

MODEL DATA REQUEST FORM (MDRF)

**An Employer Tool for Improving In-Network Access for
Mental Health and Substance Use Disorders (MH/SUD)**

**A Recommendation by the
NATIONAL ALLIANCE OF HEALTHCARE PURCHASER COALITIONS**

[Introduction for Employers](#) (The MDRF begins on the following page)

In response to employers' calls for improving in-network access to care for mental health and substance use disorders (MH/SUDs), this Model Data Request Form (MDRF) was developed to enable employers to: (a) measure the adequacy of their TPA's behavioral provider network, (b) assess any barriers to the network, including actual participation by psychiatrists in their TPA's MH/SUD provider network(s), and (c) request improvements as necessary. The MDRF provides definitions, instructions and data requests that employers can send to their TPAs (or consultants) to obtain meaningful data reporting on four key and readily measurable areas, set forth in a specified format. This document was initially developed by the Mental Health Treatment and Research Institute LLC (MHTARI), a tax-exempt subsidiary of The Bowman Family Foundation, and has been adopted as a best practice by The National Alliance of Health Care Purchaser Coalitions. This document may be updated from time to time. A current version of the MDRF can be found at http://www.mhtari.org/Model_Data_Request_Form.pdf. The MDRF can be used as a tool for effectively measuring network adequacy as part of any existing employer/TPA contract.

The MDRF focuses on four (4) key quantitative measures:

- (1) Out-of-Network Use** of MH/SUD providers versus medical/surgical (M/S) providers
- (2) In-Network Reimbursement Rates** for MH/SUD versus M/S providers
- (3) Denial Rates** for MH/SUD versus M/S services
- (4) Network Adequacy and Participation** for Psychiatrists

When sending the MDRF (with appropriate employer-specific modifications, if any) to TPAs or consultants, employers should indicate in a cover letter which health plans ("Specified Plans" including at least one PPO) and geographic regions ("Specified Regions") are to be analyzed. If, for example, 2 Specified Plans and 2 Specified Regions are identified, then 4 separate versions of MDRF tables should be completed, as well as a 5th "aggregate" version.

DISCLAIMER - No Legal Advice: The MDRF is made available for informational purposes only and is not intended to provide legal advice. Each situation is highly fact specific. Therefore, each employer or other user ("User") of the MDRF should carefully consider: (1) whether the MDRF would achieve its intended purpose and (2) whether modifications to the MDRF are needed, for example, to address the User's specific circumstances. MHTARI disclaims any and all representations and warranties, express or implied, regarding the MDRF, including without limitation, the ability of the MDRF to achieve its intended purpose.

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MODEL DATA REQUEST FORM BEGINS HERE.

[To TPA or consultant]:

Please provide the plan data analyses set forth below within ___ days of today's date. This information will allow our executives to better understand the experience of our plan members when seeking to access MH/SUD treatment as compared to medical/surgical ("M/S") treatment. For each of the four (4) sections set forth below, please provide the data analyses for the health plans ("Specified Plans") and geographic regions ("Specified Regions") *identified in separate instructional correspondence*, and/or for all TPA covered lives in the Specified Region when indicated. Please also provide aggregate versions for Specified Plans and Specified Regions when requested. Please contact us with any questions.

Please provide all information in a manner compliant with HIPAA's Privacy Rule (45 CFR Part 164) and Confidentiality of Substance Use Disorder Records (42 CFR Part 2), as applicable.

SECTION I: OUT-OF-NETWORK USE (BASED ON CLAIMS ALLOWED)

For the Specified Plans that have Out-of-Network ("OON") benefits, (i.e., PPO and/or POS plans, not including plans such as HMOs or plans with only "network gap exceptions"), utilizing total claims allowed for both In-Network ("INN") and OON services, complete Table 1 with respect to the percentage of all allowed claims that were for OON services.

Definitions. For purposes of this MDRF:

- Claims "allowed" are sometimes referred to as claims "paid", and consist of claims approved for payment by the TPA. In some cases, the actual payment may be the member's responsibility, either in whole or in part (e.g., unmet deductible, copay or coinsurance). However, all claims approved for payment by the TPA are considered "allowed" claims.
- Inpatient facility is defined as (a) a hospital, non-hospital based facility or residential treatment facility and encompasses all medical and surgical admissions to general acute care hospitals, long-term acute care hospitals, inpatient rehabilitation facilities and skilled nursing facilities; and (b) all MH/SUD admissions to psychiatric hospitals, general acute care hospitals, non-hospital based inpatient facilities and residential treatment facilities.
- Outpatient facility is defined as (a) physical, occupational, speech, and cardiovascular therapy, surgeries, radiology, pathology and pharmacy services for medical or surgical care provided in an outpatient facility setting; and (b) intensive outpatient and partial hospitalization services for MH/SUD conditions in an outpatient facility setting.
- Office visit is defined as a non-facility based medical/surgical or MH/SUD office visit.

Please refer to the following Milliman report for further definitions regarding OON analyses:

http://assets.milliman.com/ektron/Addiction_and_mental_health_vs_physical_health_Widening_disparities_in_network_use_and_provider_reimbursement.pdf

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Please complete versions of Table 1 below for: (a) the employers' members only, and (b) all TPA covered lives for self-insured plans in the Specified Region, with claims data for Calendar Year 2021 or for the period January 1, 2021 through the latest month in 2021 for which reasonably complete claims data is available.

Instructions for Completing Table 1:

- In Rows 1–3, Columns A and B, insert the percentage of all allowed claims that were for OON services for M/S Providers (Column A) and for MH/SUD Providers (Column B) for inpatient facility stays, outpatient facility visits, and office visits, separately.

“Percentage of allowed claims” is to be based on volume of individual claims (including claims for services delivered via telehealth) and not based on dollar amounts. If there are multiple claims for an extended admission or treatment course, each claim should be counted individually.

For the percentages in question, the numerator and denominators are defined as:

- (1) Numerator for M/S for each setting: # **Out-of-Network** claims **submitted and allowed** for medical and surgical services for the specified time period

Denominator for M/S for each setting: **Total # claims** (In and Out-of-Network) that were **submitted and allowed** for medical and surgical services for the specified time period

- (2) Numerator for MH/SUD for each setting: # **Out-of-Network** claims **submitted and allowed** for MH/SUD services for the specified time period

Denominator for MH/SUD for each setting: **Total # claims** (In and Out-of-Network) **submitted and allowed** for MH/SUD services for the specified time period

- For each row in Column C, subtract the percentage in Column A from the percentage in Column B.
- For each row in Column D, divide the percentage in Column B by the percentage in Column A.

		Table 1 – Data for January 1, 2021 through _____, 2021			
		Column A	Column B	Column C	Column D
	Setting	<u>M/S Providers</u> Percentage of all allowed claims that were for OON services	<u>MH/SUD Providers</u> Percentage of all allowed claims that were for OON services	Percentage of all allowed claims for OON services for MH/SUD Providers <u>minus</u> percentage of all allowed claims for OON services for M/S Providers	How many times more often MH/SUD services were provided OON <u>as compared to</u> M/S services
1	Inpatient Facility Stays	%	%	pct points	x
2	Outpatient Facility Visits	%	%	pct points	x
3	Office Visits	%	%	pct points	x

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Table 1 Comparisons to be Conducted:

For any version of Table 1, in Column C, if the percentage of all allowed claims for OON services for MH/SUD Providers minus the percentage of all allowed claims for OON services for Medical/Surgical Providers is more than 5 percentage points for inpatient facility, outpatient facility or office visits, please provide a **Plan of Improvement** in a separate report within ___ days from the date of your response.

The **Plan of Improvement** should include: specific steps you will undertake to reduce OON use of MH/SUD providers, for example: increasing INN reimbursement rates, by how much and during what time period; reducing utilization review “hassle factors” such as frequency of reviews, time constraints within which peer to peer reviews must be conducted, paperwork (e.g., written treatment plans and updates) not required for M/S providers; overall micromanagement of cases resulting in increased provider administrative costs; length of time it takes for a provider to be admitted to the network; other delays in network provider admission; restraints on appeals for denied care; etc.

Table 1 Relevance:

A differential of 5 percentage points or greater in Column C suggests that members are experiencing greater difficulty in securing timely appointments with In-Network providers for MH/SUD care. Any figure above 1.0 in Column D demonstrates that OON services for MH/SUD were received more often than OON services for M/S. OON use is a key measure for network access, in addition to other measures such as wait times and actual network participation by behavioral health care providers listed in directories. Measures of reimbursement rates and denial rates are also important to consider in assessing network adequacy.

SECTION II: IN-NETWORK REIMBURSEMENT RATES

For In-Network provider office visits only, for the CPT codes provided in Tables 2A, 2B(1) and 2B(2) below, provide the weighted average allowed amounts for the following four (4) groups of providers:

- Primary Care Physicians, “PCPs”, defined as general practice, family practice, internal medicine, and pediatric medicine physicians.
- Non-psychiatrist Medical/Surgical Specialist Physicians, defined to include non-psychiatrist specialty physicians, such as orthopedic surgeons, dermatologists, neurologists, etc. This category excludes PCPs.
- Psychiatrists, including child psychiatrists.
- Psychologists and Clinical Social Workers, defined to include psychologists and clinical social workers who are licensed, credentialed, practice independently and are eligible to be reimbursed for MH/SUD services billed. Other Masters-level MH/SUD clinicians, nurses and psychiatric nurse practitioners should be excluded.

*Please complete versions of Tables 2A, 2B(1) and 2B(2) for **(a) the employers’ members only, and (b) all TPA covered lives for self-insured plans in the Specified Region, with claims data for Calendar Year 2021 or for the period January 1, 2021 through the latest month in 2021 for which reasonably complete claims data is available.***

Instructions for Completing Table 2A:

- In Rows 1–4, insert the weighted average in-network allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for Column A (CPT Code 99213) and Column B (CPT Code 99214). This calculation will provide the same result as calculating the sum of the

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allowed amounts for every in-network 99213 and 99214 claim, separately, that was allowed for these providers, and dividing each sum by the total number of such claims allowed for such providers.

- In Row 5, insert the percentage amount (if any) by which the in-network reimbursement for PCPs and other non-psychiatrist M/S specialist physicians (combined) was greater than for psychiatrists, i.e. $((\text{Row 3} / \text{Row 4}) - 1) \times 100 = __\%$. If this calculation results in zero or a negative number, there was no “higher In-Network reimbursement”.

Table 2A – Data for January 1, 2021 through ____, 2021 Medical/Surgical Physicians <u>compared to</u> Psychiatrists			
	Description	Column A	Column B
	For In-Network Office Visits Only (non-facility based)	CPT Code 99213	CPT Code 99214
1	Weighted average allowed amount for primary care physicians (PCPs) – general practice, family practice, internal medicine, and pediatric medicine physicians	\$	\$
2	Weighted average allowed amount for non-PCP, non-psychiatrist M/S specialist physicians	\$	\$
3	Weighted average allowed amount for PCPs and non-psychiatrist M/S specialist physicians (combined)	\$	\$
4	Weighted average allowed amount for psychiatrists, including child psychiatrists	\$	\$
5	Percentage by which in-network allowed amounts for PCPs and non-psychiatrist M/S specialist physicians (combined) were higher <u>compared to</u> psychiatrists	%	%

Table 2A Comparisons to be Conducted:

If, in any version of Table 2A, the percentage in Row 5, Column A and/or B is a positive number, (indicating that PCPs and non-psychiatrist M/S specialist physicians (combined) receive higher allowed amounts than psychiatrists), provide a **Plan of Improvement** in a separate report within ____ days from the date of your response.

Your **Plan of Improvement** should include an explanation of your plan to increase in-network reimbursement rates for psychiatrists (including by how much and during what time period), as an economic incentive for more psychiatrists to join the network.

Table 2A Relevance:

Reimbursement rates are important to consider when examining adequacy of network participation by psychiatrists and other MH/SUD providers, just as they are for M/S providers. Reimbursement rates are especially important to examine when multiple network adequacy measures indicate disparities in access, such as high OON utilization for MH/SUD and low In-Network participation by MH/SUD providers.

MODEL DATA REQUEST FORM (MDRF)**Instructions for Completing Tables 2B(1) and 2B(2):**

- In Rows 1–3, Column A, insert the plan weighted average in-network allowed amounts (weighted by the proportion of claims allowed at each allowed amount level) for the CPT Codes listed. This calculation will provide the same result as calculating the sum of the allowed amounts for every in-network 99213, 99214, 90834, and 90837 claim, separately, that was allowed for these providers, and dividing each sum by the total number of such claims allowed for such providers.
- There is only one National Medicare Physician Fee Schedule allowed amount for all providers participating in Medicare for the following four (4) CPT codes for which data is requested: 99213, 99214, 90834 and 90837. The Medicare fee schedule allowed amounts for 2021 for non-facility based services have been provided in Column B of the template tables that follow and can be verified by following the instructions in the footnote.¹ National Medicare fee adjustments are sometimes made for non-physician providers. In this regard, the adjusted fee schedule allowed amount for clinical social workers has been provided in the template tables. Provider locality adjustments have not been taken into account for regional markets, as the testing herein is comparative (MH/SUD vs. M/S), rather than absolute, and will thus yield useful allowed amount comparative information irrespective of region.
- Rows 1–3, Column C, insert the plan weighted average in-network allowed amount as a percentage of the Medicare Fee schedule amount.
- In Rows 2–3, Column D, insert the percentage by which in-network allowed amounts for PCPs and non-psychiatrist M/S specialist physicians (combined) (indexed to Medicare) were higher compared to psychologists and clinical social workers (indexed to Medicare). If this calculation results in zero or a negative number, there was no “higher In-Network reimbursement”.
 - For Psychologists: $((\text{Column C Row 1} / \text{Column C Row 2}) - 1) \times 100 = \underline{\quad}\%$
 - For Clinical Social Workers: $((\text{Column C Row 1} / \text{Column C Row 3}) - 1) \times 100 = \underline{\quad}\%$

¹ The Medicare Physician Fee Schedule can be found at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/>. Click on [Medicare Physician Fee Schedule Look-up Tool](#), click the “Begin Search” button, accept the license for use, select the last complete calendar year, select “Pricing information,” select “list of HCPCS codes,” enter each of the four codes, select “All modifiers,” select “National payment amount,” and click the “Search fees” button. **Please utilize the “Non-facility Price” column.** Also refer to the one page [“Medicare Physician Fee Schedule \(MPFS\) Quick Reference Search Guide”](#) for a step-by-step summary of how to use the MPFS. Also refer to [“Medicare Claims Processing Manual,” Chapter 12, “Physicians / Nonphysician Practitioners”](#) to verify any adjustments to the MPFS.

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Table 2B(1) – Data for January 1, 2021 through ____, 2021 Medical/Surgical Physicians compared to Psychologists and Clinical Social Workers for CPT Codes 99213 & 90834, Indexed to National Medicare Fee Schedule						
			Column A	Column B	Column C	Column D
	Provider Type For In-Network Office Visits Only (non-facility based)	CPT Codes	Plan Weighted Average Allowed Amount	National Medicare Fee Schedule Amount	Plan Weighted Average Allowed Amount as a Percentage of Medicare	Percentage by which In-Network allowed amounts for PCPs and non-psychiatrist M/S specialist physicians (combined) (indexed to Medicare) were higher <u>compared</u> <u>to</u> psychologists and clinical social workers (indexed to Medicare)
1	PCPs and non-psychiatrist M/S specialist physicians (combined)	99213	\$	\$92.47	%	
2	Psychologists	90834	\$	\$103.28	%	%
3	Clinical Social Workers	90834	\$	\$77.46	%	%

Table 2B(2) – Data for January 1, 2021 through ____, 2021 Medical/Surgical Physicians compared to Psychologists and Clinical Social Workers for CPT Codes 99214 & 90837, Indexed to National Medicare Fee Schedule						
			Column A	Column B	Column C	Column D
	Provider Type For In-Network Office Visits Only (non-facility based)	CPT Codes	Plan Weighted Average Allowed Amount	National Medicare Fee Schedule Amount	Plan Weighted Average Allowed Amount as a Percentage of Medicare	Percentage by which In-Network allowed amounts for PCPs and non-psychiatrist M/S specialist physicians (combined) (indexed to Medicare) were higher <u>compared</u> <u>to</u> psychologists and clinical social workers (indexed to Medicare)
1	PCPs and non-psychiatrist M/S specialist physicians (combined)	99214	\$	\$131.20		
2	Psychologists	90837	\$	\$152.48		%
3	Clinical Social Workers	90837	\$	\$114.36		%

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Tables 2B(1) and 2B(2) Comparisons to be Conducted:

If, in any version of Tables 2B(1) and 2B(2), the percentage in Column D is a positive number (indicating that PCPs and non-psychiatrist M/S specialist physicians (combined) receive higher allowed amounts relative to the National Medicare Fee Schedule than psychologists and/or clinical social workers), provide a **Plan of Improvement** in a separate report within ____ days from the date of your response.

Your **Plan of Improvement** should address the comparability of reimbursement rates, as well as the adequacy of MH/SUD rates if there are disparities in OON use shown in Section I. Please include specific actions you plan to take, such as increasing in-network reimbursement rates that would address lack of comparability in rates and/or high MH/SUD OON use.

Tables 2B(1) and 2B(2) Relevance:

As is the case with psychiatrists, reimbursement rates are important to consider when examining adequacy of network participation for psychologists and other MH/SUD professionals, just as they are for M/S providers. Reimbursement rates are especially important to examine when multiple network adequacy measures indicate disparities in access, such as high OON utilization for MH/SUD and/or, low In-Network participation by MH/SUD providers.

SECTION III: DENIAL RATES

Using the definitions below, in Tables 3A and 3B provide a breakdown of In-Network (INN) and Out-of-Network (OON) denial rates for MH/SUD and for M/S services.

A **denial** is defined as a determination not to authorize or allow any or all parts of a service requested or performed in any of the following 3 settings: (1) Inpatient facility; (2) Outpatient facility; and (3) Office visits. These settings, as well as the term “allow(ed)” are defined in **Section I**.

A **denial** is further defined as follows:

- Any “modified” authorizations, i.e., for lower-cost services than requested by the provider;
- Any “partial denials” i.e., number of days or visits approved are less than what the provider requested unless subsequently authorized on concurrent or retrospective review of the full requested number of days or visits.

Please do **not** include as a **denial**:

- Claims for which less than 10% of the cost value of the entire claim was denied;
- Denials based on coordination of benefits (COB);
- Denials based on lack of member eligibility.

For purposes of this MDRF:

- *A denial on initial review* counts as a denial whether or not ultimately overturned on appeal. Appeal overturn rates are not addressed in the MDRF.
- *For cases in which there are authorizations at precertification and for some concurrent review, and then a denial is issued on a subsequent concurrent review*, the last relevant review with a denial is to be counted as a denial for which no claim was submitted.
- *Concurrent reviews* are to be counted based on the volume of reviews conducted. Each denial for any concurrent review conducted within an episode of care counts as a denial.
- *For inpatient M/S denials*, include both DRG and non-DRG based claims.

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Please complete the tables listed below for: **(a) the employer's members only, and (b) all TPA covered lives for self-insured plans in the Specified Region**, with claims data for Calendar Year 2021, or for the period January 1, 2021 through the latest month in 2021 for which reasonably complete claims data is available.

Instructions for Completing Tables 3A and 3B:

- Please provide information on the number and percent of denials for MH/SUD services compared to M/S services **(1)** by setting and **(2)** reported separately for:
 - (a) *lack of medical necessity* reasons; and
 - (b) *administrative reasons* (not based on a clinical review), as shown in Tables 3A and 3B and as described below.
- **Table 3A – Denials on Utilization Review for Which No Claim was Submitted**, shown as a percentage (%) – i.e., authorization for coverage of service was denied, and service was either not received or was received and paid for by the member. (Data is located in the case (UR/UM) database as well as the claims database)

Complete separate versions of Table 3A for:

(1) Pre-authorization denials:

- (a) Numerator: No. of **pre-authorization** denials based on **lack of medical necessity** for the specified services in the specified setting
Denominator: Total no. of **pre-authorization** reviews conducted for the specified services in the specified setting
- (b) Numerator: No. of **pre-authorization** denials based on **administrative reasons** for the specified services in the specified setting
Denominator: Total no. of **pre-authorization** reviews conducted for the specified services in the specified setting

(2) Concurrent review denials:

- (a) Numerator: No. of **concurrent review** denials based on **lack of medical necessity** for the specified services in the specified setting
Denominator: Total no. of **concurrent reviews** conducted for the specified services in the specified setting
- (b) Numerator: No. of **concurrent review** denials based on **administrative reasons** for the specified services in the specified setting
Denominator: Total no. of **concurrent reviews** conducted for the specified services in the specified setting

- **Table 3B – Denials of Claims Submitted**, shown as a percentage (%) – i.e., coverage of service denied; service was received, and claim was submitted and not allowed (whether denial takes place prior to or upon claim submission). Do not count resubmission of the same claim as an additional denial. (Data is located in the claims database)

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Complete separate versions of Table 3B for:

(1) Claim Denials on Pre-authorization:

- (a) Numerator: No. of claim denials of **pre-authorization** based on **lack of medical necessity** for the specified services in the specified setting
Denominator: Total no. of claims submitted for the specified services in the specified setting
- (b) Numerator: No. of claim denials of **pre-authorization** for **administrative reasons** for the specified services in the specified setting
Denominator: Total no. of claims submitted for the specified services in the specified setting

(2) Claim Denials on Concurrent Review:

- (a) Numerator: No. of claim denials on **concurrent review** based on **lack of medical necessity** for the specified services in the specified setting
Denominator: Total no. of claims submitted for the specified services in the specified setting
- (b) Numerator: No. of claim denials on **concurrent review** for **administrative reasons** for the specified services in the specified setting
Denominator: Total no. of claims submitted for the specified services in the specified setting

(3) Claim Denials on Retrospective Review:

- (a) Numerator: No. of claim denials on **retrospective review** based on **lack of medical necessity** for the specified services in the specified setting
Denominator: Total no. of claims submitted for the specified services in the specified setting
- (b) Numerator: No. of claim denials on **retrospective review** for **administrative reasons** for the specified services in the specified setting
Denominator: Total no. of claims submitted for the specified services in the specified setting

- Complete all of the versions of Tables 3A and 3B described above separately for:
 - (a) INN providers; and
 - (b) OON providers – use data for plans with OON benefits, i.e., PPO and/or POS plans, not including plans such as HMOs or plans with only “network gap exceptions”

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Table 3A – Denials on Utilization Review for Which No Claim was Submitted Percentages						
Data for January 1, 2021 through _____, 2021						
Setting	Medical Necessity			Administrative		
	Med/Surg	MH/SUD	Were MH/SUD denial rates the same as or lower than M/S? (Yes/No)	Med/Surg	MH/SUD	Were MH/SUD denial rates the same as or lower than M/S? (Yes/No)
Inpatient Facility Stays	%	%		%	%	
Outpatient Facility Visits	%	%		%	%	
Office Visits	%	%		%	%	

Table 3B – Denials of Claims Submitted Percentages						
Data for January 1, 2021 through _____, 2021						
Setting	Medical Necessity			Administrative		
	Med/Surg	MH/SUD	Were MH/SUD denial rates the same as or lower than M/S? (Yes/No)	Med/Surg	MH/SUD	Were MH/SUD denial rates the same as or lower than M/S? (Yes/No)
Inpatient Facility Stays	%	%		%	%	
Outpatient Facility Visits	%	%		%	%	
Office Visits	%	%		%	%	

Tables 3A and 3B Comparisons to be Conducted:

If there is a disparity in any category of denial rates for M/S compared to MH/SUD in which MH/SUD denial rates are higher than M/S denial rates in at least 2/3rds of circumstances across all of the versions of Table 3A (various care settings, various reasons for denials, various utilization review types, in-network and out-of-network, combined), and/or across in all the versions of Table 3B, please provide a **Plan of Improvement** within ___ days from the date of your response.

Your **Plan of Improvement** should describe how you will address these disparities, including: a review of the reasons for these disparities, such as the use and application of level of care guidelines or criteria; UR practices such as frequency of reviews, duration of care authorized, application of clinically appropriate guidelines matching specific level of care requested; elimination of exclusions for residential provider types and/or levels of care; elimination of more stringent geographic exclusions or limitations than for M/S benefits, etc.

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Tables 3A and 3B Relevance:

Medical necessity reviews and denials are an important tool for TPAs to ensure appropriate payment for medically necessary services. Denial rates that are higher for MH/SUD vs M/S can be a signal that MH/SUD is reviewed differently than M/S. Denial rates are also important to be examined in the context of other network adequacy measures such as OON use, reimbursement rates and network provider actual participation.

SECTION IV: NETWORK ADEQUACY AND PARTICIPATION FOR PSYCHIATRISTS

Using Table 4, provide information regarding your MH/SUD provider network in the Specified Region. Complete a separate version of Table 4 for each Specified Plan in each Specified Region.

Instructions for Completing Table 4:

- In Rows 1–4, insert the requested figures.
 - Data should include inpatient facility, outpatient facility and office visit settings (combined) and be completed for the “Applicable Six Months” as defined in Row 1 of Table 4.
 - The intent of this question is to identify all individual psychiatrists that meet three criteria: **(i)** they are **in-network**, **(ii)** they are able to be individually identified by members via one or more directories, and **(iii)** their claims (or absence of claims) can be individually tracked by TPA. If TPA supplements its own network with contracted “Vendors” that provide additional psychiatrists (virtual or in-office, such as MDLive, Teledoc, Lyra, etc.), please review the two examples below on how to account for these additional in-network psychiatrists.

Example 1: In addition to TPA's own in-network # of 500 psychiatrists listed in TPA directory (i.e., those not provided by Vendor A):

- Vendor A has 250 psychiatrists (in total)
- TPA has in-network access to 200 (out of the 250). For these 200, TPA members can view and access each psychiatrist individually via TPA's directory or Vendor A's directory **AND** TPA has access to individual claims for these 200 psychiatrists
- Response for first row (total number in network) = 500 (TPA) + 200 (Vendor A) = 700
- Responses for other rows should follow based on **TPA and Vendor A information**

Example 2: In addition to TPA's own in-network # of 500 psychiatrists listed in TPA directory (i.e., those not provided by Vendor B):

- Vendor B has 300 psychiatrists (in total)
- TPA has in-network access to 150 (out of the 300). For these 150, TPA members can view and access each psychiatrist individually via TPA's directory or Vendor B's directory, **BUT TPA has NO access to individual claims for these 150 psychiatrists**
- Response for first row (total number in network) = 500 (TPA)
- Responses for other rows should follow based on **TPA (only) information**

- Add the figures in Rows 2, 3, and 4. If the sum does not equal the figure in Row 1, re-check the data and adjust the responses until they are equal.
- In Row 6, insert the requested figure.
- In Row 7, insert the following ratio: 1:(Row 6 / Row 4)
- In Row 8, insert the following figure: (Row 2 / Row 1) x 100 = ____%
- In Row 9, insert the sum of Rows 3 and 4.
- In Row 10, insert the following figure: (Row 7 / Row 1) x 100 = ____%

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	Table 4 – In-Network Provider Directory – Psychiatrists	Specified Plan in Specified Region
1	Total number of psychiatrists (including child psychiatrists) who were listed as participating in your MH/SUD provider networks (TPA and any contracted vendor(s) network(s)) in the Specified Region <u>during any time</u> in the most recent 6 months of 2021 for which reasonably complete claims data is available (“ Applicable Six Months ”):	
2	Number of psychiatrists (including child psychiatrists) who submitted <u>zero in-network claims</u> relating to the members of the Specified Plan in the Specified Region during the Applicable Six Months:	
3	Number of psychiatrists (including child psychiatrists) who submitted in-network <u>claims for 1 to 4 unique members</u> of the Specified Plan in the Specified Region during the Applicable Six Months:	
4	Number of psychiatrists (including child psychiatrists) who submitted in-network <u>claims for 5 or more unique members</u> of the Specified Plan in the Specified Region during the Applicable Six Months:	
5	Does the sum of the numbers in Rows 2, 3 and 4 equal the number in Row 1? (Yes/No) If “No”, please adjust responses until the answer is “Yes.”	
6	Total number of unique members of the Specified Plan in the Specified Region (i.e., covered lives):	
7	Ratio of psychiatrists who submitted in-network <u>claims for 5 or more unique members</u> of the Specified Plan in the Specified Region during the Applicable Six Months to covered lives (i.e., 1: xxxx)	1: _____
8	The percentage of total psychiatrists (including child psychiatrists) who were listed as participating in your provider networks (TPA and any contracted vendor(s) networks(s)) in the Specified Region during any time in the Applicable Six Months who submitted <u>zero in-network claims</u> during the Applicable Six Months:	%
9	Total number of psychiatrists (including child psychiatrists) who submitted in-network <u>claims for fewer than 5 unique members</u> (zero in-network claims OR claims for 1 to 4 unique members) of the Specified Plan in the Specified Region during the Applicable Six Months:	
10	The percentage of total psychiatrists (including child psychiatrists) who were listed as participating in your provider networks (TPA and any contracted vendor(s) networks(s)) in the Specified Region during any time in the Applicable Six Months who submitted in-network <u>claims for fewer than 5 unique members</u> (zero in-network claims OR claims for 1 to 4 unique members) of the Specified Plan in the Specified Region during the Applicable Six Months:	%

MODEL DATA REQUEST FORM (MDRF)

Table 4 Comparisons to be Conducted:

If the percentage listed in Row 8 is above 10% or the percentage listed in Row 10 is above 20%, provide a **Plan of Improvement**.

Your **Plan of Improvement** should describe how you will address network provider adequacy, including monitoring actual provider network participation, and improving and ensuring compliance with network adequacy standards, including wait times, to ensure sufficient and timely access to network providers, etc.

Table 4 Relevance:

Psychiatrists listed as participating in the network who are billing for few or no members may not actually be available for members seeking care. Actual network provider participation is one important network adequacy measure and should be considered in the context of other measures, including OON use, wait times, reimbursement rates, etc.

[MODEL DATA REQUEST FORM ENDS HERE.](#)