Report Summarizing the Study of Differences Between Behavioral Health and Non-Behavioral Health Treatment Records for Massachusetts Health Insurance Carriers When Referring Patients from Hospital Emergency Departments

Based on Information
Provided By
Dixon Hughes Goodman, LLP

Joseph G. Murphy
Commissioner of Insurance

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Acknowledgements

This report was prepared by Kevin Beagan, Deputy Commissioner of the Health Care Access Bureau ("HCAB") and Nancy Schwartz, Director of the Bureau of Managed Care ("BMC") within the Massachusetts Division of Insurance ("DOI"). This report was developed based upon information provided to the DOI by Dixon Hughes Goodman, LLP ("Dixon Hughes"), which was contracted by the DOI to conduct this on-site examination of the state's nine largest health insurance carriers.

Although the HCAB, BMC and Dixon Hughes have reviewed the reasonableness of information included in this report, they have not audited or otherwise verified that the reported information is correct or current, especially since available information may be somewhat dated. It should be noted that this study is not meant to contain legal advice nor should it be solely relied upon, other than to present information about the material reviewed by Dixon Hughes.

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Executive Summary

In 2012, the Division of Insurance ("DOI") contracted with Dixon Hughes Goodman, LLP to visit Massachusetts' nine largest health insurance carriers[1] to examine a random sample of the Utilization Review ("UR") records for insureds who were treated in hospital emergency departments ("ED") and required follow-up treatment for behavioral health ("BH") or nonbehavioral health ("NBH") conditions. The examinations were conducted to identify whether there were differences in the ways that the health insurance carriers reviewed and authorized benefits for BH patients as compared to NBH patients.

According to the consultant's review of the health insurance carriers' UR records for ED visits, there are differences in the outcomes for BH patients when compared to those for NBH patients. While almost all NBH patients are discharged from the ED to an inpatient bed or outpatient care within 24 hours, many BH patients waited two days or longer for transfer from the ED to other treatment. As BH patients stay longer in the ED than NBH patients, the resulting delay places demands on ED resources and impedes appropriate care for BH patients.

Although there are outcome differences, it has not been possible to draw clear conclusions about the reasons for the delays, primarily due to the lack of clean and standardized information within and across the carriers' records. It does appear, however, that the following observations were common across the health plans:

1. Many BH patients are evaluated by an external Emergency Service Provider ("ESP") when they come to the ED. ESPs do not evaluate NBH patients.
2. Many BH patients face long delays in EDs as hospitals, ESPs and health carrier UR staff attempt to locate appropriate BH inpatient beds for the BH patients. It is unclear from the data available to what extent the delays in finding inpatient beds are due to any of the following:
   lack of inpatient BH beds within the health plan's network;
   lack of inpatient BH beds appropriate for the patient's specific needs;
   lack of inpatient BH beds at the hospital in which the ED is located; or
   lack of inpatient BH beds within a desired physical distance from the ED.
3. NBH patients do not commonly face similar long delays in EDs because NBH patients receive treatment in other specialty areas until beds in the appropriate specialty area become available. The BH patient may not receive treatment while awaiting an appropriate available BH bed.

Recommendations

- DOI, working in collaboration with carriers, providers, consumer advocates and other interested parties, will develop standards for the level of detail to be included in all provider and carrier records, so that they provide a clear, complete and time-sensitive record of all that occurs within the review process for BH and NBH patients. Once completed, the DOI should modify its regulations to require that health carriers maintain records that meet the developed standards.
- The DOI will require that carriers use the best available tools, such as the Massachusetts Behavioral Health Access website, to find available beds for approved inpatient care at an out-of-network hospital when in-network hospitals are not available within a reasonable timeframe – and in no case longer than 24 hours.

[1] The largest health insurance carriers are all licensed as Health Maintenance Organizations under M.G.L. c. 176G.

- The DOI will require that carriers submit a monthly report whenever an insured member requiring inpatient care is detained in an ED for longer than 24 hours and will identify the reasons that the insured member was detained for that time period as well as the efforts that the carrier took to find appropriate care for the patient outside the ED.
- The DOI will work with providers, advocates, carriers and other interested parties to develop a subsequent study to examine the real-time problem in obtaining BH follow-up care.
- The DOI will meet with providers, insurance carriers, consumer advocates and other interested parties to strengthen its annual Mental Health and Addiction Equity Act ("MHPAEA") certification process to collect more information about the systems used in reviewing BH and NBH care for ED patients.
- The DOI will meet with the Departments of Mental Health and Public Health to look into the development of standards identifying services and types of providers to include within insured health plan networks for the plans to be considered adequate.

Introduction

In March 2012, representatives of 16 organizations[2] wrote to the attention of Insurance Commissioner Joseph G. Murphy calling for him to look into situations where, the organizations alleged, the Commonwealth's health insurance carriers were operating in a manner that was not consistent with the requirements under the federal Mental Health Parity and Addiction Equity Act ("MHPAEA"). The letter alleged that care for behavioral health ("BH") patients in the Commonwealth's hospital emergency departments was being delayed by the health insurance carriers' systems in ways not permitted under MHPAEA. Carriers review requests for covered services to determine whether they find them to be medically necessary according to their medical criteria.

In response to this letter, the Division of Insurance ("DOI") called a special examination in May 2012 to collect samples of carriers' records so that the DOI might determine whether any of the health insurance carriers were not in compliance with MHPAEA. The DOI contracted with consultants from Dixon Hughes Goodman, LLP ("Dixon Hughes") to coordinate the collection of the sample files from the companies and visit the companies to monitor compliance with MHPAEA.

Dixon Hughes' staff conducted their reviews and followed up with carriers when information was incomplete. Dixon Hughes subsequently met with DOI staff to provide updates on the reviewed materials. The DOI staff in turn met with staff from the federal Department of Labor in Washington, D.C. on two occasions to discuss the examination and seek clarification about the federal government's positions on certain elements of its final regulations for MHPAEA.

This resulting report presents information drawn from the work by Dixon Hughes and from observations derived from the analysis. This document also highlights how the lack of necessary detail in the health insurance carriers' records hinders the ability to draw definitive conclusions.

This report is being released coincident with the release of materials the DOI collected as part of its certification of carriers' 2012 calendar year compliance with MHPAEA. As the DOI notes with this report and its certification work, further analysis will be necessary to enable the DOI, in collaboration with other parties, to ensure that all health insurance carriers comply with MHPAEA and find ways that the carriers' BH care delivery networks can work more effectively for patients and more efficiently for providers and health plans.

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Association for Behavioral Healthcare
Children's Mental Health Campaign
Greater Boston Legal Services, on behalf of our clients
Health Care for All
Health Law Advocates
Home Care Alliance of Massachusetts
Massachusetts Association of Behavioral Health Systems
Massachusetts Association of Older Americans
Massachusetts College of Emergency Physicians
Massachusetts Hospital Association
Massachusetts Medical Society
Massachusetts Organization for Addiction Recovery
Massachusetts Psychiatric Society
Massachusetts Psychological Association
National Alliance on Mental Illness of Massachusetts
National Association of Social Workers, Massachusetts Chapter

History of Mental Health Parity in Massachusetts

Massachusetts Parity Laws

The Commonwealth of Massachusetts has enacted numerous statutes over time that require carriers' insured health plans[3] to include coverage for mental health treatment. Prior to 2000, state laws permitted treatment for mental health conditions to be capped and handled differently than care for medical conditions. With the passage of Chapter 80 of the Acts of 2000[4] ("An Act Relative to Mental Health Benefits"), Massachusetts carriers' insured health plans were required to cover behavioral health treatment for biologically-based mental disorders,[5] adolescent-child behavioral health conditions,[6] and rape-related care[7] at the same benefit level as what was included for medical care. This same law also required that coverage be available for 24 inpatient days and 60 outpatient visits to treat, if medically necessary, all other mental health conditions.

Eight years later, Chapter 256 of the Acts of 2008 ("An Act Relative to Mental Health Benefits")[8] expanded the definition of biologically-based mental disorders to include eating disorders, post-traumatic stress disorder, substance abuse disorders and autism, and clarified that benefits for the treatment of biologically-based mental disorders were to be provided on a "nondiscriminatory basis...[so

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[3] As is the case in other states, Massachusetts insurance statutes only pertain to those insurance products issued or renewed in the Commonwealth of Massachusetts by licensed insurance carriers. This means that these statutes do not apply to certain government plans that are exempt from the insurance laws (*e.g.*, Medicare, Medicaid, coverage available to military personnel, the Veterans Administration, Indian Health Service or Federal Employee Health Benefit Program coverage), self-funded employment-sponsored health plans preempted under the federal Employee Retirement and Income Security Act of 1974 (ERISA) rules or insurance coverage issued in other states or jurisdictions that may cover residents of the Commonwealth. The DOI estimates that approximately 1/3 of the residents of the Commonwealth are subject to the state's health insurance mandates.

[4] See https://malegislature.gov/Laws/SessionLaws/Acts/2000/Chapter80. In addition, the DOI issued numerous bulletins (see http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/ for a list of bulletins according to year of issuance) that clarified the parity benefits, including the following:
Bulletin 2000-06 ("Mental Health Parity");
Bulletin 2000-10 ("Certain Issues Regarding Mental Health Benefits Required by C. 80 of the Acts of 2000**");**
Bulletin 2002-07 ("Mental Health Benefits");
Bulletin 2003-11 **("**Intermediate Care as part of Mental Health Parity Benefits"); and
Bulletin 2009-11 ("Access to Intermediate and Outpatient Mental Health & Substance Use Disorder Services").

[5] Chapter 80 of the Acts of 2000 defined the following mental disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association (the DSM), as biologically-based mental disorders for the mandated parity benefit: schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, panic disorder, delirium and dementia, and affective disorders.

[6] Chapter 80 of the Acts of 2000 required that certain child-adolescent behavioral health care be covered at a mandated parity benefit level for non-biologically based mental, behavioral or emotional disorders described in the DSM that substantially interfered with or substantially limited the functioning and social interactions of children and adolescents under the age of 19. The interference or limitation was to be documented and referred for treatment by the primary care physician, primary pediatrician or a licensed mental health professional, or be evidenced by conduct including, but not limited to: an inability to attend school as a result of the disorder, the need to hospitalize the child or adolescent as a result of the disorder, or a pattern of conduct or behavior caused by the disorder that posed a serious danger to self or others.

[7] Chapter 80 of the Acts of 2000 required that behavioral health treatment be provided at a mandated parity benefit level for rape-related mental or emotional disorders for victims of rape or victims of an assault with intent to commit rape, whenever the cost of the treatment exceeded the maximum compensation awarded to the victim under M.G.L. c. 258C.

[7] See https://malegislature.gov/Laws/SessionLaws/Acts/2008/Chapter256. In order to describe the features of this law, the DOI issued Bulletin 2009-04 **("**Changes to State and Federal Mental Health Parity Laws") which can be found at http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2009-doi-bulletins/2009-04-changes-to-state-and-federal-mental.htmlt exceeded the maximum compensation awarded to the victim under M.G.L. c. 258C.

[8] See https://malegislature.gov/Laws/SessionLaws/Acts/2008/Chapter256. In order to describe the features of this law, the DOI issued Bulletin 2009-04 **("**Changes to State and Federal Mental Health Parity Laws") which can be found at http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2009-doi-bulletins/2009-04-changes-to-state-and-federal-mental.html **.**

that] copayments, coinsurance, deductibles, unit of service limits (e.g., hospital days, outpatient visits), and/or annual or lifetime maximums are not [to be] greater for mental disorders than those required for physical conditions, and office visit copayments are not [to be] greater than those required for primary care visits."

Chapter 207 of the Acts of 2010 ("An Act Relative To Insurance Coverage For Autism")[9] provided additional changes to require that carriers' insured health plans provide benefits for the diagnosis and treatment of Autism Spectrum Disorder ["ASD"] on a nondiscriminatory basis to all residents of Massachusetts and to all insureds having a principal place of employment in Massachusetts.

Federal Parity Laws

In September 1996, the United States Congress enacted the Mental Health Parity Act ("MHPA")[10], which required that employer-sponsored health plans that included benefits to treat mental health conditions not impose annual or lifetime dollar limits on mental health benefits that were lower than any such dollar limits for medical and surgical benefits. The statute provided an exemption for employers with fewer than 50 employees or for any employer where the mandate would result in a 1 percent or greater increase in the cost of a group health plan's premiums .

After extending the MHPA until 2007, Congress in 2008 enacted the MHPAEA[11] to replace the MHPA and extend behavioral health parity provisions nationally. The federal law requires health plans that include benefits to treat mental health conditions to ensure that benefits, cost-sharing features – *e.g.*, co-pays, deductibles, and out-of-pocket maximums - and limitations on treatment benefits – *e.g.*, caps on visits with a provider or days in a hospital visit - for mental health or substance abuse disorders not be more restrictive than for medical and surgical benefits. MHPAEA only applies to insurance plans for public and private sector employers with over 50 employees.[12]

Since the enactment of MHPAEA, the federal Departments of the Treasury, Labor and Health and Human Services have been jointly developing regulations and guidance about the ways that MHPAEA is to be implemented by all health plans. On November 13, 2013, these agencies issued final regulations - 26 CFR Part 54, 29 CFR Part 2590 and 45 CFR Parts 146 and 147[13] - to govern the administration of MHPAEA nationally. The regulations make clear that health plans with coverage for mental health and

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[9] See https://malegislature.gov/Laws/SessionLaws/Acts/2010/Chapter207. In order to describe the features of this law, the DOI issued Bulletin 2010-15 **(**"Changes to State and Federal Mental Health Parity Laws") which can be found at http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2010-doi-bulletins/bulletin-2010-15-insurance-coverage-for.html. The DOI issued Bulletin 2011-08 ("Benefit Limits on Coverage for Autism Spectrum Disorders") which can be found at http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2011-doi-bulletins/bulletin-2011-08-issued-april-25-2011.html l to provide further clarifications on this benefit.

[10] See https://www.govtrack.us/congress/bills/104/hr4058/text.

[11] See https://www.govtrack.us/congress/bills/110/hr6983/text**.** The DOI issued Bulletin 2009-04 ("Changes to State and Federal Parity Laws") - which is available at http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2009-doi-bulletins/2009-04-changes-to-state-and-federal-mental.html – to make sure that licensed insurance carriers were fully aware of the provisions of the federal law.

[12] It should be noted that federal law applies throughout the United States of America to all health plans, whether they be insured health plans subject to state insurance laws or self-funded employment-sponsored health plans not subject to state insurance laws due to the ERISA preemption. It should also be noted that federal law applies to all insured health plans regardless of the state or U.S. jurisdiction in which the health plans are issued.

[13] See http://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf

substance abuse treatment may not impose financial or treatment limitations[14] that are different than those that apply to substantially all of the medical/surgical benefits.[15]

Separate from the MHPAEA regulations, the federal Department of Health and Human Services issued rules – 45 CFR Parts 147, 155, and 156 ("Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation")[16] – necessary for the implementation of the federal Patient Protection and Affordable Care Act of 2010 ("ACA") and these rules impacted the availability of MHPAEA protections. While the MHPAEA exempts employers with 50 or fewer employees, the ACA rules clarified that health insurance carriers offering insured coverage to individuals or small employers with 50 or fewer employees would be subject to MHPAEA requirements. All insured health plans offered to individuals and employers are therefore required to be consistent with MHPAEA for policies issued on and after January 1, 2014.

[14] It should be noted that Massachusetts state law on mental health parity only applies to financial limitations. When federal regulations refer to treatment limitations, they apply to UR systems within health plans that evaluate the medical necessity and appropriateness of certain services when determining whether they will be approved for coverage under the plan.

[15] See http://cms.hhs.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/mhpaea_factsheet.html. According to the federal Centers for Medicare and Medicaid Services, the following are the highlighted requirements of these regulations:

1. The substantially all/predominant test outlined in the statute must be applied separately to six classifications of benefits: inpatient in-network; inpatient out-of-network; outpatient in-network; outpatient out-of-network; emergency; and prescription drug. Sub-classifications are permitted for office visits separate from all other outpatient services, as well as for plans that use multiple tiers of in-network providers. The regulation includes examples for each classification. Additionally, although the regulation does not require plans to cover MH/SUD (Mental Health/Substance Abuse Disorder) benefits, if they do, they must provide MH/SUD benefits in all classifications in which medical/surgical benefits are provided.
2. The regulation requires that all cumulative financial requirements, including deductibles and out-of-pocket limits, in a classification must combine both medical/surgical and MH/SUD benefits in the classification. The regulation includes examples of permissible and impermissible cumulative financial requirements.
3. The regulation distinguishes between quantitative treatment limitations and nonquantitative treatment limitations. Quantitative treatment limitations are numerical, such as visit limits and day limits. Nonquantitative treatment limitations include but are not limited to medical management, step therapy and pre-authorization. There is an illustrative list of nonquantitative treatment limitations in the regulation. A group health plan or coverage cannot impose a nonquantitative treatment limitation with respect to MH/SUD benefits in any classification unless, under the terms of the plan (or coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to MH/SUD benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical surgical/benefits in the classification. The final regulation eliminated an exception that allowed for different nonquantitative treatment limitations "to the extent that recognized clinically appropriate standards of care may permit a difference."
4. The regulation provides that all plan standards that limit the scope or duration of benefits for services are subject to the nonquantitative treatment limitation parity requirements. This includes restrictions such as geographic limits, hospital-type limits, and network adequacy

[16] See http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf. The DOI issued Bulletin 2013-02 ("Changes to Mental Health Benefits") – which can be found at http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2013-doi-bulletins/bulletin-2013-02.html - to ensure that health insurance carriers were aware of the new requirements.

Managed Care Oversight in Massachusetts

Managed Care Law

Chapter 141 of the Acts of 2000 created M.G.L. c. 176O ("Health Insurance Consumer Protections", commonly referred to as the "Managed Care Law").[17] M.G.L. c. 176O established standards that apply to all health insurance carriers that provide or arrange for care through a network of providers or employ Utilization Review ("UR") in making decisions about whether services are medically necessary and covered benefits under a health benefit plan.

According to M.G.L. c. 176O, section 12(a),[18]

> "UR conducted by a carrier or a UR organization shall be conducted pursuant to a written plan, under the supervision of a physician and staffed by appropriately trained and qualified personnel, and shall include a documented process to (i) review and evaluate its effectiveness, (ii) ensure the consistent application of UR criteria, and (iii) ensure the timeliness of UR determinations.
>
> A carrier or UR organization shall adopt UR criteria and conduct all UR activities pursuant to said criteria. The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians, consistent with the development of medical necessity criteria pursuant to the provisions of [M.G.L. c. 176O] section 16. UR criteria shall be applied consistently by a carrier or a UR organization."

The carrier's medical director is expected to monitor the systems to ensure that they follow their UR criteria and keep records of its UR activities.

If, based on the UR process, a health insurance carrier denies or modifies a request for a certain type or quantity of care, the health insurance carrier is required to send an adverse determination notice to the affected consumer that explains the reason the request was not approved, to offer the opportunity for the consumer or his provider to appeal the decision within the health plan, and to inform the consumer of the opportunity to appeal certain adverse determinations through an external appeal organization coordinated by the Massachusetts Office of Patient Protection, currently housed within the state's Health Policy Commission.

The DOI's BMC reviews the managed care procedures of each of the managed care companies operating in Massachusetts as part of a biennial managed care accreditation. Only those carriers that can demonstrate that their systems for UR, quality assurance, credentialing and preventive health care meet the standards of M.G.L. c. 176O are accredited and permitted to continue their managed care processes in Massachusetts. For those carriers that have not been accredited by a national managed care accreditation organization, the BMC also coordinates on-site reviews to evaluate health insurance carrier systems. As of the publication of this report, a total of 31 companies are accredited in Massachusetts.[19]

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[17] See https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176O. The DOI promulgated 211 CMR 52.00 ("Managed Care Consumer Protections and Accreditation of Carriers") – which can be found at http://www.mass.gov/ocabr/docs/doi/legal-hearings/211-52.pdf - to enforce the provisions of M.G.L. c. 176O. The provisions of M.G.L. c. 176O and 211 CMR 52.00 have been amended many times since the enactment of Chapter 141 of the Acts of 2000, most recently with provisions added in Chapter 224 of the Acts of 2012.

[18] See https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXXII/Chapter176O/Section12. As noted when referring to other state insurance laws, this law only applies to those insured health plans issued in Massachusetts and does not apply to government plans, self-funded employment-sponsored plans or to health plans issued outside of Massachusetts.

[19] See http://www.mass.gov/ocabr/docs/doi/companies/accredited-carriers.pdf.

MHPAEA Certifications

Chapter 224 of the Acts of 2012 modified M.G.L. c. 26, § 8K to provide the DOI with the authority to enforce MHPAEA. In response, the DOI issued Bulletin 2013-06 ("Disclosure and Compliance Requirements for Carriers, and Process for Handling Complaints for Non-Compliance with Federal and State Mental Health and Substance Use Disorder Parity Laws"[20]) and promulgated 211 CMR 154.00 ("Enforcement of Mental Health Parity"),[21] establishing a process to annually certify the carriers' compliance with federal and state mental health and substance use disorder parity laws. At the writing of this report, the DOI is completing its review of the 2012 managed care processes of each of the accredited companies to evaluate each health plan's compliance with MHPAEA. The DOI expects to incorporate information gathered by this examination to enhance its annual accreditation process.

[20] See http://www.mass.gov/ocabr/insurance/providers-and-producers/doi-regulatory-info/doi-regulatory-bulletins/2013-doi-bulletins/bulletin-2013-06.html

[21] See http://www.mass.gov/ocabr/docs/doi/legal-hearings/211-154.pdf.

DOI Examination

During May 2012, the DOI contracted with Dixon Hughes to review the manner in which nine (9) health insurance carriers provided or arranged for coverage of services to treat BH disorders, and how—or if—carrier procedures for treating BH disorders may differ from the manner in which the carriers provide or arrange for coverage of services to treat NBH conditions. The DOI also requested that Dixon Hughes identify any procedures that may not be consistent with the requirements of the MHPAEA. The testing of the Massachusetts health benefit plans was to determine whether UR practices were in compliance with MHPAEA over a specific three-month period.

Dixon Hughes collected the carriers' UR policies and procedures in order to test them and determine whether there were instances where the documented protocols for handling BH services were more restrictive than those used for NBH services.

Dixon Hughes also coordinated the sampling of claims for each carrier to perform testing of ED claims to determine whether the carriers handled the UR process for BH services consistent with MHPAEA requirements. Dixon Hughes' testing compared the authorization and other UR policies and procedures for BH services to those for NBH services and analyzed whether or not the insured carriers' policies, procedures and practices were compliant with state and federal requirements.

Testing of Protocols

Dixon Hughes reviewed carriers' utilization guidelines for BH and NBH services to see that they were complete, internally consistent and maintained and updated on a regular basis. Pre-authorization of BH and NBH services was reviewed to determine whether inpatient stays, surgery and other services for patients with BH or NBH issues had similar requirements for pre-authorization of services. Some BH services required pre-authorization, such as outpatient services for BH patients for a greater number of visits than what is contractually allowed, and this is similar to some NBH outpatient medical services, such as physical therapy. Dixon Hughes reviewed the "paper" guidelines, processes, procedures and UR guidelines the carriers submitted for review for both BH and for NBH and did not identify BH requirements that were more restrictive than those followed for NBH.

The carrier established and maintains UR programs for BH and NBH services**.**

Four (4) carriers provided their UR guidelines for emergency services which applied to both BH and NBH services. The other five (5) carriers provided their own UR guidelines for NBH services and the UR guidelines used by their BH contract managers reviewing BH services.

The carrier monitors the activities of any organization or entity with which it contracts to perform UR and ensures that the contracting organization complies with MHPAEA.

Four (4) carriers did not contract with any other organization to perform UR and monitored their UR processes internally for both NBH and BH services. Dixon Hughes did not find any MHPAEA exceptions after reviewing the UR guidelines for these carriers.

Five (5) of the carriers contracted with another organization or entity to manage the UR of BH services. The carriers' contracted entities generally managed the provider networks, UR and quality assurance systems, case and care management processes, and the systems to pay provider claims. Dixon Hughes reviewed these five (5) carriers' own UR guidelines for NBH services and did not find any exceptions.

Dixon Hughes reviewed the UR guidelines of the contracting organization for BH services and did not find any exceptions in the UR guidelines when comparing them with the UR guidelines for NBH services.

Identifying Appropriate Records to Test

Dixon Hughes worked closely with the DOI and the carriers to identify criteria by which to select a representative sample of records. Dixon Hughes instructed companies to identify patients who presented to a hospital ED and received inpatient or outpatient care for the same condition identified in the ED after discharge from the ED.

Each of the carriers provided a sample of ED claims for NBH care (identified by revenue and diagnosis codes) for a 3-month period in 2011.[22] These claims involved the covered person receiving follow-up inpatient or outpatient NBH care within three (3) calendar days after the discharge or "through-date" from the hospital ED. Dixon Hughes looked at each carrier's sample to ensure that there were twenty-five (25) acceptable claims that met the qualifying criteria. After identifying the appropriate NBH claims, Dixon Hughes looked at the carrier's records to analyze how review was conducted for the NBH claims. Each of the carriers' handling of requests for NBH care was to be used as a source of comparison to how the carrier handled requests for BH care.

Each of the carriers provided a sample of its ED claims for BH care (identified by revenue and diagnosis codes) – or those ED claims processed by the contracted UR organization – for the same 3-month period used for the review of ED claims for NBH care. These ED claims involved the covered person receiving follow-up inpatient or outpatient BH care within three (3) calendar days after the discharge or "though-date" from the hospital ED. Dixon Hughes looked at each carrier's sample to ensure that there were fifty (50) acceptable claims that met the qualifying criteria. After identifying the appropriate BH claims, Dixon Hughes looked at the carrier's records to analyze how review was conducted.

Dixon Hughes reviewed UR records to determine whether there were ways that the carriers handled BH and NBH requests for care that were potentially non-compliant with MHPAEA or Massachusetts law.

Testing the Records

Nonbehavioral Health (NBH) Care Records

Dixon Hughes reviewed two hundred and twenty-five (225) NBH records – twenty-five (25) records for each of the nine carriers under the special examination. Of the 225 NBH files, forty (40) of the patients were admitted to an inpatient NBH bed straight from the ED.[23] Four (4) of the 40 NBH in-hospital patients were transferred from the ED hospital to another hospital for inpatient admission. Three (3) of the four (4) patients needed care better suited to another hospital and one (1) patient was transferred from an ED in an out-of-network hospital to an in-network hospital.

Of the 225 NBH files tested, one hundred and eight-five (185) of the ED claims resulted in related NBH outpatient care. A total of eighteen (18) resulted in outpatient surgery, while the remaining cases required follow-up NBH visits in a medical office or clinic.

[22] One carrier provided data for the 1st quarter of 2012 because it was the best available information for review by Dixon Hughes.

[23] One carrier misunderstood the population for NBH files and the only files populated for sampling were NBH patients with an ED visit and an inpatient stay. Therefore, twenty-five (25) of the forty (40) patients with inpatient stays were from one carrier.

Dixon Hughes did not identify any records in its review that indicated that NBH patients were in an ED for more than a 24-hour period before being discharged to other care.

Behavioral Health (BH) Care Records

Dixon Hughes reviewed four hundred and fifty (450) BH records – fifty (50) records for each of the nine carriers under the special examination. Of the 450 BH files, three hundred and forty-one (341) of the patients left the ED and were admitted to an inpatient BH bed. Of those 341 patients, one hundred and ninety-eight (198) were moved at discharge from the ED hospital to a hospital at another location in order to be admitted for inpatient BH care. Dixon Hughes found that patients were generally transferred to another hospital because the ED hospital did not have BH beds or the ED hospital had BH beds but BH beds at the necessary level of care were not available when the BH patient needed to be admitted.

Of 450 BH files tested, one hundred and nine (109) of the patients received related BH outpatient care. Forty-four (44) of the 109 patients were recommended for specific outpatient programs and the other sixty-five (65) patients were evaluated and recommended for outpatient treatment with a psychologist or psychiatrist. Eight patients were already in an outpatient program, and some of those were sent by outpatient providers to the ED during an outpatient session. It appeared all of those patients returned to the outpatient program the day of or after the ED visit.

	Behavioral Health		Non Behavioral Health	
Total cases reviewed	450		225	
In ED more than 24 hours	59	13%	0	0
Admitted as inpatient	341	76%	40	18%
Transferred to other inpatient	198	58% of admits	4	10% of admits
Referred to outpatient	109 • 44 OP programs • 65 crisis eval and follow-up	24%	185 • 18 OP surgery • 167 office visit	82%

Delays in Obtaining BH Care Outside the ED

From a review of the BH UR records, it appears that for fifty-nine (59) of the 341 BH patients who were transferred to inpatient care, the time frame between when the patient was recommended for treatment outside the ED and when the patient was discharged to an inpatient bed was more than a day but the reasons were not well documented. In many cases, the record did not include complete information about the ESP's arrival time, the time the ED medical doctor provided clearance for treatment outside the ED, the time other providers completed their review of the patient or the timing of other specific decision points, the detail of which would have helped clarify the reasons for delays.

Dixon Hughes indicated that forty-four (44) of the fifty-nine (59) patients needing BH inpatient care appeared to be approved for admission less than twenty-four hours after the request, but the record did not have sufficient detail to explain what occurred during the search for a bed. The records indicated that hospitals billed for observation day charges for eleven (11) of the 44 patients who waited in the ED before a bed was located.

Dixon Hughes noted that although the records for the other fifteen (15) of the 59 patients were imprecise, it appeared to take more than twenty-four hours to locate a bed. For three of those 15 patients, a crisis evaluation was completed in the ED, there was a recommendation for an inpatient stay and the patient was admitted to a BH inpatient bed more than two days later. In the records for these 15 patients, there are notes that indicate that there was a search to find an inpatient BH bed, but there were not any notes that explained the reason that the search was taking so long.

Examples of Issues with BH UR records

- One patient started inpatient detoxification treatment more than twenty-four hours after being initially evaluated in the ED and there did not appear to be any clinical notes that supported the delay in treatment. There was information in this specific record to suggest that the patient may have left the ED and returned at a later time.
- One patient had an ED visit and was subsequently admitted to an inpatient BH bed, but there was not sufficient information in the record to indicate what the evaluation was while the patient was in the ED. The carrier either failed to retain the records or never received them, and allowed pre-authorization without a documentation of the need for admission to a BH inpatient bed. Without clinical notes, the record could not document what type of bed search occurred nor why the patient was admitted to an inpatient BH bed.
- One patient was denied admission to an inpatient BH bed by the carrier but this was overturned when the patient or family requested an expedited internal appeal of the denial. The patient remained within the ED while the denial was being appealed. The record did not explain the time needed to conduct the appeal nor the time required to find an inpatient BH bed.
- Two patients were kept in the ED under an observation status for more than two days. The ESP evaluations did not indicate a bed search, but without medical or supporting notes it could not be determined if a bed could not be located, the patient was not medically cleared, or if the patients simply left the ED.
- One patient received crisis evaluation services and a request for an admission for inpatient detoxification was approved. According to the records, the patient waited in the ED for three days during a bed search but there were not any notes to describe the reasons for the delay nor what had had occurred during the relevant time period.
- One patient received crisis evaluation services and a request for an admission for inpatient detoxification was approved. According to the records, the patient waited two days in the ED while a bed search was done for an appropriate bed. At some point, the patient appeared to no longer be willing to wait and checked himself out of the ED.
- One patient received crisis evaluation services in the ED, but the record indicates that a call for pre-authorization was received four days later. There were no notes to explain what had occurred.
- One patient had an evaluation by an ESP with a recommendation for an inpatient stay on the day of the ED visit. However, the patient remained in the ED for three days and when discharged, the notes indicate that the ESP's revised recommendation was for outpatient therapy. There were not any notes to clarify if the time in the ED was for a bed search, and there were not any notes to explain why the ESP changed the recommendation from an inpatient stay to an outpatient visit after

the patient had waited in the ED for more than two days. The carrier claimed that the records may not have included the notes from a phone call held on the day of discharge from the ED.

- One patient had been in a BH hospital when medical issues arose and the patient was sent to a medical hospital ED. A bed search was completed while the patient was in the ED even though the patient had come from a BH hospital. (The bed may have been filled, or notes may have failed to document properly why the patient was sent to the ED from the BH hospital.) Clinical notes stated the patient was discharged to an outpatient program but the notes failed to clarify why the patient did not become an inpatient at another hospital. The carrier's clinicians stated there may have been a phone call but the notes failed to document the treatment change decision.
- One patient had an evaluation completed by an ESP in the ED and the recommendation was for an inpatient stay. The records illustrate, however, that the patient was in the ED for two days prior to being admitted as an inpatient. The records show that the carrier searched for an available bed, but there is no document in the record about the length of time spent on the calls or the efforts made to find a BH bed.
- One patient had an evaluation by an ESP completed after being in the ED for two days; the ESP recommended detoxification services. The carrier denied the request because the patient had been in the ED for a two-day period. It was unclear from the records why the patient was not allowed to continue with inpatient detoxification for an additional two or three days.
- One patient appeared to wait for an ESP to arrive at the ED to meet with the BH patient. It was unclear from the records how long it took for the medical provider to contact the ESP, since the carrier's records do not identify the timing of all of the events.
- One patient left the ED during the bed search and about 36 hours later was called to return to the ED to be transported to an inpatient hospital for inpatient detoxification. Clinical notes failed to document what occurred in the ED. Dixon Hughes hypothesized that a bed could not be located and the patient checked out of the ED, but notes supporting what actually occurred in the ED were missing.
- For one young patient, the record noted that the ESP recommended he go home with his parents, but the parents felt the youth needed inpatient care and was a danger to his mother. From the ESP evaluation notes, the length of time the patient spent in the ED was not clear, but the notes suggest the ED visit appeared to have been two days prior to the inpatient stay and it appeared the patient was in the ED until being moved to another inpatient hospital for BH care. The UR record failed to support the timing of events leading up to the inpatient stay.
- In four cases for the same carrier, although inpatient stays were authorized, the carrier could not locate the ESP evaluations for the patients within the records. According to the carrier's protocols, it did not authorize BH care without an ESP evaluation, so it was unclear why the UR record was not complete. For each patient, time spent waiting for medical clearance, ESP evaluation, and bed searches could not be determined, and timing in the ED was an issue. None of the cases was for inpatient detoxification.

Common Issues Identified in the BH records

Emergency Service Providers

From a review of the records, it appears that many BH patients were evaluated by an ESP during the ED visit. ESPs do not evaluate NBH patients.

The DOI is aware that Massachusetts' Medicaid program (MassHealth) has contracts with ESPs throughout Massachusetts to provide services to MassHealth patients who need BH treatment. ESPs provide crisis assessment, short-term crisis counseling, crisis intervention, crisis stabilization, medication evaluation and bed searches when deemed necessary (i.e., locating beds for patients in need of 24-hour care). MassHealth specifies that when a MassHealth patient in an ED requires BH treatment, an ESP evaluate the patient. ESPs do not evaluate or treat patients who require only NBH treatment.

When considering medical necessity decisions for privately-insured members outside the MassHealth program, Dixon Hughes found that all but one of the carriers contracted with ESPs to evaluate members in EDs who required BH treatment, except when the BH treatment was for substance abuse detoxification. When ESPs were involved in an ED visit, the ESP provided services in the ED until the ESP requested further care. ESPs do not evaluate or treat patients who require only NBH treatment. Dixon Hughes found that when a patient in the ED required BH treatment, an ESP evaluated and treated the patient to determine the level of care needed outside the ED.

According to the records, the use of ESPs does add time to the ED stay but the length of this time cannot be determined. It appeared from some records that patients sometimes needed to wait until the ESP came in from outside the ED hospital. It is unclear from the records how much this may have contributed to BH wait times because there was not always enough information in the records to identify all the times that an ESP was involved with the member's care.

Dixon Hughes indicated that the carriers noted that they used ESP services in different ways. One carrier indicated that it would approve inpatient care whenever an ESP recommended it. Other carriers indicated that the ESP evaluation was used by the carrier's staff, but the carriers continued to use their own systems for final decisions. Others indicated that they did not require the use of ESPs but used ESPs when available in the hospital at the time of the patient's visit to the ED, in order to allow for the evaluation of the patient by a mental health clinician.

Difficulties Finding BH Inpatient Beds

In many records, Dixon Hughes confirmed that finding appropriate BH beds was often more difficult than finding NBH beds. There were instances where a patient requiring an NBH admission was admitted to a bed of a different specialty, for example an adult medical patient admitted to a bed in the intensive care unit or pediatric unit, until an appropriate NBH bed opened up. It appeared that this practice was more limited for ED patients needing BH care because the facility was not able to provide the BH treatment needed in another location in the facility.

In each of the files examined, when an appropriate BH bed was not available, the patient remained in an observation status in the ED. It is not clear from claims data and clinical records where the BH patient stayed in the ED. While some of the records were clear in documenting all attempts to find beds for those BH patients who needed to be transferred to BH care, this was not universally the case.

Dixon Hughes noted that according to certain of the carriers' records, BH patients in a hospital ED were kept in what is referred to as the "purple room" – assumed to be an observation or holding room – for the safety of the patient and other patients, until a suitable inpatient BH bed could be located. Dixon Hughes also found that certain records were incomplete, such as in cases where patients presenting for BH care checked themselves out of the ED; patients may have left the ED due to the length of time needed to find a BH bed or because they were refusing any further BH care.

BH Networks

Dixon Hughes also found that carriers had different UR guidelines when attempting to authorize care from in-network BH providers as opposed to out-of-network BH providers. When securing care from in-network providers, carriers would often authorize treatment for a greater number of days than for treatment from out-of-network providers. In some cases, when care was given at an out-of-network hospital, the carrier or its contracted reviewer would require that the care be authorized for an initial period and then re-authorized after the initially authorized period had expired.

Most of the carriers had authorization policies for BH inpatient admissions which directed that care only be authorized at network hospitals. It also appeared that the carriers initially hunted for beds in in-network BH facilities before looking for out-of-network inpatient beds. Guidelines for two of the health maintenance organizations ("HMO") tested clearly indicated that both companies would only look for beds in in-network facilities.

It is unknown from the records whether the size of any carriers' BH network impacted the availability of care. Most of the carriers with HMO and PPO patients indicated that an in-network facility would be contacted first to look for beds, but if not available, out-of-network hospitals were contacted to find beds. For out-of-network care, carriers appeared to negotiate payments so that the patient would not be balance-billed for care. Dixon Hughes also noted that the availability of a bed at an in-network hospital appeared to be based on the day and time of day that the patient was in the ED.

From a review of the records, it appears that access to care at non-network facilities was handled in a manner that was similar for all BH care. Since it did not appear that there were many requests for out-of-network NBH care, it was not possible to examine whether carriers handle all requests for out-of-network care in a similar manner.

In many of the UR records, it appeared that the designated BH hospital in the patient's network found a bed for the patient in the hospital. This appeared to work similarly for both point of service ("POS") and preferred provider organization ("PPO") patients because of the contracts the carrier had established with the BH facilities. It appeared from file review that beds in the carrier's in-network facilities were generally available for the HMO, POS and PPO patients.

It also appeared from the records that certain designated BH facilities and providers determined the lengths of stay for each patient and these BH facilities may be ones that are under global payment arrangements with carriers to manage BH care. While such arrangements may have offered easier access to beds for its patients, it may also have impacted patients' overall length of stay.

Other Issues Associated with BH Care

In several of the records for BH treatment, it appeared that BH patients left the ED or inpatient BH facilities against the recommendation of the providers. This was not observed in the sample of records for the NBH patients.

Most of the carriers tested produced several cases where clinicians documented attempts to contact BH patients who were recommended for outpatient care and the patients failed to respond. Based on claims and UR records, it appears that NBH patients generally attended follow-up care for physical therapy, radiology, and other outpatient services as recommended by medical providers.

There were only a few documented denials of coverage, appeals, or peer reviews in the sample files tested. It is possible that the carriers incurred more of these activities, but that they did not appear in the sampled files.

Summary and Recommendations

From a review of the records, it appears that certain BH patients had long waits to move from the ED to inpatient BH care, which was not the case for NBH patients moving from the ED to inpatient care. In a number of records, it appeared that BH patients waited over two days for transfer to appropriate BH care, while most NBH patients were admitted to inpatient care or discharged to outpatient care within 24 hours. It appears that the BH patients eventually obtained the appropriate BH care, but some waited a much longer period of time than an NBH patient waited to obtain inpatient or outpatient care.

The examination also identified that bed searches appeared to take longer for BH patients than for NBH patients. When BH patients are "stuck" in the ED, they are not able to get appropriate care. Moreover, BH patients place demands on ED staff. The DOI is also aware that there is a financial drain on hospitals when BH patients are not admitted, because hospitals are not able to bill health plans for inpatient care until the BH patients have been transferred from the ED to an inpatient setting.

It is clear from the records that there is a problem with the treatment for BH care. However, it is not clear from an examination of these records whether the carriers are handling referrals for BH care from EDs in a manner that is out of compliance with the requirements of MHPAEA. Despite the fact that BH and NBH outcomes are not equal, the DOI is not able to conclude that current practices are inconsistent with MHPAEA until it obtains more detailed and consistently reported information from the health carriers. Although the health insurance carriers' records may be the best available evidence of their handling of both BH and NBH claims, the records do not have enough information to draw conclusions, especially since the records are not consistent from one carrier to another, or even within a given carrier.

Concerns with the Completeness of Records

Carriers which rely on managed care systems to review the medical necessity of a patient's or provider's health care requests are required under M.G.L. c. 176O to be accredited with the DOI Bureau of Managed Care. According to DOI's managed care regulations – at 211 CMR 52.08(2) - carriers are required to establish "[u]tilization review conducted by a carrier or a UR organization…pursuant to a written plan, under the supervision of a physician and staffed by appropriately trained and qualified personnel, [which] shall include a documented process to:

(a) review and evaluate its effectiveness;
(b) ensure the consistent application of UR criteria; and
(c) ensure the timeliness of UR determinations."

As part of their managed care accreditation applications, health insurance carriers have demonstrated that they do have written plans of UR and do test to ensure the consistent application of criteria and timeliness of UR determinations. The DOI has not, however, taken steps to require that carriers' log standardized information within each record so that it may be examined after the fact for consistency with certain laws, including MHPAEA.

For example, Dixon Hughes found that many records do not consistently record the time of all actions (e.g., when the ESP arrived, when an ESP completed the evaluation, when a bed search was initiated, every time that a hospital was called to attempt to obtain a BH bed). Without this information, it is not possible to identify what obstacles or procedures may be responsible for the delays in obtaining care.

Carriers have established practices to test for compliance with certain managed care laws, including M.G.L. c. 176O, but those practices need to be updated and standardized to capture consistently recorded information in order to test for compliance with MHPAEA. As the DOI makes and implements changes required by Chapter 224 of the Acts of 2012, the DOI intends to examine 211 CMR 52.00 carefully and propose changes to standardize the information recorded in UR carriers records.

Need to Strengthen Certification of Behavioral Health Systems

With the enactment of Chapter 224, the DOI has the authority to enforce federal MHPAEA. The DOI promulgated 211 CMR 154.00 to establish a process to evaluate carriers' compliance with all appropriate parity systems. Carriers are annually required to submit detailed comprehensive information that will illustrate the systems that they employ to operate their BH and NBH UR and any and all differences between their BH and NBH systems.

As the DOI completed its first review of certification materials submitted in the fall of 2013 regarding the carriers' 2012 activities, it became clear that the DOI will need to obtain more specific information to understand the exact details that are part of the carriers' review processes and how they may differ between NBH and BH services. It will also be necessary to collect information that separately examines the processes for differing BH conditions (e.g. eating disorders, depression, substance abuse), because protocols and processes may differ when examining treatment for such services. The certification reviews will need to detail how each type of BH care may differ based on the many different health care locations in which the many BH conditions might be treated.

The certification process going forward will rely on better and more comprehensive information that will be available for the DOI and the general public. The DOI expects that each iteration will enable it to unravel the different systems so as to obtain a clearer picture of where systems provide parity and where they may need to be amended.

Recommendations

This examination finds that carriers' utilization review records do not contain sufficiently available information to draw meaningful conclusions about the carriers' parity compliance. The DOI recommends the following:

- DOI, working in collaboration with carriers, providers, consumer advocates and other interested parties, will develop standards for the level of detail to be included in all provider and carrier records, so that they provide a clear, complete and time-sensitive record of all steps that occur within the review process for BH and NBH patients. Once completed, the DOI should modify its regulations to require that health carriers maintain records that meet the developed standards.
- The DOI will require that carriers use the best current tools, such as the Massachusetts Behavioral Health Access website, to find available beds for approved inpatient care at an out-of-network hospital when in-network hospitals are not available within a reasonable timeframe – never longer than 24 hours. The DOI will require that carriers submit a monthly report whenever an insured member requiring inpatient care is detained in an emergency department for longer than 24 hours and will identify the reasons that the insured member has been detained for that time and the efforts that the carrier had taken to find appropriate care for the patient outside the emergency department.

- The DOI will work with providers, advocates, carriers and other interested parties to develop the protocols for another study to examine the real-time problem in obtaining BH follow-up care.

- The DOI will meet with providers, insurance carriers, consumer advocates and other interested parties to strengthen its annual Mental Health and Addiction Equity Act ("MHPAEA") certification process to collect more information about the systems used in reviewing BH and NBH care for ED patients.

- The DOI will meet with the state Departments of Mental Health and Public Health to examine the development of standards that will identify services and types of providers to include within insured health plan networks for the plans to be considered adequate.