

LARRY HOGAN  
Governor

BOYD K. RUTHERFORD  
Lt. Governor



AL REDMER, JR.  
Commissioner

NANCY GRODIN  
Deputy Commissioner

ERICA BAILEY  
Associate Commissioner

200 St. Paul Place, Suite 2700, Baltimore, Maryland 21202  
Direct Dial: 410-468-2299 Fax: 410-468-2245  
Email: [darcim.smith@maryland.gov](mailto:darcim.smith@maryland.gov)  
410-468-2000 1-800-492-6116  
TTY: 1-800-735-2258  
[www.insurance.maryland.gov](http://www.insurance.maryland.gov)

October 6, 2017

**Sent Via E-Mail and Via Certified Mail**

[CARRIER/ADDRESS]

RE: [CARRIER NAME]  
2017 Mental Health Parity Survey – Maryland Business Only  
[INVESTIGATION No.]

Dear [CONTACT]:

Pursuant to §§ 2-108 and 2-205 of the Insurance Article, Annotated Code of Maryland, the Maryland Insurance Administration (“Administration”) is gathering information to verify compliance with the Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”). This is the last of the three surveys the Administration began in 2014. Please provide a detailed response to the following questions by November 13, 2017, as they relate to fully-insured group and individual health benefit plans. Do not include any self-funded groups or federal programs. When referencing small and large groups, the employer/group contract must be situated in the state of Maryland with one or more Maryland employees. Provide requested data regarding mental health and substance use disorder benefits directly from any contracted managed behavioral health organization (“MBHO”) that manages plan behavioral health benefits.

Nonquantitative Treatment Limitations

Under MHPAEA, a plan may not impose a nonquantitative treatment limitation (“NQTL”) with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.<sup>1</sup>

---

<sup>1</sup> See 45 C.F.R. 146.136(c)(4)(i) and for a description of what is included in NQTL’s see 45 C.F.R. 146.136(c)(4)(ii).

## Delegation Contracts

1. MHPAEA does not prohibit the use of separate managed behavioral health organizations to provide utilization review and other services with respect to mental health and/or substance abuse benefits.<sup>2</sup> However, to comply with MHPAEA, group health plans, their health issuers, and other service providers should work together to ensure that they are complying with MHPAEA.<sup>3</sup>
  - a. Do you delegate the development and/or management of plan behavioral health benefits to another entity? If yes, please provide the name of that entity, a copy of the delegation contract, a list of which products the entity provides/administers the behavioral health benefit for (if less than all of the products offered by the carrier) and an explanation of the scope of the entity's responsibility (i.e. sets network access standards and manages the network of behavioral health providers, credentials behavioral health providers, develops and applies utilization review criteria, etc.).
  - b. What processes are in place for overseeing the behavioral health entity to verify MHPAEA compliance as to nonquantitative treatment limitations in writing and in operation?
    - i. What audits are conducted to determine compliance with NQTL rules and how frequently?
    - ii. What documents, algorithms and evidentiary standards do you obtain from the MBHO in order to complete this review?

## Utilization Review

2. Describe the process you have implemented to evaluate whether the utilization management standards imposed on mental health and substance use disorder services are, *as written and in operation*, comparable to and applied no more stringently than the utilization management standards for medical/surgical services.
  - a. Provide any internal policy documents establishing this review process.
  - b. Provide a description of all audits the carrier conducts to assess compliance.
  - c. Does the utilization reviewer's discretion factor into the utilization review determination for medical/surgical and mental health/substance use disorder services? How does a utilization reviewer allow deviations from the norm when justified on a case by case basis?
  - d. Where the reviewer's discretion is a factor (such as when determining whether a service is medically necessary or which level of care to approve) how do you determine that such discretion is not resulting in a more stringent application of utilization review to mental health and substance use disorder services than to medical/surgical services?
  - e. Provide a copy of your written administrative processes and safeguards to ensure and to verify that benefit claim determinations are made in accordance with the insurance policy provisions and utilization review guidelines and that, where appropriate, the insurance policy guidelines are applied consistently with respect to similarly situated covered individuals.
3. Utilization Review Process
  - a. Provide a detailed explanation of the utilization review process in each of the six MHPAEA classifications<sup>4</sup> (if it differs) for each type of utilization review conducted (prior authorization and certification, concurrent review, retrospective review, etc.) for both medical/surgical and mental health/substance use disorder services. Identify who (contracting utilization review organization, MBHO, provider, etc.) conducts utilization

---

<sup>2</sup> See Understanding Implementation of the Mental Health Parity and Addiction Equity Act of 2008, Question 5, May 9, 2012.

<sup>3</sup> *Id.*

<sup>4</sup> See 45 C.F.R. 146.136(c)(2)(ii).

- review in each classification for medical/surgical and mental health and substance use disorder services.
- b. Please identify any information that is requested to be submitted by a mental health and substance use disorder provider at each step of the utilization review process for mental health and substance use disorder services and any information that is requested to be submitted by a medical/surgical provider at each step of the utilization review process for medical/surgical services.
    - i. Provide copies of any treatment request forms used in this process.
    - ii. Provide screen shots of each information gathering step in any systems used during the processing of a utilization review request and/or any worksheets completed by staff while gathering information during the utilization review process.
  - c. Identify the systems (*e.g.* mailed claim forms, telephone, e-mail, internet portal) that your organization or contracting utilization review organization use for mental health and substance use disorder providers and for medical/surgical providers to submit requests for services. If any of the systems are different depending on the type of service requested, including, for example, the use of different internet portals, please explain why your organization finds this to be appropriate under MHPAEA.
  - d. Identify the methods used by your organization or a contracting utilization review organization to communicate to a provider the information that the provider must submit so that the carrier/utilization review entity can conduct its utilization review of the request for services. If any of the methods used to communicate information to medical/surgical and mental health and substance use disorder providers are different, please explain why your organization finds this to be appropriate under MHPAEA.
  - e. Explain how your company instructs medical/surgical providers to communicate with your company (or the contracted utilization review organization) to complete the utilization review process and how your company instructs mental health and substance use disorder providers to communicate with your company (or the contracted utilization review organization) to complete the utilization review process.
  - f. Identify the methods used by your organization or contracting utilization review organization to notify a mental health and substance use disorder provider that the utilization reviewer needs additional information that is necessary for the carrier to complete its utilization review of the request for services. Please identify the methods used by your organization or a contracting utilization review organization to notify a medical/surgical provider that the utilization reviewer needs additional information that is necessary for the carrier to complete its utilization review of the request for services. If any of the methods used to communicate information is different, please explain why your organization finds this to be appropriate under MHPAEA.
  - g. If the utilization review process is different when a member is accessing benefits from an out-of-network provider, provide the above information for the out-of-network utilization review process. Provide separate answers for medical/surgical and mental health and substance use disorder benefits.
    - iii. Is the member responsible for collecting documentation or communication to receive services? Provide a separate answer for medical/surgical and mental health and substance use disorder benefits.
    - iv. Does the carrier contact the provider if any required information is missing during utilization review? Provide a separate answer for medical/surgical and mental health and substance use disorder benefits.

#### Level of Care

4. Identify the number and percentage of total requests that were initiated for inpatient services (including residential treatment services) for medical/surgical, mental health or substance use

services that were approved at a lower level/less intensive level of care. Provide the data separately for 2015, 2016, and 2017 (please indicate what dates the 2017 data encompasses).

- a. In providing the data, identify both the requested and authorized level of care and separate out the medical/surgical, mental health and substance use disorder determinations.
  - b. In providing the data, separate the data into those requests that were denied and later approved at a lower level of care and requests that were not denied but resulted in a lower level of care approved than the inpatient level of care initially requested.
5. Identify the number and percentage of total requests that were initiated for partial hospitalization/day treatment or intensive outpatient treatment for medical/surgical, mental health or substance use services that were authorized at a lower level/less intensive level of care. Provide the data separately for 2015, 2016, and 2017 (please indicate what dates the 2017 data encompasses).
- a. In providing the data, identify both the requested and authorized level of care and separate out the medical/surgical, mental health and substance use disorder determinations.
  - b. In providing the data, separate the data into those requests that were denied and later approved at a lower level of care and requests that were not denied but resulted in a lower level of care approved than the level of care initially requested.

#### Adverse Decisions and External Review

6. Complete Attachment A- Adverse Decision and Appeals Data. Provide the data separately for 2015, 2016, and 2017 (please indicate what dates the 2017 data encompasses).

#### Facility Credentialing

7. Provide a detailed explanation of the facility credentialing process for medical facilities, MH facilities, and SUD facilities. If the process differs based on the facility type (hospital vs nonhospital facility vs community behavioral health facilities) please explain those differences.
  - a. Identify how facilities are instructed to contact the carriers to begin the credentialing process.
  - b. Explain the requirements, processes and standards used in the carrier's facility credentialing process for mental health, substance use disorder, and medical facilities, and provide documentation, such as audits, to demonstrate the carrier implements these requirements to mental health and substance use disorder facilities in a manner that is comparable to and no more restrictive than the implementation process for facilities that provide medical services.
  - c. Provide copies of all required credentialing forms for facilities and any guidance documents used by staff to complete the credentialing process.
  - d. If you delegate management of your behavioral health network to another entity, is the facility required to be credentialed by both you and the contracted entity? Provide a description of any such requirement.
8. Complete Attachment B- Facility Credentialing Data for all facilities that contacted the carrier to begin the credentialing process. You should include all facilities that did not submit an application because they were informed the network was closed. Provide a separate chart for requests that began in 2015, 2016, and 2017 (please indicate what dates the 2017 data encompasses).

#### Reimbursement Rates

9. Identify and provide documents that describe the criteria/data the carrier considers and the rules the carrier implements to determine the allowable amount for out-of-network mental health, substance

use disorder and medical/surgical services, respectively, for the following classifications including any reductions made in the allowable amounts for specific providers/services and provide all audits the carrier conducts to assess compliance with its rules:

- a. Outpatient
- b. Inpatient
- c. Sub-acute residential services

Out-of-Network Access

10. Complete the following chart for each out-of-network level of care: Inpatient, Residential (non-hospital facility), Intensive Outpatient, and Outpatient. Please provide a list of the services that you are including in each classification for the purposes of this data reporting. Provide the data separately for 2015, 2016, and 2017 (please indicate what dates the 2017 data encompasses).

| Classification (example: Inpatient- OON) |  |   |  |   |   |   |
|--|--|---|--|---|---|---|
|  | Total # of claims (IN and OON) for this level of care. | # of OON claims for this level of care. | % of total claims that were OON for this level of care | # of OON claims approved for this level of care | % of OON claims approved for this level of care | # approved because no provider available in-network |
| M/S                                      |  |   |  |   |   |   |
| MH                                       |  |   |  |   |   |   |
| SUD                                      |  |   |  |   |   |   |

11. Explain how members access out-of-network benefits for each product subject to this survey. For the products where prior authorization or an exception is required to access out-of-network benefits, provide the specific criteria that must be met to approve out-of-network access. Provide the following data for each level of care (Inpatient hospital, Residential non-hospital facility, Intensive Outpatient, Outpatient). Provide the data separately for 2015, 2016, and 2017 (please indicate what dates the 2017 data encompasses):

- a. The number of requests for approval to access an out-of-network provider for each of medical/surgical, mental health and substance use disorder services.
- b. The number of those requests made for each of the following reasons:<sup>5</sup> (1) there was no available in-network provider, (2) the wait time to see an in-network provider was too long or (3) the distance to travel to an in-network provider was too far, and (4) Other (please describe the type of requests that fall under this category).
- c. The number of requests that were denied for each of medical/surgical, mental health and substance use disorder services and a list of the reasons for the denials and the number of denials which correlate with each reason.
- d. The number of requests that were approved for each of medical/surgical, mental health and substance use disorder services and a list of the reasons for the approvals (such as no in-network provider) and the number of approvals that correlate with each reason for each of medical/surgical, mental health and substance use disorder services.

<sup>5</sup> This data should be based on the reason the member provided in the request, regardless of whether the carrier ultimately found that the reason provided was correct (i.e. no in-network provider was the reason for the request and should be included in this data regardless of whether the carrier was able to locate five providers that could provide the service).

## Prescription Drugs

12. Provide a copy of each current formulary that the company uses. If the formulary document does not indicate where prior authorization requirements apply please advise where the prior authorization requirement is noted for prescription drugs and please provide the documents that include that requirement.
  - a. Demonstrate compliance with HB 887 which became effective May 25, 2017.
  - b. Explain how the company plans to comply with HB 1329/SB 967 starting January 1, 2018. Provide any final contract provisions, directions to pharmacists, and formularies that demonstrate compliance.
  
13. Provide the following information regarding utilization management requirements for prescription drugs for mental health medications (as a group), substance use disorder medications (as a group), and medications for somatic conditions (as a group), and separated by brand and generic drugs. Provide the data separately for 2015, 2016, and 2017 (please indicate what dates the 2017 data encompasses).
  - a. Number of pharmacy inquiries, as defined by Maryland Insurance Article § 15-10D-01(n), received by any method, including computer, fax or phone.
  - b. Number and percentage of pharmacy inquiries for prescriptions that required pre-authorization and number and percentage of inquiries for prescriptions that did not require preauthorization.
  - c. Number and percentage of pharmacy inquiries for prescriptions that required pre-authorization that were approved and denied.
  - d. Number and percentage of pharmacy inquiries for prescriptions that were dispensed as a different medication than ordered due to carrier authorization, fail first or formulary tiering policies.

Pursuant to COMAR 31.04.20.05 E, the Company is required to confirm the accuracy of all information provided and submit a "Certificate of Compliance" signed by an officer of the Company acknowledging in a written certification that the information provided is, "to the best of the individual's knowledge, information, and belief, a full, complete, and truthful response to the Commissioner's response," and that the "individual making the certification has undertaken an adequate inquiry to make the required certification."

Please return your response to this survey along with the Certificate of Compliance to me no later than close of business on November 13, 2017. If you have any questions or concerns, please call or e-mail Darci Smith, MHPAEA Special Assistant at 410-468-2299 or [darcim.smith@maryland.gov](mailto:darcim.smith@maryland.gov).

Thank you in advance for your timely response to this request.

Sincerely,

Joseph Fitzpatrick  
Supervisor  
Compliance and Enforcement  
Maryland Insurance Administration