LD 1196
DRAFT AMENDMENT PROPOSED BY HCIFS CHAIRS
FOR REVIEW
February 14, 2022
Revised March 8, 2022

DRAFT PROPOSED AMENDMENT TO LD 1196
BASED ON STAKEHOLDER GROUP RECOMMENDATIONS
AND PRESENTATION TO HCIFS ON 1/25/22

PROPOSED DRAFT COMMITTEE AMENDMENT "." TO **LD 1196, An Act Regarding Targets for Health Plan Investments in Primary Care and Behavioral Health**

Amend the bill by striking out everything after the enacting clause and before the summary and inserting in its place the following:

PART A

Sec. A-1. 24-A MRSA §6903, sub-§1-A is enacted to read:

1-A. Behavioral health care. "Behavioral health care" means services to address mental health and substance use conditions~~, health behaviors, life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization, provided by licensed healthcare practitioners providing services within their scope of practice, regardless of practice setting~~.

Sec. A-2. 24-A MRSA §6951, sub-§13 is enacted to read:

13. Behavioral health care reporting. Beginning January 15, 2023 and annually thereafter, the forum shall submit to the Department of Health and Human Services and the joint standing committee of the Legislature having jurisdiction over health coverage and health insurance matters a report on behavioral health care spending using claims data from the Maine Health Data Organization and information on the methods used to reimburse behavioral health care providers requested annually from payors, as defined in Title 22, section 8702, subsection 8. The report must include:

A. Of their respective total medical expenditures, the percentage paid for behavioral health care by commercial insurers, the MaineCare program, Medicare, the organization that administers health insurance for state employees and the Maine Education Association benefits trust and the average percentage of total medical expenditures paid for behavioral health care across all payors; ~~and~~

B. The total behavioral health care-related non-claims based payments and associated member months;

C. The total payments associated with substance use disorder services that are redacted from the payor's claims data submissions to the organization as required under the Code of Federal Regulations, 42 Part 2 and the methodology used to redact the substance use disorder claims, including specific code lists that are used for procedure codes, revenue codes, diagnoses codes, provider types and any other detail on the claim that is required to select the substance use disorder redacted claim; and

B. The methods used by commercial insurers, the MaineCare program, Medicare, the organization that administers health insurance for state employees and the Maine Education Association benefits trust to pay for behavioral health care.

Within 60 days of a request from the organization, a payor shall provide the following supplemental data sets specific to payments for behavioral health care services necessary to provide the information required in paragraphs B and C. In its request to a payor, the organization shall specify the time period for which the data is requested and the definitions of the data sets requested to ensure uniformity in the data submitted by payors.

Sec. A-3. Maine Quality Forum to conduct health spending reporting study. The Maine Quality Forum, established in the Maine Revised Statutes, Title 24-A, section 6951, shall consult with other state and national agencies and organizations to determine the best practices for reporting spending on behavioral health care services by insurers. For purposes of this section, "behavioral health care" means services to address mental health and substance use conditions.

PART B

~~**Sec. B-1. 24-A MRSA §4301-A, sub-§2-A** is enacted to read:~~

~~**2-A. Behavioral health care services.** "Behavioral health care services" means services, to address mental health and substance use conditions, health behaviors, life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization, provided by licensed healthcare practitioners providing services within their scope of practice, regardless of practice setting.~~

~~**Sec. B-2. 24-A MRSA §4303, sub-§2, paragraph A** is amended to read:~~

~~**2. Credentialing.** The credentialing of providers by a carrier is governed by this subsection.~~

~~A. The granting of credentials must be based on objective standards that are available to providers upon application for credentialing. A carrier shall consult with appropriately qualified health care professionals in developing its credentialing standards. A carrier may not use a credentialing process for a provider of behavioral health care services, or a provider that integrates primary care services with behavioral health care services, that is separate from or more restrictive than the credentialing process used for any other provider.~~

~~**Sec. B-3. 24-A MRSA §4303, sub-§2-B** is enacted to read:~~

~~**2-B. Prohibition on carve-out for payment for behavioral health care**. A carrier may not use a process for submitting a claim for payment for a provider of behavioral health care services, or a provider that integrates primary care services with behavioral health care services, that is separate from or more restrictive than the process used for any other provider.~~

Sec. B-1. 24-A MRSA 24-A MRSA §4303, sub-§2 is amended to read:

2. Credentialing. The credentialing of providers by a carrier is governed by this subsection.

A. The granting of credentials must be based on objective standards that are available to providers upon application for credentialing. A carrier shall consult with appropriately qualified health care professionals in developing its credentialing standards.

B. All credentialing decisions, including those granting, denying or withdrawing credentials, must be in writing. The provider must be provided with all reasons for the denial of an application for credentialing or the withdrawal of credentials. A withdrawal of credentials must be treated as a provider termination and is subject to the requirements of subsection 3-A.

C. A carrier shall establish and maintain an appeal procedure, including the provider's right to a hearing, for dealing with provider concerns relating to the denial of credentialing for not meeting the objective credentialing standards of the plan and the contractual relationship between the carrier and the provider. The superintendent shall determine whether the process provided by a carrier is fair and reasonable. This procedure must be specified in every contract between a carrier and a provider or between a carrier and a provider network if a carrier does not contract with providers individually.

D. A carrier shall make credentialing decisions, including those granting or denying credentials, within 60 days of receipt of a completed credentialing application from a provider. ~~The time period for granting or denying credentials may be extended upon written notification from the carrier within 60 days following submission of a completed application stating that information contained in the application requires additional time for verification. All credentialing decisions must be made within 180 days of receipt of a completed application.~~ For the purposes of this paragraph, an application is completed if the application includes all of the information required by the uniform credentialing application used by carriers and providers in this State, such attachments to that application as required by the carrier at the time of application and all corrections required by the carrier. Within 30 days of initial receipt of a credentialing application, ~~A~~a carrier shall review the entire application and, if it is incomplete, shall return ~~returning~~ it to the provider for corrections with a comprehensive list of all corrections needed at the time the application is first returned to the provider. A carrier may not require that a provider have a home address within the State before accepting an application. A carrier that is unable to make a credentialing decision on a completed credentialing application within the 60 days as required in this paragraph shall notify the bureau in writing prior to the expiration of the 60 days on that application and request authorization for an extension on that application. A carrier that requests an extension shall also submit to the bureau an explanation of the reasons why the credentialing decision on an application is taking longer than is permitted, or, if the problem is not specific to a particular application, a written remediation plan to bring the carrier's credentialing practices in line with the 60-day limit in this paragraph.

~~PART C~~

~~Sec. C-1. 22 MRSA §3187-A~~ ~~is enacted to read:~~

~~§3187-A. Prohibition on carve-out for behavioral health care services~~

~~1. Behavioral health care services defined.~~ ~~For the purposes of this section, "behavioral health care services" means services, to address mental health and substance use conditions, health behaviors, life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization, provided by licensed healthcare practitioners providing services within their scope of practice, regardless of practice setting.~~

~~**2. Licensing of primary care provider.** The department may not require under the MaineCare program that a provider that integrates primary care services with behavioral health care services to obtain a separate license or authorization as a provider of behavioral health care services as a condition of reimbursement under the MaineCare program.~~

~~**3.Credentialing process.** The department may not require under the MaineCare program the use a credentialing process for a provider of behavioral health care services, or a provider that integrates primary care services with behavioral health care services, that is separate than the credentialing process used for any other provider.~~

~~**4. Billing process.** The department may not require under the MaineCare program a process for submitting a claim for payment for a provider of behavioral health care services, or a provider that integrates primary care services with behavioral health care services, that is separate than the process used for any other provider.~~

~~**Sec. C-2. Department of Health and Human Services to complete review of reimbursement rates for behavioral care services.** That, no later than December 31, 2022, the Department of Health and Human Services shall complete its review of reimbursement rates under MaineCare for behavioral health services. The department shall submit the completed review to the joint standing committees of the Legislature having jurisdiction over health and human services matters. The joint standing committees of the Legislature having jurisdiction over health and human services matters Legislature may submit legislation to the First Regular Session of the 131st Legislature based on the department's review.~~

SUMMARY

This amendment replaces the bill. The amendment implements certain recommendations of a stakeholder group established to discuss issues raised by the original bill.

Under current law, the Maine Quality Forum has been required to submit an annual report on primary care spending began in 2020. Part A of the amendment requires the Maine Quality Forum to submit an annual report, beginning January 15, 2023, for behavioral health care spending based on claims data reported to the Maine Health Data Organization and information on methods of reimbursement reported by insurers.

Part B of the amendment requires ~~prohibits health insurance carriers from carving out separate or more restrictive credentialing or billing processes for providers of behavioral health care services or providers that integrate primary care services with behavioral health care services.~~ carriers to make all credentialing decisions on a completed application within 60 days and requires a carrier to notify a provider if an application is incomplete and needs correction within 30 days of initial receipt of an application. A carrier that is unable to make a credentialing decision on a completed credentialing application within the 60 days shall notify the bureau in writing prior to the expiration of the 60 days on that application and request authorization for an extension on that application. A carrier that requests an extension shall also submit to the bureau an explanation of the reasons why the credentialing decision on

an application is taking longer than is permitted, or, if the problem is not specific to a particular application, a written remediation plan to bring the carrier's credentialing practices in line with the 60-day limit.

~~Part C of the amendment prohibits the Department of Health and Human Services from carving out separate credentialing or billing processes for providers of behavioral health care services or providers that integrate primary care services with behavioral health care services under the MaineCare program. The department is also prohibited from requiring that a provider that integrates primary care services with behavioral health care services obtain a separate license or authorization as a provider of behavioral health care services as a condition of reimbursement under the MaineCare program. Part C also requires the department to complete its review of the reimbursement rates under MaineCare for behavioral health services no later than December 31, 2022.~~