



MASSACHUSETTS
MEDICAL SOCIETY

*Every physician matters,
each patient counts.*



September 28, 2012

Kevin Beagan
Deputy Commissioner and Director of the State Rating Bureau
Massachusetts Division of Insurance
1000 Washington Street
Boston, MA 02118

Re: Joint Provider Comments on Implementing Chapter 224 of the Acts of 2012 provisions related to Mental Health Parity (Section 23 & 254)

Dear Mr. Beagan:

On behalf of our respective members, the Massachusetts Hospital Association (“MHA”), the Massachusetts Association of Behavioral Health System (“MABHS”), the Massachusetts Medical Society (“MMS”), the Massachusetts College of Emergency Physicians (“MACEP”), and the Massachusetts Psychiatric Society (“MPS”) jointly request that the Division of Insurance (Division) consider the following comments with regard to implementing Sections 23 and 254 of Chapter 224 of the Acts of 2012.

Sections 23 and 254 specifically require the Division of Insurance to implement and enforce the federal *Mental Health Parity and Addiction Equity Act (MHPAEA)*¹, section 511 of Public Law 110-343, and applicable state mental health parity laws through: (1) establishing regulations applicable by January 1, 2013, and (2) continually monitoring and enforcing commercial insurers’ compliance with parity and regulations through annual reports, audits, and public hearings.

We jointly commend the Division for taking an active role prior to the passage of Chapter 224, by auditing and reviewing commercial health plans activities related to complying with *MHPAEA*. We applaud these efforts and implore the Division to continue its work through implementing, monitoring, and enforcing Sections 23 and 254 of Chapter 224.

During its special hearing held on September 19th, the Division had requested from interested stakeholders comments regarding the: (1) process; (2) priorities; and (3) enforcement consistent

¹ Pub. L. No. 110-343 §§ 511 – 12, 122 Stat. 3765, 3881 – 93 (Oct. 3, 2008).

with federal and state parity laws/guidance. While we comment below on each of those items, it is important that we also request that any enforcement pay particular attention to the Division's authority under both Sections 23 & 254 of Chapter 224. From the provider's perspective, we are providing comments on those areas within this letter. However, at the outset, we wish to reiterate two priority goals that the Division must make clear in regulations and any subsequent bulletins:

- (1) To obtain true parity, all plans must ensure that the medical necessity criteria (such as pre- and post-utilization review and prior authorization criteria for emergent and urgent level services as determined by the treating healthcare provider) **must be no more restrictive for behavioral health patients than for medical-surgical patients;** and
- (2) Pursuant to the authority provided for under Sections 23 & 254 of Chapter 224 as well as recognized case law, the Division must make it clear that *MHPAEA* must apply to all commercial insurers **including group health plans, small group health plans, and self-funded plans.**

1) Medical Necessity Criteria and Application to Health Plans

To implement *MHPAEA*, the Division of Insurance must ensure that medical necessity criteria, including use of (a) prior authorization as well as (b) pre/post-utilization reviews for emergent and urgent, are no more restrictive for behavioral health patients than for medical-surgical patients. We discuss both of these issues in further detail below.

It is a top priority for hospitals and physicians that the Division addresses these inequities in medical necessity review criteria. To implement true parity and abide by the intent of Chapter 224 and *MHPAEA*, there must be equal access to care for both behavioral health and medical-surgical patients. In order to do so, the Division must make apparent in its regulations and through its continued monitoring and enforcement of the law that differences in medical necessity criteria and prior authorization requirements for behavioral health and medical-surgical patients will not be tolerated.

The *Mental Health Parity and Addiction Equity Act* requires commercial insurers and their contractors, including group health plans and health insurance insurers, to treat behavioral health patients (those suffering from mental health and/or substance abuse conditions) no more restrictively than medical-surgical patients.² *MHPAEA* further mandates that plans shall not place more restrictive financial or treatment limitations on behavioral health benefits than those applied to medical-surgical benefits. Treatment limitations include both quantitative (e.g., frequency of treatment, number of visits, days of coverage etc.) and non-quantitative limitations (e.g., medical management standards, formulary design, and plan methods for determining usual, customary, and reasonable charges etc.).³

Currently such parity does not exist in Massachusetts with respect to inpatient or outpatient care for behavioral health services. Commercial health plans continue to require more strict criteria for behavioral health patients in regards to medical necessity criteria than for medical-surgical patients. In particular, insurers require behavioral health patients to obtain prior authorization for care over and above what is required for medical-surgical patients.

² Pub. L. No. 110-343 §§ 511 – 12, 122 Stat. 3765, 3881 – 93 (Oct. 3, 2008).

³ See 29 CFR 2590.712(c); 29 CFR 2590.712(c)(4).

- (a) *Prior Authorization requirements for behavioral health patients who need emergent and urgent level services as determined by the treating healthcare provider are in violation of MHPAEA. The regulations should specifically mention key terms such as prior authorization in any prohibition as outlined in the federal MHPAEA law and the federal Department of Labor guidance.***

Such requirements for prior authorization are seen time and time again in Emergency Departments throughout the Commonwealth where behavioral health patients have waited up to 15 days to obtain access to inpatient care. A portion of these long waits are due to insurers inequitable prior authorization requirements; such obligations are placed on behavioral health patients but not medical-surgical ones.

A real-life example portrays the notable differences in policies for behavioral health and medical-surgical patients.

On Friday August 3, 2012, Mr. S, suffering from severe bipolar decompensation including aggressive behavior, entered the Emergency Department at his hospital. His providers recommended inpatient psychiatric care. Due to a variety of circumstances, including a lack of beds, it took the hospital's social worker four days to secure Mr. S a bed at a psychiatric hospital. Once a bed was found, the social worker attempted to obtain prior authorization from the commercial insurer's behavioral health carve-out. The social worker spoke with a case manager who informed the social worker that the case would have to go to a "doctor-to-doctor" review – an appeal that occurs when the initial authorization for care is denied. The review was to occur the following day. The social worker tried to explain that delaying the review would mean the loss of the inpatient bed that had taken four days to secure, but the insurance company did not relent. The social worker continually attempted to move up the review, but ultimately they had to wait until the next day and lost the bed. It took another 24 hours to obtain prior authorization and a final 6 hours to obtain a bed.

Medical-surgical patients are not put through these reviews. If Mr. S had come into the Emergency Department suffering from a heart attack, he would have been assessed, admitted, and treated immediately. There would have been no need to obtain prior authorization for his care. Rather, the hospital is simply required to notify the carrier. The medical necessity of his care would have been clear and inarguable. There would be no need to call insurers, no concern that outpatient care would be suggested as an alternative, and no issue that, on post-utilization review, the provider's decisions would have been challenged.

This inequity is not parity and is not in line with MHPAEA or Chapter 224. Under Chapter 224, the Division is obligated to implement and enforce parity and must do so by eliminating prior authorization for behavioral health patients for emergent and urgent level service as determined by the treating provider.

- (b) *Medical necessity criteria for behavioral health services must be made available, upon request, to any current or potential participant, beneficiary, and provider. In addition, pre/post-utilization reviews (the use of "prior authorization in disguise") and lack of medical necessity criteria for inpatient and outpatient care***

for behavioral health patients and services are violations of *MHPAEA* and must be prohibited. Medical necessity criteria, including but not limited to pre- and post-utilization review as well as prior authorization, for behavioral health patients for inpatient and outpatient care must not be applied more restrictively than for medical-surgical patients.

The obligation of prior authorization is not confined to the Emergency Department and inpatient care. Behavioral health patients are continually required to go through prior authorizations for outpatient services as well. While medical-surgical patients may have to undergo prior authorization for outpatient care, the two are not equivalent. When such obligations are imposed on medical-surgical patients for outpatient services or other non-emergency-based care, there exists a better understanding and more apparent set of criteria issued by the plans that must be met. Such clarity makes it much easier for providers to work with insurers and the patient to obtain needed care in a timely manner. For example, physical therapy services and x-rays are often cited as comparable to inpatient psychiatric care access because prior authorizations may be required for such medical-surgical services. However, these categories do not equate to one another; requirements for obtaining physical therapy and x-rays are simple steps that are clear cut and available to providers and patients before they even need such services. Additionally, oftentimes such services are not needed on an emergency or urgent basis, and in some cases patients may be able to wait the time it takes for an insurance review; this is not the case for behavioral health patients needing outpatient psychiatric care or psycho-pharmaceutical prescriptions that need to be filled before the patient leaves his or her current visit. These patients are experiencing acute-level symptoms that may not warrant an inpatient admission, but if left untreated while waiting for an insurance review will result in an inpatient admission.

For behavioral health patients who also need to access continued inpatient level care, things do not exist in black and white. While providers can diagnosis and define behavioral health conditions and can undoubtedly determine the need for inpatient psychiatric care, insurance guidelines or medical necessity criteria for such services are not so readily accessible. The lack of availability of guidelines makes it extremely difficult to prove medical necessity documentation or determinations to insurers when attempting to gain access for behavioral healthcare – both on the inpatient and outpatient side. Prior authorization requirements are abundant, but little information is given to providers on exactly what diagnosis meets the insurer's test to gain admittance. If providers do not seek prior authorization, they risk forgoing payment as post-utilization review guidelines are just as elusive.

Even when it appears that prior authorization or pre-utilization reviews are not required for behavioral health patients initially, it is often disguised in the form of post-utilization reviews, which providers often refer to as “prior authorization in disguise.” In such a scenario, insurers do not deny services through any pre-utilization review, but routinely deny services retroactively without any details or discussion as to the reasons, other than the provided care was “not medical necessary,” thereby placing the patient and the provider at enormous financial loss. In reality, the insurers are continuing to utilize prior authorization and pre-utilization reviews but disguising it on post utilization review. Such tactics are not utilized on the medical-surgical side. To guarantee true parity, the Division must require access to medical necessity criteria and the reasonable interpretation of such criteria to protect against the practice of “prior authorization in disguise.”

Under Chapter 224, insurers are required to make medical necessity guidelines available either on their websites or, if proprietary, to individuals upon request. While this is an important step, it will not take effect until October 2015. The Division, however, in implementing Sections 23 & 254 has an obligation to go further and act now. True mental health parity as required under Sections 23 and 254 would require medical necessity criteria for behavioral health patients to be no more restrictive than as for medical-surgical patients. *MHPAEA* further requires that health insurers make available the criteria for medical necessity determinations for behavioral health services to any current or potential participant, beneficiary, or contracting provider upon request.⁴ Thus to guarantee parity under the state law and the federal *MHPAEA* provisions, medical necessity criteria for behavioral health patients must be readily accessible to patients and providers upon request.

2) To adhere to the plain meaning and intent of Sections 23 & 254 of Chapter 224, the Division of Insurance must require all commercial health plans, including group health plans for large and small employers, and self- and fully-funded plans to adhere to the federal and state mental health parity requirements.

The legislature in passing Chapter 224 clearly stated and intended for all carriers and their contractors in Massachusetts to be required to implement and abide by federal and state mental health parity laws. Section 23 clearly notes “the commissioner of insurance may implement and enforce applicable provisions of the federal Mental Health Parity and Addiction Equity Act . . . and applicable state mental health parity laws . . . *in regard to any carrier licensed under chapters 175, 176A, 176B, and 176G* (emphasis added). Furthermore, Section 254 states that “the commissioner of insurance shall promulgate regulations requiring *any carrier, as defined in section 1 of chapter 176O of the General Laws, and their contractors* to comply with and implement the federal Mental Health Parity and Addiction Equity Act . . . and applicable state mental health parity laws...” (emphasis added).

This clearly provides in writing that all carriers and their contractors are subject to the requirements of federal and state mental health parity laws. Furthermore, the intent of the legislature to capture all carriers, including those with large- and small-group health plans and limited number of employees, is apparent in the legislative history of Chapter 224. In the final House version (HB 4155) of the payment and delivery reform bill advocates were concerned that the provisions regarding mental health parity did not include all carriers. To make certain that all plans were obligated to follow the law, Section 223 was added to capture all carriers. This Section remained in the final version of the combined House and Senate bill and now appears in Section 23 of Chapter 224. Furthermore, the underlying intent of the legislature in implementing mental health parity was to guarantee that all behavioral health patients had equal access to care as their medical-surgical counterparts. It was never the intent to exclude patients by allowing certain carriers with particularly sized group plans to be exempt from the law.

We believe a clear reading of Section 23 of Chapter 224 states that the Division may implement and enforce “applicable” provisions of *MHPAEA*, as well as “applicable” provisions of state mental health parity laws, in regard to any insurance carrier licensed under state law. The use of the word “applicable” is meaningful. Applying the plain meaning of the word, *MHPAEA* provisions are “applicable” to those plans that are subject to, and not exempt from, *MHPAEA*. Thus, Section 23 of the Acts can reasonably be read to mean that the Division may enforce the

⁴ See 29 C.F.R. 2590.712(d)(2).

provisions of *MHPAEA* with respect to those plans to which *MHPAEA* provisions are not applicable, *i.e.*, plans that are exempted from *MHPAEA*.

Importantly, however, Section 254 also goes on to state that “Notwithstanding any general or special law, or rule or regulation to the contrary,” the commissioner shall promulgate regulations requiring any carrier and their contractors to “comply with and implement” *MHPAEA*, as well as “applicable” state mental health parity laws. Noticeably absent is the word “applicable” when used in connection with *MHPAEA*. Because the word “applicable” is used in Section 23 generally, but only used in connection with state parity laws in Section 254, the absence of the use of that term with respect to compliance and implementation of *MHPAEA* has legal meaning.

The well established position of Massachusetts courts when interpreting a statute is that “none of its words [are] to be regarded as superfluous. Rather, a statute should be construed to avoid rendering its words meaningless.” *Town of Milford v. Boyd*, 752 N.E.2d 733, 735 (2001) (citing *Commonwealth v. Super*, 727 N.E.2d 1175, 1180-81 (2000) and *Commonwealth v. Wade*, 360 N.E.2d 867, 870 (1977); *see also Board of Appeals of Hanover v. Housing Appeals Comm. In the Dep’t of Community Affairs*, 294 N.E.2d 393, 412 (1973) (“Our construction of the statute must be made ‘upon the whole statute, [so] that no clause, sentence or word shall prove superfluous, void or insignificant, if, by any other construction they may all be made useful and pertinent.’”) (quoting *Commonwealth v. McCaughey*, 9 Gray 296, 297 (1857)). Massachusetts courts have also applied this construction to ambiguous or poorly worded statutory amendments if “a coherent meaning can be gleaned from the amendment’s language,” in order to avoid an interpretation which ignores a portion of the amendment. *The Risk Mgmt. Found. Of the Harvard Med. Institutions, Inc. v. Comm’r of Ins.*, 554 N.E.2d 843, 846 (1990).

Accordingly, we strongly believe the best reading of Section 254 is that state regulations should require that all carriers and their contractors comply with and implement *MHPAEA*, even if *MHPAEA* would not otherwise apply. In addition, Section 254 by its terms overrides any other law that may be contrary. As such, carriers that are normally able to issue policies exempted from *MHPAEA* should be required to comply with *MHPAEA* by virtue of Section 254 and the forthcoming regulations.

Furthermore, states have the right to enact laws that are more restrictive and go further than the federal law. The Supremacy Clause of the Constitution states that federal law is the law of the land and trumps state law where there is conflict between the two. However, where a state law builds on the federal law and is more stringent, then no pre-emption problem exists and these actions are allowable. Such is the case with Chapter 224.

Finally, there is no question that all contractors as well as behavioral health carve-out companies must abide by this law. Section 254 clearly mentions “any carrier . . . and their contractors.” Furthermore, at the Division’s Special Session on September 19th, it was asked whether carve-outs fell under the law, to which the Division replied that it did. This should also be readily apparent in the regulations.

3) Processes:

The majority of the processes that we have commented on thus far can be found in the abovementioned section of “Priorities,” specifically medical necessity criteria. It is imperative that changes to medical necessity criteria be made; please reference the aforementioned section for further guidance on such changes. In addition to guidance on the processes of medical necessity criteria, regulations should focus on the process of educating consumers and providers

and following the implementation of regulations the Division should seek to issue joint bulletins to aid in comprehension and compliance with the law.

(a) In order to better understand the behavioral health system and implement parity regulations, the Division should complete its current audit and share results with providers and other interested parties before the issuance of regulations by January 1, 2013.

Prior to the issuance of regulations, we implore the Division to finish and streamline its current audit of the nine commercial health plans. During the September 19th session, the Division mentioned how it intends to use its audit to gain a better understanding of the plans' current processes and actions regarding behavioral health. However, the Division was unsure of whether this information would be gathered and analyzed prior to the January 1, 2013 regulation deadline. While we understand the difficulties in completing the audit and analysis within such a short timeframe, we highly encourage the Division to strive for a timely conclusion of the study in order to best influence the regulations. Furthermore, we request that the Division allow providers and other interested parties to review the study prior to the issuance of regulations. By allowing for such a review, the Division will not only promote transparency and openness as encouraged by the state, but also gain a better understanding of current processes and practices in the Commonwealth. It is important that the regulations on this important issue include any lessons learned or requirements expected of the plans based on this important study.

(b) Carriers must educate members regarding their rights on mental health parity under Chapter 224.

All carriers must be required as part of their education of members of the plan/policy to provide clear notice of how the member has access to mental health services in compliance with Sections 23 & 254 of Chapter 224. All plans currently provide through their own materials or working jointly with the employers a comprehensive set of materials that outline the rights, obligations, and coverage of services provided by a specific policy or plan. To meet the overall goal of Chapter 224, which is to ensure patients and citizens of the Commonwealth are provided information about the level of services that are available to them, the Division must ensure that members are receiving information about the availability of behavioral health services.

(c) The Division should work with its sister agencies to issue joint bulletins following the regulations to further help understand and implement the law.

We further urge that following the implementation of regulations, the Division work jointly with its sister agencies to issue bulletins to aid in the comprehension and compliance of Chapter 224 in relation to parity.

During the Division's Special Session on September 19th, the Division made clear that the regulations would not be able to discuss specific services, diagnosis, or level of care provided by any one hospital or provider that compares every single behavioral health verse medical-surgical service. While we understand that the regulations may not provide such specific level of medical treatment or diagnosis, it is appropriate to issue bulletins following regulations to help clarify examples of cases or scenarios that should be prohibited due to the federal and state law. Furthermore, as the Division under Sections 23 & 254 has the authority to implement the law, it has the authority to issue such bulletins.

The Division has repeatedly noted that the detail is far more complex than it is familiar with. However, to ensure that provider, patients, and policy-level issues are addressed, it is very important that the Division consult with the Office of Patient Protection, the Department of Mental Health, the Department of Public Health, the Executive Office of Health and Human Services, and MassHealth. We also believe that the Division should take the lead to develop an interagency working group of dedicated staff from the five agencies whose duties should include monitoring plans' (public and private) compliance with *MHPAEA*. Further, we strongly urge that any bulletin be issued jointly by the above agencies to ensure that the issues are addressed similarly across all health insurance programs, both public and private. In the past, the Division and other agencies have issued bulletins in regards to the passage and implementation of the state mental health parity law, which were crucial in the understanding and implementation of the law. Such bulletins will again be extremely useful here and are necessary for implementation of Chapter 224.

As outlined by Health Law Advocates, it is very important that the Division include at a minimum the following elements to any bulletin:

- (1) An explanation of federal parity requirements for fully-insured plans, using language from the federal regulations and sub-regulatory guidance;
- (2) Steps that carriers must take to comply with the state and federal parity laws;
- (3) A requirement that carriers send a notice to the insured explaining their rights under the state and federal parity laws, and include this same information in all subsequent notifications of the denial of claims by carriers (see below for additional detail); and
- (4) Reporting requirements for carriers

4) Enforcement of Sections 23 & 254 of Chapter 254 – State Plans, Meetings, and Examinations:

The Division requested stakeholders' comments regarding how it should undergo enforcing Sections 23 & 254 of Chapter 224. At the outset, it is imperative to note that Chapter 224 gives the Division outright, broad authority to enforce applicable provisions of *MHPAEA* as well as state mental health parity laws.⁵ This is a general overall authority that allows the Division to enforce the law as it sees fit. Section 23 simply states that the Commissioner of Insurance may enforce applicable provisions of *MHPAEA* and state mental health parity laws. Further, the Division is given specific authority and is obligated to require all carriers and their contractors to submit annual reports to the Division and to the Attorney General, certifying and outlining how their plans comply with federal and state parity laws. It also gives the Division the right to hold public hearings regarding the annual report.

At the Division's Special Session on September 19th, the Division commented that it foresaw a two-level enforcement role on a: (1) individual and (2) entity-wide level. While we agree with this interpretation of the law, we also feel that there should be a third level of enforcement that could occur on both an individual and entity-wide level.

a) The Division of Insurance must allow for providers, beneficiary/patients, advocates, to appeal directly to the Division when they believe a beneficiary's/patient's rights have

⁵ Section 23 of Chapter 224 of the Acts of 2012 (stating "the commissioner of insurance may implement *and enforce* applicable provisions of the federal Mental Health Parity and Addiction Equity Act . . . and applicable state mental health parity laws" (emphasis added))

been violated in respect to *MHPAEA* or applicable state mental health parity laws. If such a violation is found, insurers must reimburse providers and/or beneficiaries/patients for unreimbursed services or out-of-pocket expenses within 30 days. If a violation is found and services are still needed, a carrier must authorize them immediately. If violations are not corrected, the Division must implement fines and/or penalties.

Under Sections 23 & 254, the Division is required to enforce the provisions of *MPHAEA* and applicable state mental health parity laws. In order to do so, there must be a formal process that allows providers, advocates, and/or patients to bring detailed examples to the attention of the Division for further review and possible action. In addition, when such appeals are made, the Division should stipulate via the regulations and subsequent bulletins that the payers and their contractors must continue benefits during any internal and external appeals. Chapter 224 already includes this as a requirement under the Office of Patient Protection provisions, and this should be the same for any appeal made to the Division for a potential Mental Health Parity violation.⁶

As an example of an applicable and appropriate form, the Division recently developed a form that providers may use to document a specific or general case of coding violations by the plans for the Division to review. Such form included a detailed discussion of the coding problem, how it violated national standards, and also provided information on the provider and when the event occurred. It was signed by a certified coder who could attest to the case. Similarly, the Division should also create a form that allows a provider, advocate, patient to provide a detailed example of where a plan was not providing mental health parity, provide information of the plan and provider impacted, and also have it signed by a provider attesting to the problems or issues that occurred. This would give enough information for the Division to at least start a review to determine if further action is required. We would also request that as part of this process the Division work with the Office of Patient Protection (“OPP”) to conduct the review for the Division. This would not only provide for a more equal sharing of costs related to these reviews, but would also allow for a broader review and determination if similar cases are being sent to the OPP through other appeals mechanism to identify potential trends of mental health parity violations.

If on review, it is found that a carrier did not comply with *MHPAEA* or state mental health parity laws, the carrier should be required to reimburse the provider and or the beneficiary for any unreimbursed costs or out-of-pocket expenses that occurred as a result of the denial or violation of mental health parity requirements. Reimbursement must occur within 30 business days of the decision by the Division. Additionally, if the service is still necessary, the carrier must provide coverage immediately. Finally, if the carrier does not reimburse the beneficiary and/or provider, then necessary coverage fines and/or penalties may ensue.

b) On an entity-wide/state level, the Division enforcement should include collection and review of carriers’ reports as well as continued examinations of carriers’ practices to ensure compliance with the law.

Section 254 of Chapter 224 makes clear that the Division require all carriers and their contractors to submit annual reports to both the Division and to the Attorney General, certifying and

⁶ See Section 24(d) of Chapter 176O, added by Section 206 of Chapter 224 of the Acts of 2012.

outlining how their plans comply with federal and state parity laws. It also gives the Division the right to hold public hearings regarding the annual report.

In regards to the annual reports, it is essential that the Division make certain that plans provide updated annual reports as envisioned by the legislature. Only by providing updated annual reports can the Division ensure that insurers are continually abiding by parity laws each year. Within each report, there should be a listing of total internal and external cases that were appealed by providers, patients, and/or advocates through the plan, OPP, or directly to the Division related to mental health parity violations. And for each case that was appealed, there should be information about the actions taken by the plan that refute the claim or how the plan corrected its internal policies and medical necessity criteria to be in compliance with federal and state mental health parity.

Section 23 of Chapter 224 gives the Division an overall general authority to enforce *MHPAEA* and applicable state mental health parity laws. In order to do so, it is not enough for the Division to simply require and collect carriers' reports each year. Rather, a more in-depth examination must be required to guarantee compliance. The regulations must stipulate that on a yearly basis, the Division examine a random sampling of carriers pre- and post utilization claims. A sampling of these claims should then be compared to the respective claims on the providers' sides. In this manner, the Division will be able to make certain that parity is being complied with.

Additionally, in this examination, the Division should examine each carrier's medical necessity on both the behavioral health and medical-surgical side to ensure parity is being upheld. These criteria should be reviewed in the context of the random sampling of claims to make certain that they are being followed in practice.

We would like to request that the Division consider the following additional elements on top of those requested by Health Law Advocates for information to be contained in the carrier's annual reports to the Division and the Office of the Attorney General:

- (1) The standards for classifying mental health/substance use disorder benefits and medical benefits as outpatient or inpatient services, including the use of observation or other post-utilization reviews that re-classify inpatient to outpatient level services;
- (2) All criteria used to determine medical necessity for inpatient and outpatient level services (e.g., level of care guidelines, medical necessity criteria);
- (3) All criteria and procedures used for utilization review, including both pre- and post-utilization reviews;
- (4) A review of the credentials and expertise of clinical and case management staff who are reviewing medical necessity and utilization review of inpatient and outpatient behavioral health and substance abuse services;
- (5) All standards for requiring and granting prior authorization for both inpatient and outpatient services; and
- (6) The number and type of requests for internal and external reviews filed by insured and providers for both mental health/substance use disorder and medical surgical claims, including the type of services at issue, the resolution of the internal review, and a comparison of the two categories (mental health/substance use disorder and medical surgical claims).

c) The Division should hold annual meetings with interested stakeholders to review insurers' reports and the Division's examinations.

Section 254 of Chapter 224 gives the Division the right, at its discretion, to hold public hearings relative to a carrier's or contractor's annual report. Section 23 gives the Division general authority to implement and enforce parity laws. The Division, through these powers, should convene an annual meeting with interested stakeholders to review its findings of the annual reports. This is a good-faith process that would allow providers and advocates alike to provide input on what they are experiencing to further guarantee compliance.

d) Carriers should be given 30 business days to correct instances of noncompliance and if they fail to do so, penalties and/or fines should ensue.

In order to fully implement and enforce the parity provisions of Chapter 224, it is necessary for insurers to be held accountable for their actions if they are found to be in noncompliance with the law. Upon a finding of noncompliance, insurers should be given 30 days to take corrective action. If after those 30 days, action has not occurred, the Division should implement penalties and/or fines.

MHA, MABHS, MMS, MACEP, and MPS truly appreciate the Division's continued commitment to implementing mental health parity including pursuing regulations in a timely manner and providing interested parties with the opportunity to comment on such rules. Should you have any questions about the issues we have raised, please feel free to contact any of our respective associations.

Sincerely,



Anuj K. Goel, Esq.
Vice President, Legal and Regulatory Affairs
Massachusetts Hospital Association



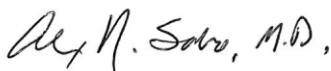
David Matteodo
Executive Director
Massachusetts Association of Behavioral
Health Systems



William Ryder, Esq.
Legislative & Regulatory Affairs Counsel
Massachusetts Medical Society



Gregory Volturo, MD
President
Massachusetts College of Emergency
Physicians



Alex N. Sabo, MD
President
Massachusetts Psychiatric Society