

**Human Services Committee
Representative Kathy Hogan, Chairwoman
May 11, 2016**

Chairman Hogan, members of the Human Services Committee, I am Dr. Stephen Nelson, Sr. Director of Medical Services at Sanford Health Plan and a practicing Neonatologist at Sanford Fargo. I appear before you to provide information regarding the health plans' application of the federal Mental Health Parity and Addiction Equity Act (MHPAEA) as it pertains to medical necessity reviews and utilization management. Just to clarify, a utilization review process is a set of formal techniques designed to monitor the use of, evaluate the clinical necessity of, appropriateness, efficacy, or efficiency of, health care services, procedures, or facilities.

How Sanford Health Plan applies mental health parity to Utilization Review

- In conducting Utilization Reviews, the UM Nurse/practitioner will evaluate the member's Presentation/Complaint, Relevant History, Medical History/Medications, Previous Treatment, Mental Health and Substance Use Disorder History, and Treatment Plans and Recommendations.
- "Medically necessary" means health care services that are appropriate in terms of type, frequency, level, setting, and duration to the member's diagnosis or condition, and diagnostic testing. Not all services prescribed or recommended by Plan physicians are necessarily covered by the Plan, based on their medical necessity. The Plan's Chief Medical Officer (or Sr. Medical Director), uses consultants as needed, makes the final determination of which services are covered by the Plan.
- The Plan's Chief Medical Officer or the Senior Medical Director (or Sr. Director of Pharmacy for Pharmacy related decisions), determine whether a service, treatment, technology, prescription drug, or supply (service) is Medically Necessary by applying the following criteria:
 - It must be consistent with generally accepted standards of medical practice, as determined by health care practitioners in the same or similar specialty as typically manages the condition, procedure, or treatment or issue.
 - It should help, restore, or maintain the member's health.
 - The services are required for reasons other than the convenience of the covered person or his/her physician, or solely for custodial, comfort, convenience, appearance, educational, recreational or vocational reasons.
 - It must prevent deterioration of the member's condition.
 - It must prevent the reasonably likely onset of a health problem or detect an incipient problem; and
 - It is not considered experimental or investigational unless part of an Approved Clinical Trial.
- Medical necessity standards and protocols for Mental Health/Substance Abuse services are no more stringent than the Medical necessity standards for a medical/surgical service.
- Prior-authorization requirements for mental health/substance abuse (MH/SA) services are no more stringent than the prior-authorization requirements for a medical or surgical service, such as outpatient knee surgery, or an inpatient admission for heart surgery.
- There are no limits on MH/SA services that are any more stringent than the limits on medical/surgical services. For example, a hospital stay for back surgery is not limited to a certain amount of days, therefore there is no limit on inpatient/residential stays for MH/SA services on how many days the patient is in the inpatient setting.

- Drugs to treat MH/SA services do not require more stringent step-therapy than what would be required in drugs used for diabetes treatment, for example.

Sanford Health Plan has embedded checkpoints for mental health parity at many operational levels:

- A doctoral level behavioral health practitioner is represented on our Physician Quality Committee to advise the Committee on the behavioral health care aspects of the Utilization Management Program and Quality Improvement Program.
- Our UM Coordinator(s)/Technician(s) are required to refer any mental health/substance abuse (MH/SA) cases to a designated behavioral health practitioner, when medical necessity protocols are not met. UM Coordinator(s)/Technician(s) do not have the authority to make denial decisions on MH/SA cases. Only a licensed behavioral health practitioner (i.e., psychiatrist, doctoral-level clinical psychologist or certified addiction medicine specialist) has the authority to deny MH/SA claims based on medical necessity.
- There is no referral requirement for members seeing participating behavioral health care providers at any time. If, for some reason, the participating (contracted) provider listing is not able to provide a service or provide it in a timely manner, procedures are in place for making referrals to providers outside of the network in order to ensure appropriate access, treatment, and coordination of care for the member.
- Behavioral health care providers are contracted to ensure every member is within 50 miles of behavioral health care providers for outpatient services. Sites of service and levels of care for behavioral health services are evaluated through our contracting and credentialing/recredentialing process.
- Our UM nurses must comply with very strict review timelines set by state and federal laws to ensure there is no delay in approving a members stay or care plan including specific timelines to account for urgent care requests.
- Emergency MH/SA care never requires prior-authorization.
- Urgent Care requests for prior-authorization are reviewed and a decision is made by as soon as possible, but no later than seventy-two (72) hours after receipt of the request.

In conclusion, Sanford Health Plan is very committed to the health and well-being of our members, ensuring they get the MH/SA care they need, where they need it, all while following very strict mental health parity rules.

Thank you for your time today.