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;
This is not applicable for Student Resources (SR). SR does not define nor review claims for medical necessity.

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

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

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

N/A

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

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;

Prior Authorization is only applicable to Prescription Drugs. Please note: When prescription drugs are reviewed, medical necessity is not part of the review process for Student Resources.

Prescription –
Prior Authorization and Step Therapy applies to prescription drugs provided to a member at the point-of-sale. Prior Authorization and Step Therapy begin after a provider or member requests coverage for prescription drug services and receipt of clinical information. A Prior Authorization or Step Therapy request may be submitted by fax, telephone, or electronically. The Medical Director or healthcare professional assesses whether a prescription drug should be covered. The Prior Authorization or Step Therapy request is approved based on whether the drug criteria has been met. Please note that the request is not reviewed for medical necessity. If a Medical Director or

healthcare professional determines that the prescription drug will not be covered, the member and the prescriber will be notified consistent with state and federal requirements and applicable appeal rights will be provided.

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

Prescription –

Factor:

- Assessment of the prescription drug's place in therapy

Factor:

- Availability of clinically similar lower cost medications to treat the condition
- Administrative burden to implement Prior Authorization/Step Therapy

Factor:

- Relative safety and efficacy
- Prevention of off-label use or unproven uses

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

Prescription –

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, potential for off label use and claims data analysis as relevant

Evidentiary Standard:

- State and/or Federal regulations and guidelines
- Review of external clinical evidence
- Nationally recognized evidence-based guidelines and benchmarks
- Pharmacy & Therapeutics (P&T) Committee

Factor:

- Availability of clinically similar lower cost medications to treat the condition
- Administrative burden to implement Prior Authorization/Step 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, potential for off label use and claims data analysis as relevant

Evidentiary Standard:
- State and/or Federal regulations and guidelines
- Review of external clinical evidence
- Nationally recognized evidence-based guidelines and benchmarks

Factor:
- Relative safety and efficacy
- Prevention of off-label use or unproven uses

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, potential for off label use and claims data analysis as relevant

Evidentiary Standard:
- State and/or Federal regulations and guidelines
- Review of external clinical evidence
- Nationally recognized evidence-based guidelines and benchmarks
- Pharmacy & Therapeutics (P&T) Committee assesses the prescription drug's place in therapy, and its relative safety and efficacy. The committee reviews decisions consistent with published evidence relative to these factors

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 to determine if the drug criteria has been met.

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.

Please note: When prescription drugs are reviewed, medical necessity is not part of the prior authorization review process for Student Resources.

Prescription –

Findings: The findings of the analysis reflected the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply for a particular prescription drug service "as written." Further, both M/S and MH/SUD utilize generally accepted types of data, evidentiary sources, and trend analysis in order to create and maintain a Prior Authorization or Step Therapy requirement.

Conclusion: The plan concluded the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply for a particular prescription drug service "as written."

Findings: The following are results of each analysis in 2021: January 2021 - 20.6% (114) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 16.1% (1,241) of M/S drugs are subject to these programs. May 2021 - 17% (94) of MH/SUD drugs are subject to Prior Authorization, Step Therapy, and/or Quantity Limits, while 16.1% (1,242) of M/S drugs are subject to these programs. September 2021 – 16% (94) of MH/SUD drugs are subject to Prior Auth, Step Therapy, and/or Quantity Limits, while 16.3% (1,249) of M/S drugs are subject to these programs.

Conclusion The plan concluded the strategy, processes, factors, evidentiary standards, and source information MH/SUD used to determine whether the requirement will apply for a particular prescription drug service were comparable to, and applied no more stringently than, the strategy, processes, factors, evidentiary standards, and source information M/S used to determine whether the requirement will apply for a particular prescription drug service "in operation."

2. Concurrent Review Process

Not applicable for Student Resources. Student Resources does not perform Concurrent Reviews

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

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

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

N/A

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

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

F. Retrospective Review Process

Please note: When services are reviewed retrospectively, medical necessity is not part of the review process for Student Resources.

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;

INN IP –
Retrospective review begins after the Plan receives notification post-discharge or post-service and/or after a submission of a claim. The claim is reviewed against the provisions of the plan (e.g., plan limits, exclusions, experimental/investigational, etc.). The retrospective review does not review for medical necessity.

OON IP –
Retrospective review begins after the Plan receives notification post-discharge or post-service and/or after a submission of a claim. The claim is reviewed against the provisions of the plan (e.g., plan limits, exclusions, experimental/investigational, etc.). The retrospective review does not review for medical necessity.

INN OP –

Retrospective review begins after the Plan receives notification post-service and/or after a submission of a claim. The claim is reviewed against the provisions of the plan (e.g., plan limits, exclusions, experimental/investigational, etc.). The retrospective review does not review for medical necessity.

OON OP –
Retrospective review begins after the Plan receives notification post-service and/or after a submission of a claim. The claim is reviewed against the provisions of the plan (e.g., plan limits, exclusions, experimental/investigational, etc.). The retrospective review does not review for medical necessity.

Emergency – N/A

Prescription – N/A

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;

M/S

Factor:
• Plan exclusions for EIU technologies and EIU definitions as outlined in plan documents
Source:
• Plan documents
Evidentiary Standards:
• Plan documents
Factor:
• Committee considerations (Clinical efficacy, Safety, Appropriateness of the proposed technology)
Source:
• Plan documents
Evidentiary Standards:

- Scientifically based clinical evidence
- Peer-reviewed literature
- Hierarchy of Clinical Evidence
  - Statistically Robust, well-designed randomized controlled trials;
  - Statistically Robust, well-designed cohort studies;
  - Multi-site observational studies;
  - Single-site observational studies

(No M/S service is deemed unproven solely on the basis of a lack of randomized controlled trials particularly for new or emerging medical technologies)

In the absence of strong and compelling scientific evidence, the committee would review:

- National guidelines and consensus statements
- Centers for Medicare and Medicaid Services (CMS) National Coverage Decisions (NCDs)
- Clinical position papers based upon rigorous review of scientific evidence or clinical registry data from professional specialty societies when their statements are based upon referenced clinical evidence, e.g., ACP, AMDA, AAFP, ACOG, ACC, etc.

MH/SUD

Factor:

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

Source:

- Plan documents

Evidentiary Standards:

- Plan documents

Factor:

- Committee considerations (Clinical efficacy, Safety, Appropriateness of the proposed technology)

Source:

- Scientifically based clinical evidence
- Peer-reviewed literature
- Hierarchy of Clinical Evidence

Evidentiary Standards:

- Scientifically based clinical evidence
- Peer-reviewed literature
- Hierarchy of Clinical Evidence Systematic reviews and meta analyses
  - Randomized controlled trials
  - Large non-randomized controlled trials
  - Large prospective trials
  - Comparative and cohort studies
  - Cross sectional studies
  - Retrospective studies
  - Surveillance studies
  - Case Reviews/Case series
  - Anecdotal/editorial statements
  - Professional opinions

(No MH/SUD service is deemed unproven solely on the basis of a lack of randomized controlled trials particularly for new and emerging behavioral health technologies)

In the absence of strong and compelling scientific evidence, clinical policies may be based upon:

- National consensus statements
- Publications by recognized authorities such as government sources and/or professional societies

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

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]

[redacted]

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.

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 is not applicable to Student Resources.
B. Identify the factors used in the development of the limitation(s);
N/A
C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;
N/A
D. Identify the methods and analysis used in the development of the limitation(s); and

N/A

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

O. 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.

P. <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

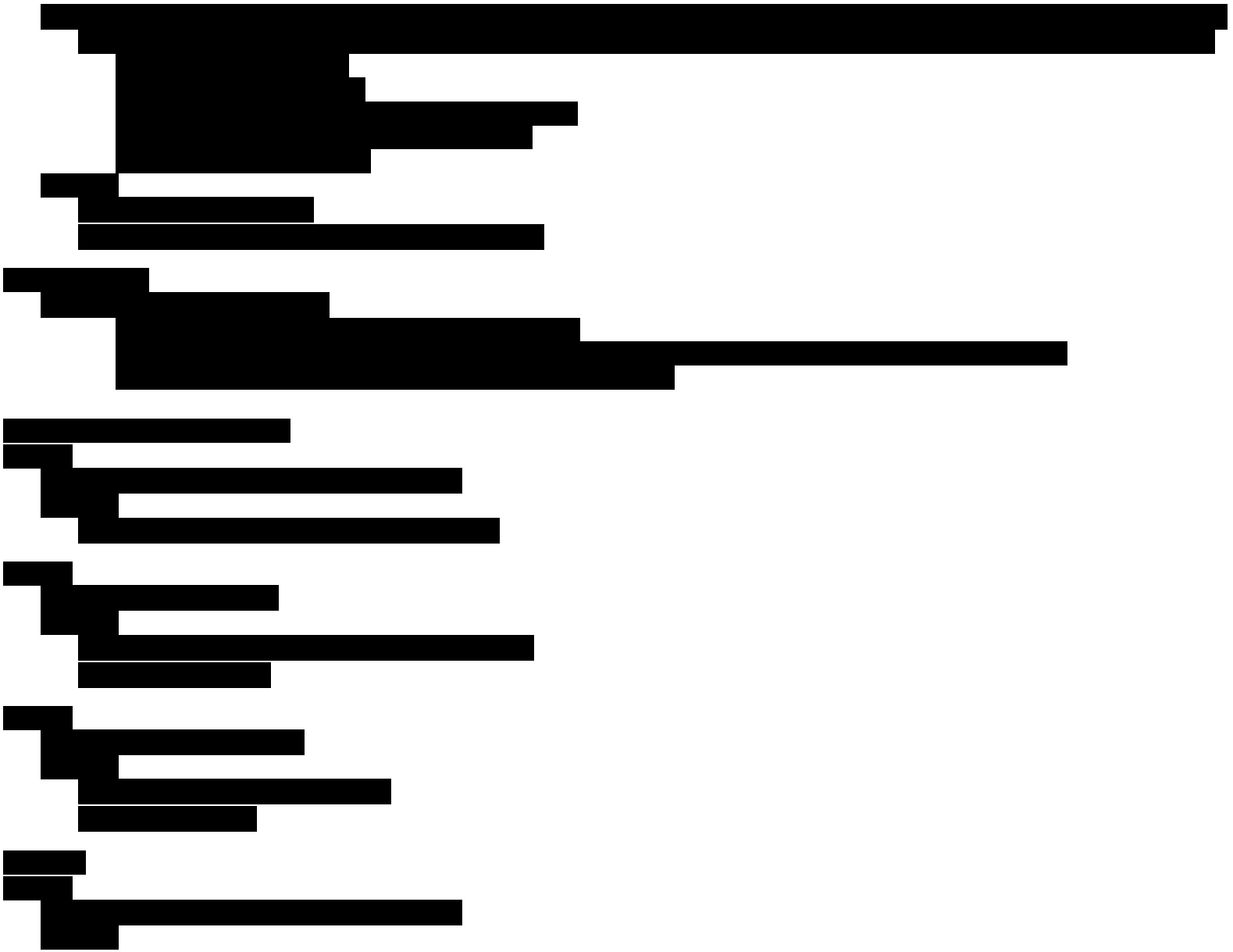
B. Identify the factors used in the development of the limitation(s);

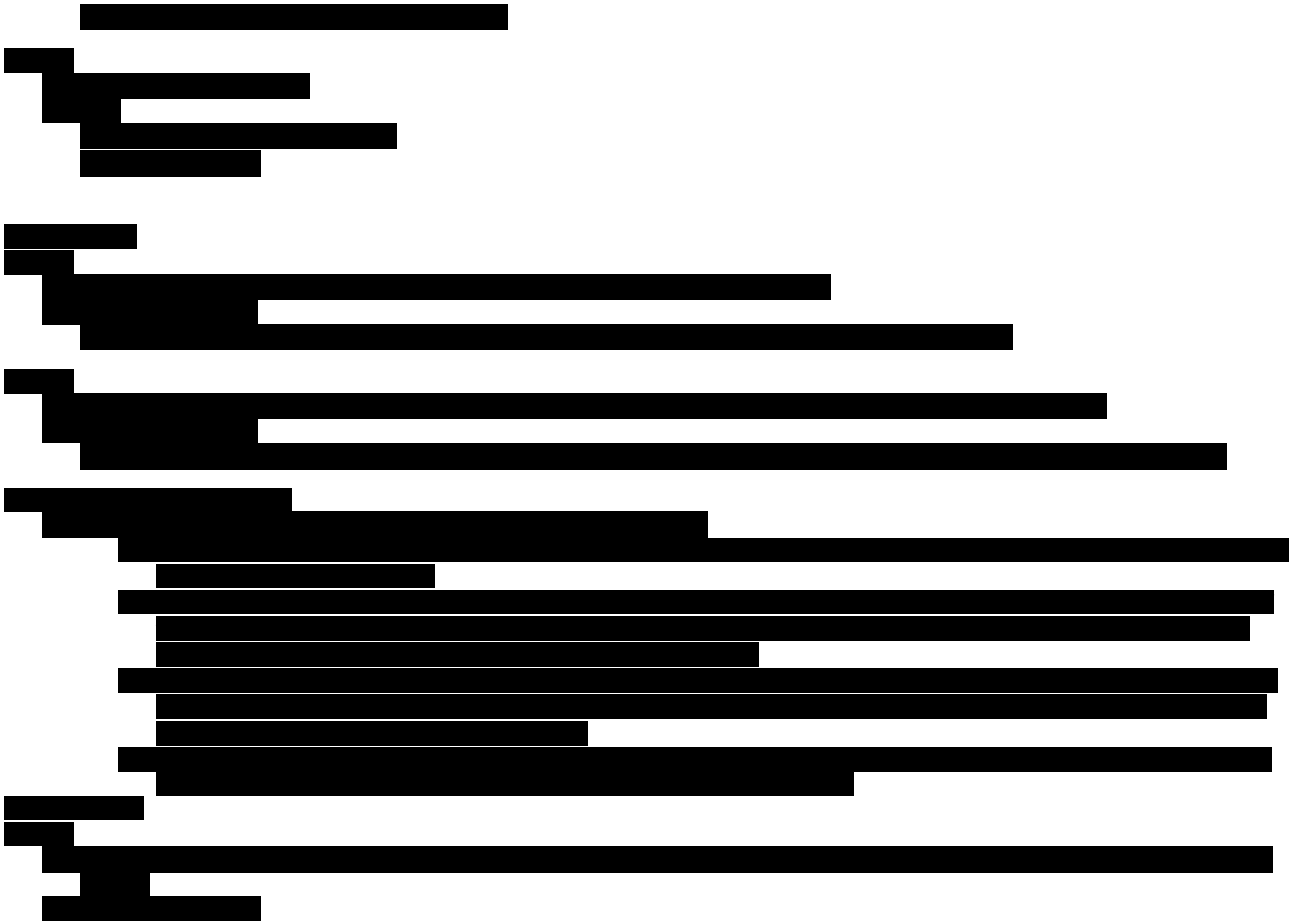
[redacted]

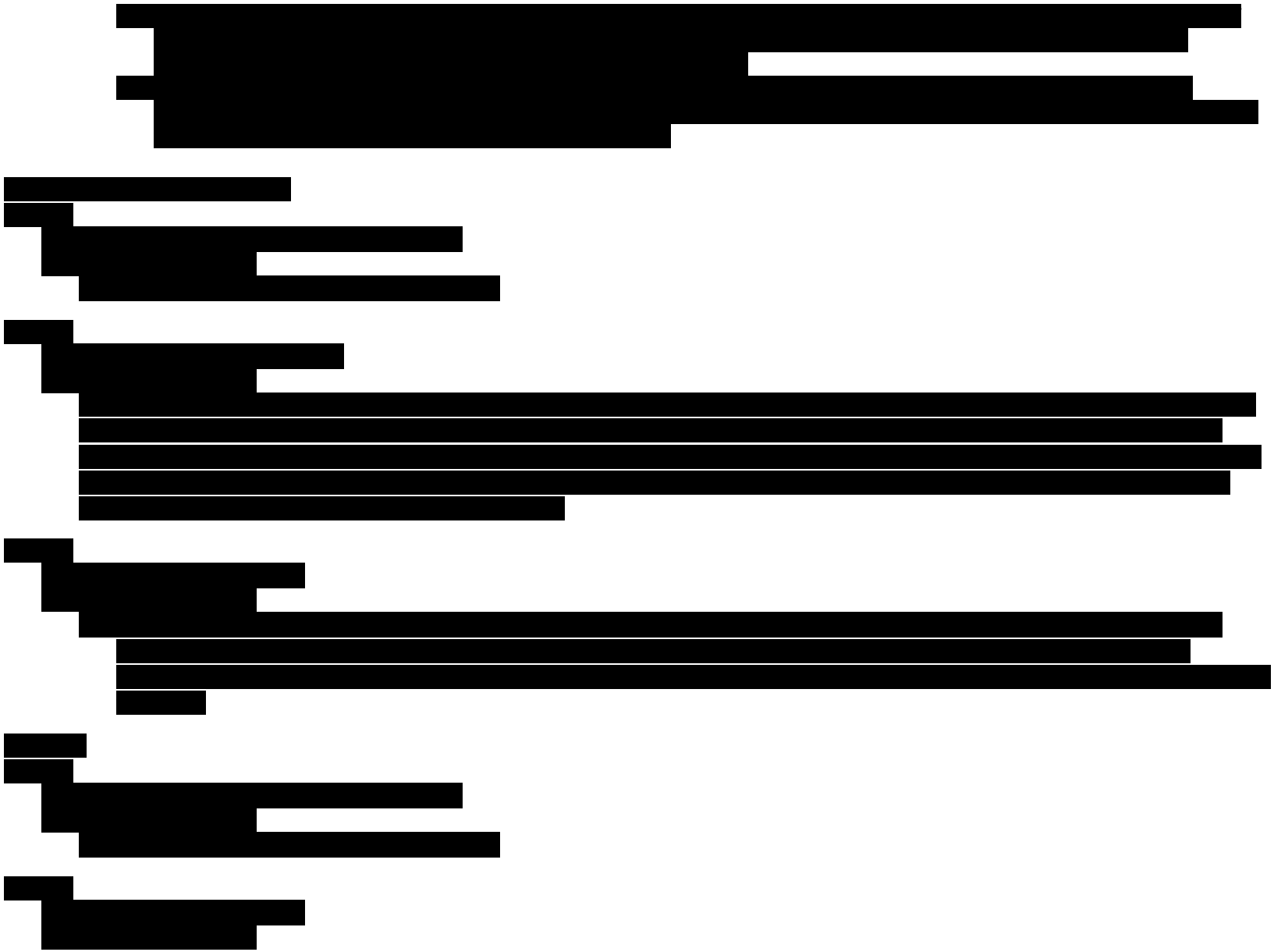
[redacted]

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

[redacted]







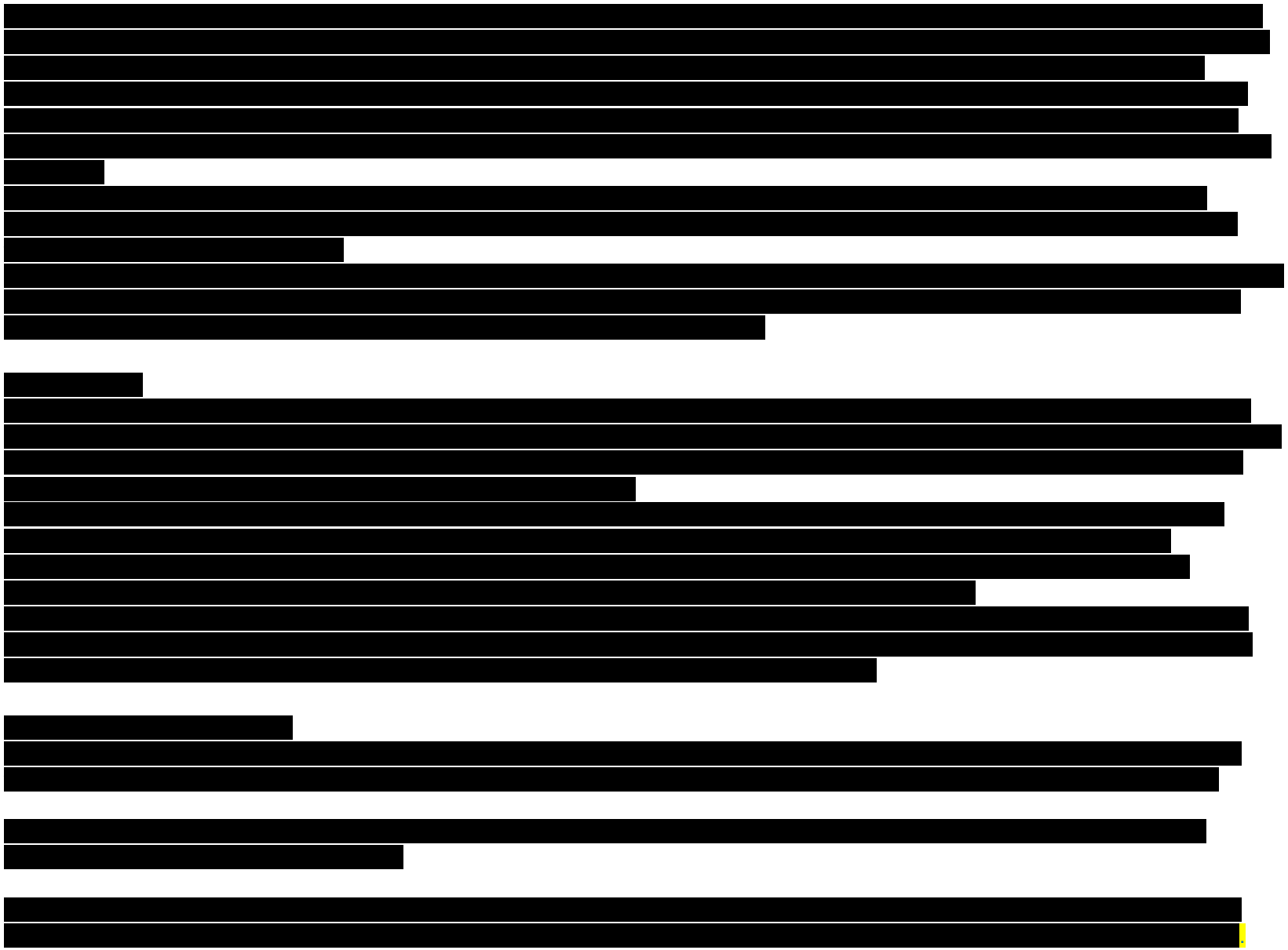
[redacted]

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.

[redacted]



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