Maryland - MHPAEA Summary Form Instructions

The below summary form is prepared to satisfy the requirements of §15-144 (m)(2), Insurance Article, Annotated Code of Maryland. The summary form must be made available to plan members and to the public on the carrier's website.

Confidential and proprietary information must be removed from the summary form. Confidential and proprietary information that is removed from the summary form must satisfy § 15-144(h)(1), Insurance Article, Annotated Code of Maryland.

The MHPAEA Summary Form includes the MHPAEA Data Report.

Carriers must use the terms defined in COMAR 31.10.51 and the *Instructions for MHPAEA NQTL Analysis Report and Data Report* to complete the summary form.

MHPAEA Summary Form

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), UnitedHealthcare must make sure that there is "parity" between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that financial requirements and treatment limitations applied to mental health or substance use disorder benefits cannot be more restrictive than the financial requirements and treatment limitations applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements—such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- Treatment limitations—such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization).

UnitedHealthcare has performed an analysis of mental health parity as required by Maryland law and has submitted the required report to the State of Maryland. Below is a summary of that report.

If you have questions on your specific health plan, please call the toll-free number on the back of your insurance card.

Overview:

We have identified the five health benefit plans with the highest enrollment for each product we offer in the individual, small, and large group markets, as applicable. These plans contain items called Non-Quantitative Treatment Limitations (NQTLs) that put limits on benefits paid. What these NQTL's are and how the health plans achieve parity are discussed below.

1. Definition of Medical Necessity

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

[redacted]

B. Identify the factors used in the development of the limitation(s);

Committee considerations:

a. Clinical efficacy
b. Safety
c. Appropriateness of the proposed technology

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

[redacted]

[redacted]

D. Identify the methods and analysis used in the development of the limitation(s); and

To approve medical policy/behavioral clinical policy and/or clinical criteria, committees have been established and a standard process is followed. [redacted]

[redacted]

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Findings "In writing": The findings of the analysis reflected the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to (1) develop internal evidence-based medical/clinical policies and (2) approve externally developed criteria for use in utilization management were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to develop evidenced-based medical policies "as written."
Conclusion "In writing": The Plan concluded the methodologies used to (1) develop MH/SUD internal evidence-based medical/clinical policies and (2) approve MH/SUD externally developed criteria for use in utilization management were comparable to, and applied no more stringently than, the methodologies used to (1) develop M/S internal evidence-based medical/clinical policies and (2) approve M/S externally developed criteria for use in utilization management "in-writing."
Findings "In operation": The findings of the analysis revealed the processes and methodology MH/SUD used to assess and develop clinical policies "in operation" was comparable to, and applied no more stringently than, the processes and methodology M/S used to assess and develop medical policies.
Conclusion "In operation": The Plan concluded the methodologies used to (1) develop MH/SUD internal evidence-based medical/clinical policies and (2) approve MH/SUD externally developed criteria for use in utilization management were comparable to, and applied no more stringently than, the methodologies used to (1) develop M/S internal evidence-based medical/clinical policies and (2) approve M/S externally developed criteria for use in utilization management "in-operation."

2. Prior Authorization Review Process

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

See Addendum A for list of M/S and MH/SUD services

B. Identify the factors used in the development of the limitation(s);

Factor:
- Clinical Appropriateness: The application of prior authorization promotes optimal clinical outcomes
- Value: The value of applying prior authorization review outweighs the associated costs

- Variation Identified: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor:

- Clinical Appropriateness: The application of prior authorization promotes optimal clinical outcomes

Source:

- Expert Medical Review
- Objective, evidence-based clinical criteria, and nationally recognized guidelines

Evidentiary Standard:

- Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines

Factor:

- Value: The value of applying prior authorization review outweighs the associated costs

Source:

- Internal claims data
- UM program operating costs
- UM authorization data

Evidentiary Standard:

- Value is defined as the value of subjecting the outpatient services to prior authorization review exceeds the administrative costs by at least 1:1

Factor:

- Variation Identified: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits

Source:

- Internal claims data

Evidentiary Standard:

- Variation is defined as cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members

D. Identify the methods and analysis used in the development of the limitation(s); and

Prior authorization is a component of the Plan's utilization management (UM) program that helps ensure members receive appropriate care, based on their specific clinical status and health care needs before care is received. The purpose of prior authorization is to enable the facility or provider and the member to have an informed pre-service review; in cases where it is determined that the service will not be covered the member can then decide whether to receive and pay for the service. When the in-network provider or facility or member requests prior authorization, the Plan reviews the request utilizing applicable medical/clinical policies and/or guidelines, criteria, and Plan terms, and then renders a coverage determination. Adverse determinations are rendered by appropriately qualified clinical reviewers (e.g., MD or PhD/PsyD). The provider, facility, and member are notified of an adverse determination, which includes the credentials of the individual who rendered the decision, and is consistent with state, federal and accreditation requirements and applicable appeal rights are provided.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.
Findings: The findings of the analysis indicated the strategy, process, factors, evidentiary standards, and source information used to subject MH/SUD services to prior authorization were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject M/S services to prior authorization "as written."

Conclusion: The Plan concluded the methodology used to determine which MH/SUD services are subject to prior authorization "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S services are subject to prior authorization "as written."

Findings: The findings of the analysis of the shared factors as evidenced by the factor grid and the findings of the analysis of outcomes data indicated the prior authorization medical necessity approval and denial rates and appeals outcomes for MH/SUD services were comparable to the prior authorization medical necessity approval and denial rates and appeals outcomes for M/S services.

Conclusion: The Plan concluded the methodology used to determine which MH/SUD services are subject to prior authorization "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S services are subject to prior authorization "in operation."

3. Concurrent Review Process

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

See Addendum A for list of M/S and MH/SUD services

B. Identify the factors used in the development of the limitation(s);

Factor:

- Clinical Appropriateness: The application of prior authorization promotes optimal clinical outcomes
- Value: The value of applying prior authorization review outweighs the associated costs
- Variation Identified: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor:

- Clinical Appropriateness: The application of prior authorization promotes optimal clinical outcomes

Source:

- Expert Medical Review
- Objective, evidence-based clinical criteria, and nationally recognized guidelines

Evidentiary Standard:

- Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines

Factor:

- Value: The value of applying prior authorization review outweighs the associated costs

Source:

- Internal claims data
- UM program operating costs
- UM authorization data

Evidentiary Standard:

- Value is defined as the value of subjecting the outpatient services to prior authorization review exceeds the administrative costs by at least 1:1

Factor:

- Variation Identified: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits

Source:

- Internal claims data

Evidentiary Standard:

- Variation is defined as cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members

D. Identify the methods and analysis used in the development of the limitation(s); and

Concurrent review is a component of the Plan's utilization management program (UM) that helps ensure members receive appropriate care, based on their specific clinical status and health care needs. The process is designed to achieve optimal clinical outcomes by applying objective, evidence-based clinical criteria and nationally recognized guidelines and best practices to reduce unnecessary variation in clinical use of services. The reviewer's assessment of whether a continuing course of outpatient treatment is covered is based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria and nationally recognized guidelines, and the terms of the Plan. When the Medical Director, Physical Therapist, Chiropractor or Psychologist determines that the continuing course of treatment is not medically necessary, and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided. An in-network provider, depending on the provider contract, may bill the member for non-covered charges.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Findings: The findings of the analysis indicated the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD outpatient services to concurrent review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S outpatient services to concurrent review "as written."

Conclusion: The Plan concluded the methodology used to determine which MH/SUD INN outpatient services are subject to concurrent review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S INN outpatient services are subject to concurrent review "as written."

Findings: The findings of the analysis of the shared factors as evidenced by the factor grid and the findings of the analysis of outcomes data indicated the medical necessity approval and denial rates and appeals outcomes for MH/SUD outpatient services were comparable to the medical necessity approval and denial rates and appeals outcomes for M/S outpatient services.

Conclusion: The Plan concluded the methodology used to determine which MH/SUD OON outpatient services are subject to concurrent review "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to concurrent review "in operation."

F. Retrospective Review Process

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

See Prior Auth lists of services in Addendum A for list of services that are also subject to retrospective review.

B. Identify the factors used in the development of the limitation(s);

Factor:

- Clinical Appropriateness: The application of prior authorization promotes optimal clinical outcomes
- Value: The value of applying prior authorization review outweighs the associated costs
- Variation Identified: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor:

- Clinical Appropriateness: The application of prior authorization promotes optimal clinical outcomes

Source:

- Expert Medical Review
- Objective, evidence-based clinical criteria, and nationally recognized guidelines

Evidentiary Standard:

- Clinical Appropriateness is defined as those inpatient services that as determined by internal medical experts, are in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines

Factor:

- Value: The value of applying prior authorization review outweighs the associated costs

Source:

- Internal claims data
- UM program operating costs

- UM authorization data

Evidentiary Standard:

- Value is defined as the value of subjecting the outpatient services to prior authorization review exceeds the administrative costs by at least 1:1

Factor:

- Variation Identified: Outpatient services subject to variability in cost per episode of service relative to other services within the classification of benefits

Source:

- Internal claims data

Evidentiary Standard:

- Variation is defined as cost per episode of service (service units X unit cost) that trigger 2x the mean of other outpatient services and provided to a minimum of twenty unique Plan members

D. Identify the methods and analysis used in the development of the limitation(s); and

Retrospective review is a component of the Plan's utilization management (UM) program. Retrospective review begins after the Plan receives notification post-service and/or after a submission of a claim. Services are reviewed based on whether the member's clinical condition meets criteria for coverage based on the application of objective, evidence-based clinical criteria, and nationally recognized guidelines. If an appropriately qualified clinical reviewer (e.g., Medical Directors) determines that a service was not medically necessary and will not be covered, the member, facility and the physician will be notified consistent with state, federal or accreditation requirements and applicable appeal rights are provided.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Findings: The findings of the analysis confirmed the strategy, process, factors, evidentiary standards, and source information used to subject certain MH/SUD outpatient services to retrospective review were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards, and source information used to subject certain M/S outpatient services to retrospective review "as written."
Conclusion: The Plan concluded the methodology used to determine which MH/SUD OON outpatient services are subject to retrospective review "as written" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to retrospective review "as written."

Findings: The findings of the analysis of the shared factors and the findings of the analysis of outcomes data indicated the retrospective review medical necessity approval and denial rates and appeals outcomes for MH/SUD outpatient services were comparable to the retrospective review medical necessity approval and denial rates and appeals outcomes for M/S outpatient services.
Conclusion: The Plan concluded the methodology used to determine which MH/SUD OON outpatient services are subject to retrospective review "in operation" were comparable to, and applied no more stringently than, the methodology used to determine which M/S OON outpatient services are subject to retrospective review "in operation."

G. Emergency Services

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

The Plan does not impose Non-quantitative Treatment Limitations (NQTL's) on Emergency Services

B. Identify the factors used in the development of the limitation(s);

The Plan does not impose Non-quantitative Treatment Limitations (NQTL's) on Emergency Services

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

The Plan does not impose Non-quantitative Treatment Limitations (NQTL's) on Emergency Services

D. Identify the methods and analysis used in the development of the limitation(s); and

The Plan does not impose Non-quantitative Treatment Limitations (NQTL's) on Emergency Services

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

The Plan does not impose Non-quantitative Treatment Limitations (NQTL's) on Emergency Services\

H. Pharmacy Services

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

N/A – See Prior Authorization

B. Identify the factors used in the development of the limitation(s);

N/A – See Prior Authorization

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

N/A – See Prior Authorization

D. Identify the methods and analysis used in the development of the limitation(s); and

N/A – See Prior Authorization

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

N/A – See Prior Authorization

I. Prescription Drug Formulary Design

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

PDL a/k/a Formulary design applies to all prescription drugs

B. Identify the factors used in the development of the limitation(s);

Factor:

- Assessment of the prescription drug's place in therapy

- Relative safety and efficacy
- Available therapeutic equivalent prescription drugs

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor:

- Assessment of the prescription drug's place in therapy

Source:

- FDA approved product labeling
- Peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, and potential for off label use
- Claims data

Factor:

- Relative safety and efficacy

Source:

- FDA approved product labeling
- Peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, and potential for off label use
- Claims data

Factor:

- Available therapeutic equivalent prescription drugs

Source:

- FDA approved product labeling
- Peer-reviewed medical literature, including randomized clinical trials, drug comparison studies, pharmacoeconomic studies, outcomes research data, published clinical practice guidelines, comparisons of efficacy, side effects, and potential for off label use
- Claims data

Evidentiary Standard:

- The Initial Tier Placement and Product Coverage Policy is used to assign tiers for all prescription drugs.
- Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. Generic prescription drug includes a prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UHC identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load

memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.

- The Initial Tier Placement and Product Coverage Policy is used to assign tiers for all prescription drugs.
- Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. Generic prescription drug includes a prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UHC identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.

- The Initial Tier Placement and Product Coverage Policy is used to assign tiers for all prescription drugs.
- Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. Generic prescription drug includes a prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UHC identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.

D. Identify the methods and analysis used in the development of the limitation(s); and

Prescription Drug List (PDL) a/k/a Formulary Design is a component of the Plan's utilization management (UM) program. The goal of PDL/Formulary Design is to assess the prescription drug's place in therapy. The Pharmacy & Therapeutics (P&T) Committee assesses a prescription drug's place in therapy, and its relative safety and efficacy, in order to provide a clinical recommendation/designation used in determining coverage and tier assignment. The P&T Committee is comprised of a diversity of clinical disciplines including behavioral health. Additional physician specialists with specific expertise are consulted as part of the clinical evaluation of new and existing drugs. PDL a/k/a Formulary Design is based on the Plan's policy to assign tiers for prescription drugs. Newly launched generic prescription drugs are also reviewed to determine initial tier placement on the PDL and/or benefit coverage. Generic prescription drug includes a prescription drug: (1) that is chemically equivalent to a brand drug; or (2) that UnitedHealthcare (UHC) identifies as a generic based on available data resources including, but not limited to, the daily Medi-Span file load memo that classifies drugs as either brand or generic based on a number of factors. Generics will be considered for initial tier placement and/or benefit coverage equal to that of the current placement of the brand prescription drug.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

The following are results of each analysis in 2021:

- **January 2021** –
  - 58.9% of MH/SUD drugs are on Tiers 1 and 2
  - 54% of M/S drugs are on Tiers 1 and 2
- **May 2021** –
  - 59.1% of MH/SUD drugs are on Tiers 1 and 2
  - 53.6% of M/S drugs are on Tiers 1 and 2
- **September 2021** –
  - 60.0% of MH/SUD drugs are on Tiers 1 and 2
  - 53.7% of M/S drugs are on Tiers 1 and 2

J. Case Management

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;
Case Management is not an NQTL.

B. Identify the factors used in the development of the limitation(s);
Case Management is not an NQTL.

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;
Case Management is not an NQTL.

D. Identify the methods and analysis used in the development of the limitation(s); and
Case Management is not an NQTL.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.
Case Management is not an NQTL.

K. Process for Assessment of New Technologies

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;
All technologies determined to be Experimental/Investigational/Unproven (EIU)

B. Identify the factors used in the development of the limitation(s);

Factor:

- Plan exclusions for EIU technologies and EIU definitions as outlined in plan documents
- Committee considerations (Clinical efficacy, Safety, Appropriateness of the proposed technology)

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor:

- Plan exclusions for EIU technologies and EIU definitions as outlined in plan documents

Source:

- Plan documents

[redacted]

D. Identify the methods and analysis used in the development of the limitation(s); and

[redacted]

[redacted]

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Findings: The findings of the analysis reflected the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to (1) assess whether technologies are EIU and (2) develop evidenced-based clinical policies were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to 1) assess whether a technology is EIU and (2) develop evidence-based clinical policies "as written."
Conclusion: The Plan concluded the methodologies MH/SUD used to 1) assess whether a technology is EIU and (2) develop evidence-based clinical policies were comparable to, the methodologies M/S used to 1) assess whether a technology is EIU and (2) develop evidence-based clinical policies "as written."
Findings: The comparative analysis revealed the strategy, process and methodology MH/SUD used to assess EIU technologies and develop clinical policies "in operation" was comparable to, and applied no more stringently than, the strategy, process and methodology M/S used to assess EIU technologies and develop of medical policies.
Conclusion: The Plan concluded the methodologies MH/SUD used to 1) assess whether a technology is EIU and (2) develop evidence-based clinical policies were comparable to, the methodologies M/S used to 1) assess whether a technology is EIU and (2) develop evidence-based clinical policies "in-operation."

L. Standards for Provider Credentialing and Contracting

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

Credentialing - Applies to all in-network providers and facilities providing covered services in the Inpatient In-Network, Outpatient In-Network, and Emergency Care classifications

B. Identify the factors used in the development of the limitation(s);

Factor:
- The provider or facility completes and attests to the accuracy of the content of the application
- The Plan verifies certain information, i.e., primary source verification, in the application
- The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with the Plan

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor:
- The provider or facility completes and attests to the accuracy of the content of the application

Source:
- Submission of application

Factor:
- The Plan verifies certain information, i.e., primary source verification, in the application

Source:
- The UHC and UBH Credentialing plans describes the information, i.e., primary source verification, that is required

Factor:
- The provider or facility continues to meet the requirements set forth in the credentialing plan while they are contracted with the Plan

Source:
- The State and federal regulatory requirements, for example, Medicare Managed Care Manual, Section 6
- National accreditation standards, for example NCQA CR3 and CR4
- The UHC and UBH Credentialing plans

Evidentiary Standard:
- Submission of application
- The UHC and UBH Credentialing plans describes the information, i.e., primary source verification, that is required
- The State and federal regulatory requirements, for example, Medicare Managed Care Manual, Section 6
- National accreditation standards, for example NCQA CR3 and CR4
- The UHC and UBH Credentialing plans

D. Identify the methods and analysis used in the development of the limitation(s); and

Credentialing is performed to determine if a provider or facility meets standards to join (credential) or maintain (recredential) their status in the Plan's network of participating providers. The Plan uses its credentialing and recredentialing processes to validate that its network of contracted providers and facilities providing inpatient, outpatient, and emergency services meet the baseline criteria, as applicable, to the State and practicing specialty. The process is triggered by a provider or facility seeking to join or continue participation in the Plan's network to determine whether the provider or facility has the appropriate level of education/licensure/certification and satisfies additional qualifications (as applicable) to provide covered care to Plan members. The Plan uses credentialing processes and plans based on NCQA standards and applicable state or Federal regulatory requirements when determining whether to credential M/S and MH/SUD providers or facilities. To successfully complete the credentialing process, both M/S and MH/SUD providers and facilities must meet the baseline criteria as applicable to the State and practicing specialty, which can be found in the UnitedHealthcare (UHC) Credentialing Plan or United Behavioral Health (UBH) Credentialing Plan or state addendum. Individual (and certain facility-based) providers must complete the CAQH application, or state-mandated application where applicable, and attestation.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.
Findings: The findings of the parity analysis revealed the Credentialing Plan for MH/SUD network providers was comparable to, and applied no more stringently than, the Credentialing Plan for M/S network providers.
Conclusion: In light of the above, the Plan concluded the credentialing requirements applied to MH/SUD network providers were comparable to, and applied no more stringently than, the credentialing requirements applied to M/S network providers "as written."
Findings: The findings revealed there were no significant disparate outcomes for MH/SUD providers as compared to M/S providers.
Conclusion: The Plan concluded the credentialing requirements applied to MH/SUD network providers were comparable to, and applied no more stringently than, the credentialing requirements applied to M/S network providers "in operation."

M. Exclusions for Failure to Complete a Course of Treatment

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;
The Plan does not exclude benefits for failure to complete a course of treatment.

B. Identify the factors used in the development of the limitation(s);
The Plan does not exclude benefits for failure to complete a course of treatment.

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;
The Plan does not exclude benefits for failure to complete a course of treatment.

D. Identify the methods and analysis used in the development of the limitation(s); and
The Plan does not exclude benefits for failure to complete a course of treatment.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.
The Plan does not exclude benefits for failure to complete a course of treatment.

N. Restrictions that Limit Duration or Scope of Benefits for Services

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

Geographic Restrictions - Under the Plan benefit documents, services received at the following facilities are subject to the out-of-network geographic restriction: Health care services from an Out-of-Network provider for non-emergent, sub-acute inpatient, or outpatient services at any of the following non-Hospital facilities: Alternate Facility, Freestanding Facility, Inpatient Rehabilitation Facility, or Skilled Nursing Facility received outside of the Covered Person's state of residence.

B. Identify the factors used in the development of the limitation(s);
Out-of-network (OON) facilities providing non-emergent, subacute inpatient and/or outpatient services located outside of the member's state of residence

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Source:

- Provider Directory
- Treatment type requested and/or billed. e.g., revenue codes, HCPCS, etc.
- Facility service location/address
- Member address
- Plan benefit documents

Services not subject to geographic restriction include:

- Out-of-network facilities providing emergency acute inpatient and/or outpatient services located outside of the member's state of residence;
- Out-of-network facilities providing non-emergent, subacute inpatient and/or outpatient services located within the member's state of residence and
- All in-network services

D. Identify the methods and analysis used in the development of the limitation(s); and

Geographic Restrictions, out-of-network, out-of-area service limitation is intended to encourage members to utilize in-network providers. The out-of-network, out-of-area, geographic restriction does not limit coverage for out-of-network benefits within the member's service area, nor does it limit in-network services nationally. The goal is to promote access to evidence-based care and improved treatment outcomes. A member's request for care is assessed to determine whether the servicing provider is an in- or out-of-network provider and within a level of care subject to the restriction. Service requests rendered by an out-of-network provider, out of the member's service area are denied administratively as a non-covered benefit.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Findings: The findings of the analysis revealed that both M/S and MH/SUD services received at comparable OON facilities outside of the member's state of residence were subject to the Geographic Restriction. The same triggering events for the NQTL were applied to both M/S and MH/SUD services and the State of Residence was defined similarly for all services. The same sources of information were used to define the factors.
Conclusion: Based on this comparative analysis, the Plan concluded the strategy, process, factors, evidentiary standards, and source information used to develop the Geographic Restriction applied to MH/SUD services were comparable to, and applied no more stringently than, the strategy, process, factors, evidentiary standards and source information applied to M/S services "as written."

Restrictions for Provider Specialty

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;
The Plan does not restrict the types of provider specialties.

B. Identify the factors used in the development of the limitation(s);
The Plan does not restrict the types of provider specialties.

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;
The Plan does not restrict the types of provider specialties.

D. Identify the methods and analysis used in the development of the limitation(s); and
The Plan does not restrict the types of provider specialties.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.
The Plan does not restrict the types of provider specialties.

O. <u>Reimbursement for INN Providers, OON Providers, INN Facilities, OON Facilities (separately)</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

Reimbursement – INN IP, INN OP, OON IP, OON OP, Emergency

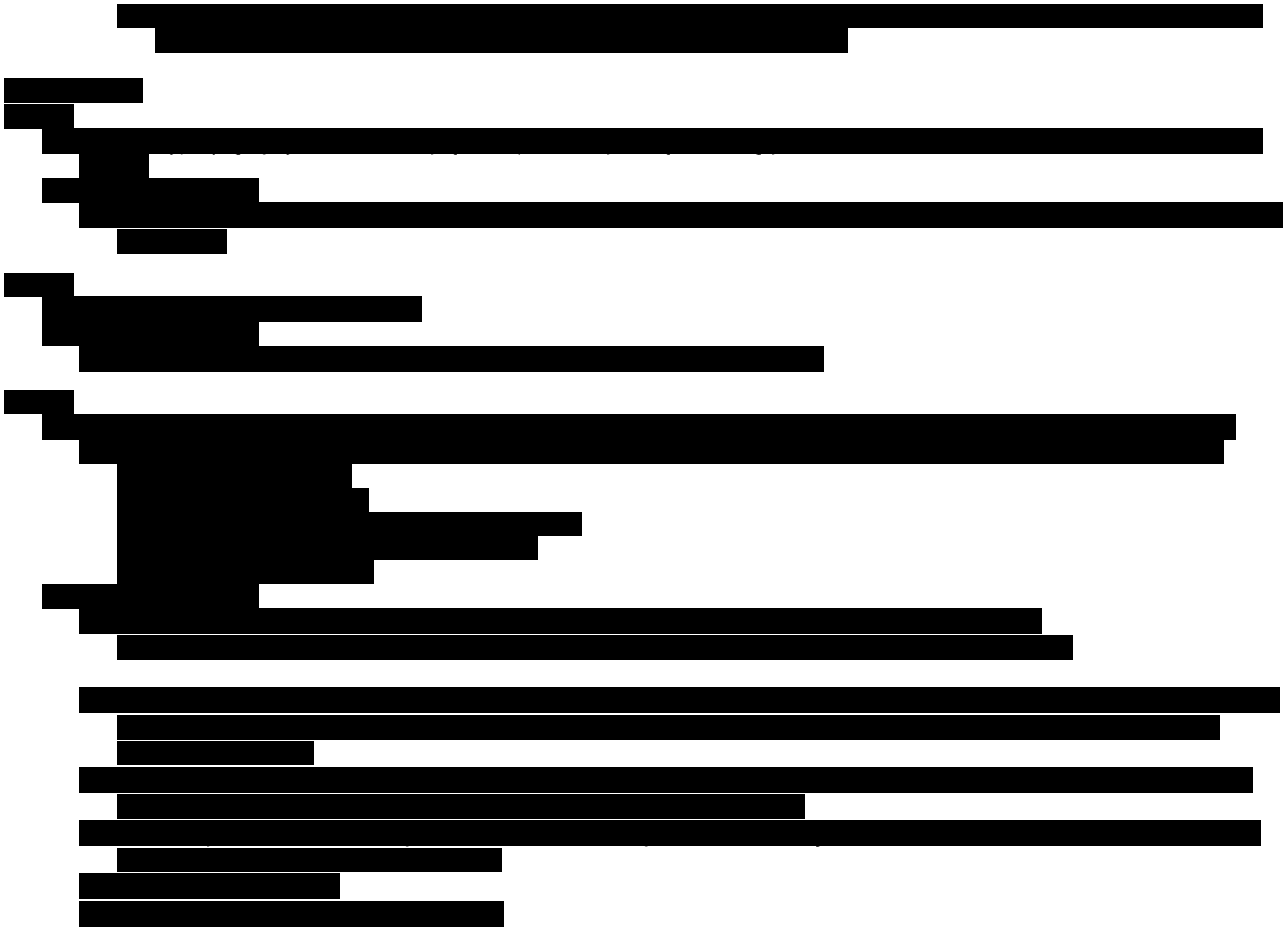
B. Identify the factors used in the development of the limitation(s);

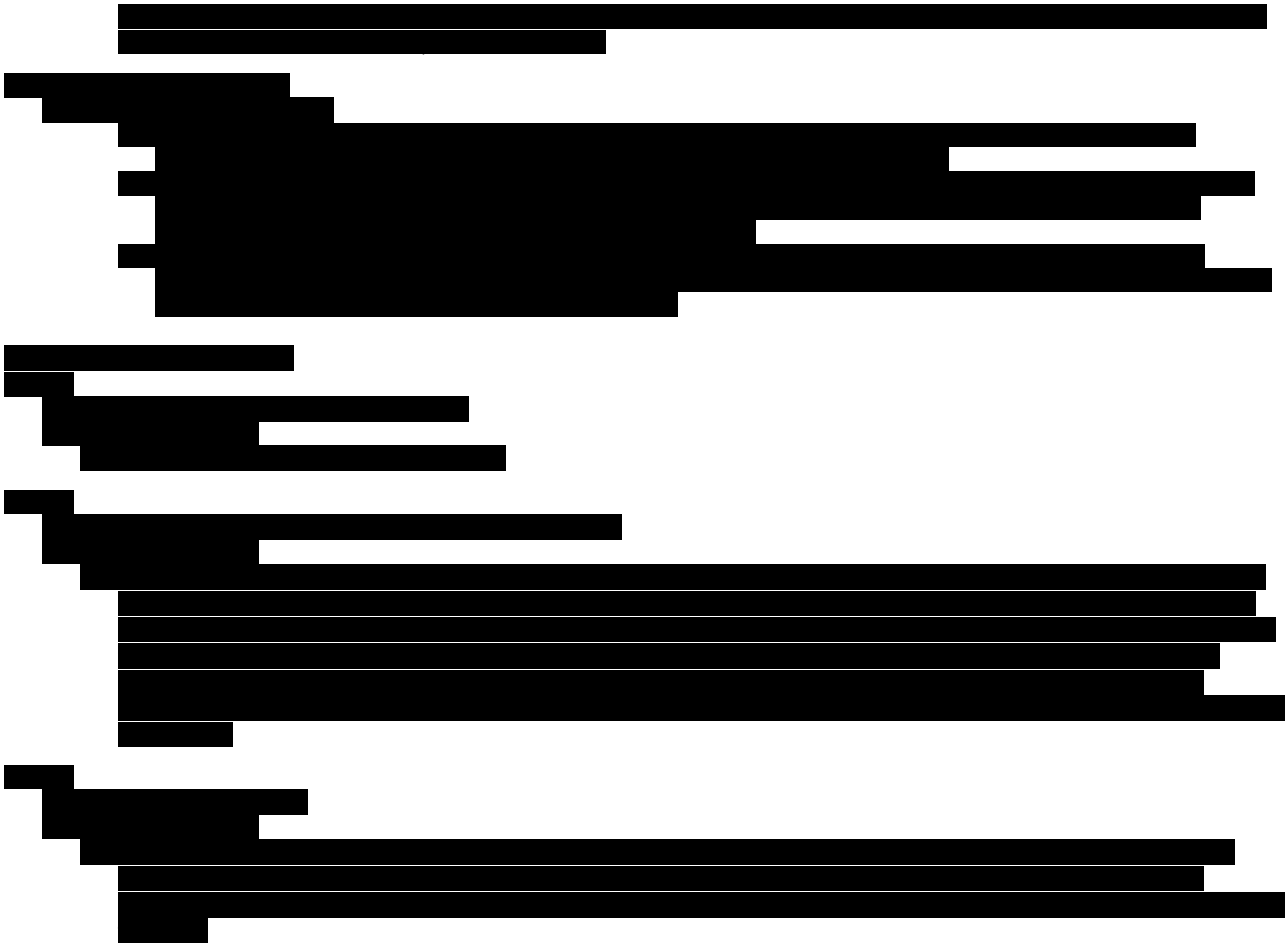
[redacted]

[redacted]

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

[redacted]





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D. Identify the methods and analysis used in the development of the limitation(s); and

[redacted]

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

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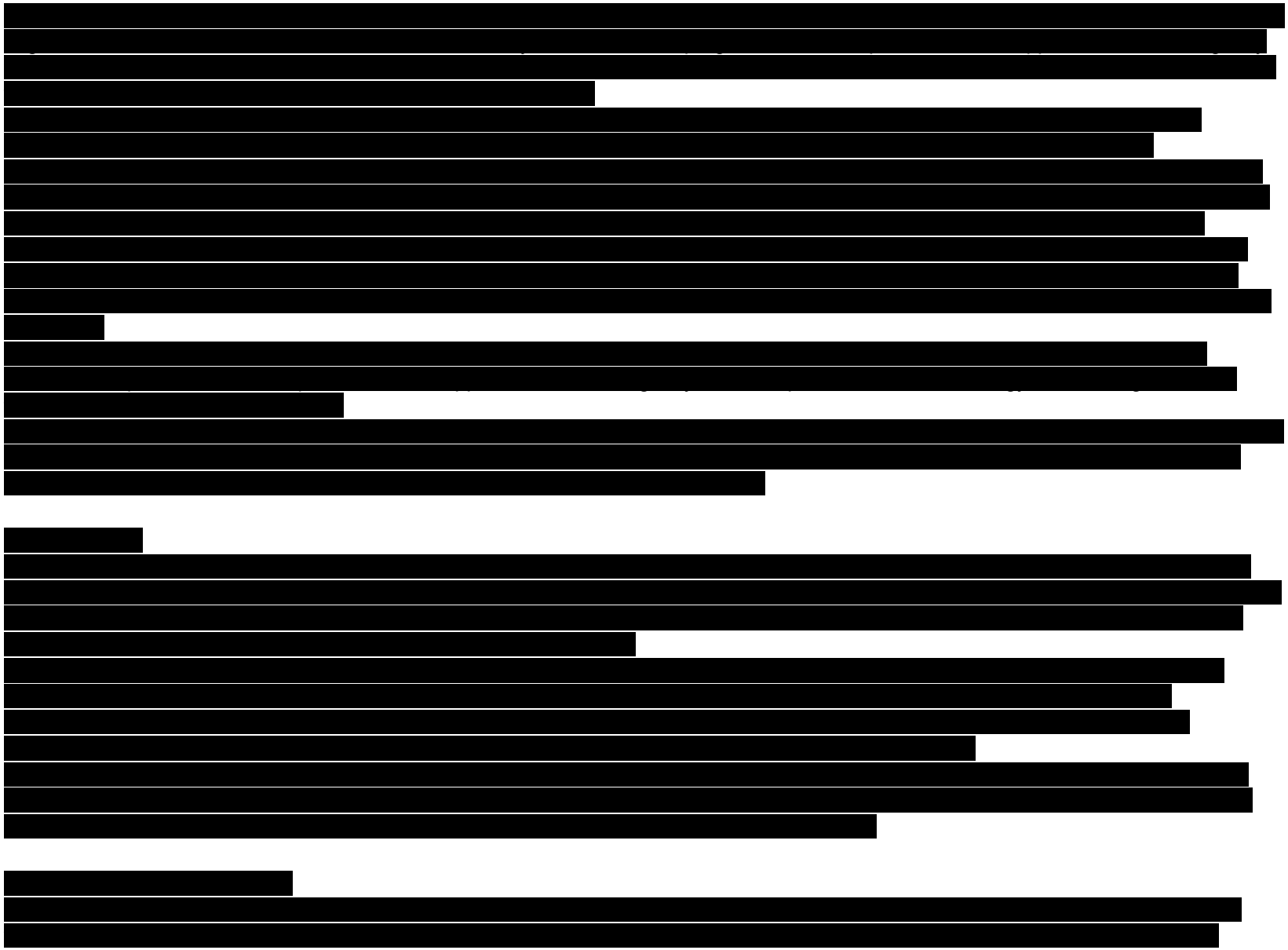

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