentially deny patients due process by not issuing adverse benefit determinations subject to appeal rights.

(B) Proposed contract terms

1. ***With respect to any claim for coverage that MCO modifies, MCO shall issue an adverse benefit determination for the unapproved portion of the claim and shall provide required appeals rights.***

2. ***MCO shall provide the State, at a frequency set by the State, with all relevant metrics regarding coverage modifications and shall count unapproved portions of modified claims as adverse benefit determinations for purposes of statistical data.***

7. 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.[15]

(B) Proposed contract terms

1. ***Pursuant to written requests from patients or providers acting as authorized representatives, MCO shall transmit (via email or fax, as requested) complete claims files (including all case management, utilization review, and appeals notes) within 24-hours for any expected appeals of adverse benefit determinations deemed "urgent" by either MCO or providers. With respect to all expected appeals not deemed "urgent" by either MCO or providers, MCO shall make complete claims files accessible by email, fax, or hard copy (as requested) within (TBD) calendar days.[16]***

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15. *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. at 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.")

16. *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.") Since MCOs must generally adjudicate urgent appeals within 72 hours of their receipt (unless extending the time frame must be extended in patients' interests), and since managed Medicaid plans must provide patients only 60 days in which to appeal initial adverse determinations, it is important that necessary information (like claims files) be furnished well in advance of any appeals deadlines or urgent timeframes.

2. ***MCO shall conspicuously post claims file access forms on its public website and shall make these forms available through other means upon request. These forms shall be in addition to any State-approved authorized representative forms for providers.***

3. ***MCO shall provide the State, at a frequency set by the State, with all relevant metrics regarding turnaround times for producing claims files related to expected urgent and non-urgent appeals.***

8. 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.[17] Therefore, in cases in which mental health or addiction parity violations are suspected, it is imperative that providers have prompt access to mental health parity analyses that health plans are required to undertake to achieve and maintain compliance.[18] 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, regardless of whether the MCO or the State is responsible for undertaking the analyses.***

2. ***Pursuant to (verbal or written) requests from patients or providers acting as authorized representatives, MCO shall electronically transmit all requested mental health and addiction parity analyses within 24-hours for any expected appeals of adverse benefit determinations deemed "urgent" by either MCO or providers. With respect to all expected appeals not deemed "urgent" by either MCO or providers, MCO shall electronically transmit all requested mental health and addiction parity analyses within (TBD) calendar days.***

3. ***MCO shall provide the State, at a frequency set by the State, with all relevant metrics regarding turnaround times for producing mental health and addiction parity analyses related to expected urgent and non-urgent appeals.***

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17. *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.

18. *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.***"

9. PENALTIES FOR MCO NON-COMPLIANCE

Ultimately, the above safeguards are of limited value in the absence of consequences for their breach. To monitor MCO compliance, states should require MCOs to provide complete, accurate, and timely metrics with respect to each of the points discussed above.

While recently enacted Medicaid rules provide that patients may initiate State fair hearings when MCOs fail to adhere to notice and timing requirements,[19] and while states may elect to offer external medical reviews that are independent of the states and MCOs,[20] additional enforcement strategies may be warranted. These may include contractual provisions for automatic reversals of adverse benefit determinations for violations of due process (including failing to adjudicate appeals and failing to provide requested appeals-related data within State-established timeframes), with MCOs bearing the full costs of providing the disputed services. States may also wish to contractually allow for third party beneficiary clauses that permit patients to directly sue MCOs in lieu of suing the states hiring them.

Additionally, states may elect to assign MCOs the ultimate financial responsibility for payment of continued benefits pending appeals, even if ultimately decided against patients. See 81 Fed. Reg. at 27518. ("We decline to assign, at the federal level, the financial liability on the enrollee or the managed care plan for services furnished while the appeal is pending, including in the context of the 14 calendar day extension. Consistent with the notice requirements at §§ 438.404(b)(6) and 438.408(e)(2)(iii), and the requirements specified at § 438.420(d), enrollees may be held responsible or may be required to pay the costs of these services, consistent with state policy. Such requirements must be consistently applied within the state under both managed care and FFS, as specified at § 438.420(d).") Also see 42 C.F.R. §438.420(d) ("If the final resolution of the appeal or state fair hearing is adverse to the enrollee, that is, upholds the MCO's, PIHP's, or PAHP's adverse benefit determination, the MCO, PIHP, or PAHP may, consistent with the state's usual policy on recoveries under § 431.230(b) of this chapter and as specified in the MCO's, PIHP's, or PAHP's contract, recover the cost of services furnished to the enrollee while the appeal and state fair hearing was pending, to the extent that they were furnished solely because of the requirements of this section.")

States that elect to offer external medical reviews as a voluntary option following internal appeals (or deemed exhaustion thereof) must be mindful that external medical review organizations are not conflict-free if they maintain any contractual relationships with MCOs in the commercial markets, if MCOs have any authority to choose them, or if MCOs are permitted to directly interact with them. External medical review organizations that lack technical sophistication and the ability to adjudicate mental health and addiction parity or due process violations (using legal rather than only medical experts) are also unsuitable. Thus, while the external medical review process has the potential to streamline appeals, reduce administrative delays (particularly in urgent cases), and curb costs associated with State fair hearings, external medical review organizations with private market contracts (such as those organizations adjudicating outsourced internal appeals for commercial payers or those organizations with direct MCO contracts for self-funded external appeals) may be incapable of exercising true independence, regardless of any non-conflict affirmations that they may issue to the contrary.

Questions? Contact Rebecca Farley, Vice President, Policy & Advocacy, National Council for Behavioral Health at **RebeccaF@TheNationalCouncil.org**

19. See 42 C.F.R. §438.408(c)(3)("In the case of an MCO, PIHP, or PAHP that fails to adhere to the notice and timing requirements in this section, the enrollee is deemed to have exhausted the MCO's, PIHP's, or PAHP's appeals process. The enrollee may initiate a State fair hearing.")

20. See 42 C.F.R. §438.408(f)(1)(ii).