**REPORTING FORM FOR**

**MEDICAL MANAGEMENT PROTOCOLS FOR INSURANCE COVERAGE**

**FOR SERIOUS MENTAL ILLNESS AND DRUG AND ALCOHOL DEPENDENCY**

**PURSUANT TO**

**18 *DE Admin. Code* 1410**

1. Carrier[[1]](#footnote-1) Name and NAIC number (if applicable):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. Carrier address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Name of health benefit plan[[2]](#footnote-2) about which Carrier is reporting: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Check whether this report is an initial report or an amended report .
2. Indicate the date by which this report was required to be submitted[[3]](#footnote-3): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. Did the Carrier submit a request for an extension of the date by which this report is required to be submitted?

YES If yes, please submit a copy of the extension request.

1. Is the health insurance plan about which this report pertains exempt from MHPAEA[[4]](#footnote-4)?

YES If yes, indicate the reason for the exemption, which may include, by way of example only, retiree-only plan, exceptedbenefits (45 CFR § 146.145(b)), short term limited duration insurance, small employer exemption (45 CFR § 146.136(f)), or increased cost exemption (45 CFR § 146.136(g)).

The exemption that applies is: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*After indicating on the line above which MHPAEA exemption applies, STOP filling out this form and follow the below instructions for submitting this form.*

NO If no, respond to the following:

1. How does the health insurance coverage provide MH and/or SUD benefits in addition to providing M/S benefits?[[5]](#footnote-5) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_ (*attach additional sheets as necessary) \_\_\_\_\_\_\_\_\_\_\_\_*\_\_\_\_\_\_\_\_\_\_\_\_

1. Fill out the data collection tool below. Guidance concerning how to respond to the NQTL portion of the tool is attached to Domestic and Foreign Insurer’s Bulletin No.109.

Submit one copy of the completed report to each of the following addresses:

|  |  |
| --- | --- |
| Delaware Health Information NetworkAttn.: Mental Health Parity Report107 Wolf Creek Blvd. #2Dover, DE 19901 | Delaware Department of InsuranceAttn.: Mental Health Parity Report 1351 West North Street, Suite 101Dover, DE 19904The Department prefers that the report be submitted electronically to:consumer@delaware.gov Include in the subject line **“Attn.: Mental Health Parity Report”**  |

**DATA COLLECTION TOOL FOR MENTAL HEALTH PARITY ANALYSIS**

Most parity analysis examines benefits by comparing MH/SUD to M/S within a classification. 45 CFR 146.136(c)(2)(i). The exception is aggregate lifetime or annual dollar limits (to the extent the plan is not prohibited from imposing such limits under Federal or State law), which are examined for the plan as a whole. See 45 CFR 146.136(b). The following is intended to simplify data collection for parity analysis at the classification level.

**A-1 GUIDANCE FOR PLACING BENEFITS INTO CLASSIFICATIONS:**

MH/SUD and M/S benefits must be mapped to one of six classifications of benefits: (1) inpatient in-network, (2) inpatient out-of-network, (3) outpatient in-network, (4) outpatient out-of-network, (5) prescription drugs, and (6) emergency care (see subsection 5.1.3 of this regulation and 45 CFR 146.136(c)(2)(ii)):

* The “inpatient” classification typically refers to services or items provided to a beneficiary when a physician has written an order for admission to a facility, while the “outpatient” classification refers to services or items provided in a setting that does not require a physician’s order for admission and does not meet the definition of emergency care.
* “Office visits” are a permissible sub-classification separate from other outpatient services.
* The term “emergency care” typically refers to services or items delivered in an emergency department setting or to stabilize an emergency or crisis, other than in an inpatient setting. *See* 18 **Del.C.** Chapters 33 and 35 concerning emergency care standards.
* Some benefits, for example lab and radiology, may fit into multiple classifications depending on whether they are provided during an inpatient stay, on an outpatient basis, or in the emergency department.
* Insurers should use the same decision-making standards to classify all benefits, so that the same standard applies to M/S and MH/SUD benefits. For example, if a plan classifies care in skilled nursing facilities and rehabilitation hospitals for M/S benefits as inpatient benefits, it must classify covered care in residential treatment facilities for MH/SUD benefits as inpatient benefits.

**A-2 FINANCIAL REQUIREMENTS AND QUANTITATIVE TREATMENT LIMITATIONS:**

Types of FRs include deductibles, copayments, coinsurance, and out-of-pocket maximums. See 45 CFR 146.136(c)(1)(ii). Types of QTLs include annual, episode, and lifetime day and visit limits, for example number of treatments, visits, or days of coverage. See 45 CFR 146.136(c)(1)(ii). A two-part analysis applies to FRs and QTLs. In general, MHPAEA regulations require that any FR or QTL imposed on MH/SUD benefits not be more restrictive than the predominant level of financial requirement or treatment limitation of that type that applies to substantially all medical/surgical benefits in a classification.

If the plan applies a cumulative FR or QTL (a FR or QTL that determines whether or to what extent benefits are provided based on accumulated amounts), the FR or QTL must not accumulate separately from any established for M/S benefits in a classification.

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| **FINANCIAL REQUIREMENTS**  |
| Benefit Plan Design(s) Identifier(s):Submit a separate form for each benefit plan design.Plan Name: Date:Contact Name: Telephone Number: Email:Line of Business (HMO, EPO, POS, PPO):Contract Type (large group, small group, individual): Benefit Plan Effective Date: |
|  | Inpatient In-Network (if network tiers, may separate into tiers in accordance with 45 CFR 146.136(c)(3)(iii)(B)). | Inpatient Out-of- Network | Outpatient In-Network (Issuer may choose to have sub-classifications for Outpatient Office Visits, and Other Outpatient Services) (if network tiers, may separate into tiers in accordance with 45 CFR 146.136(c)(3)(iii)(B)) | Outpatient Out-of-Network (Issuer may choose to have sub-classifications for Outpatient Office Visits, and Other Outpatient Services) | Emergency Care | Prescription Drugs |
| Does the plan provide MH/SUD benefits? |  |  |  |  |  |  |
| Does the plan provide M/S benefits? |  |  |  |  |  |  |
| Total dollar amount of ALL plan payments for M/S benefits expected to be paid for the relevant plan year |  |  |  |  |  |  |
| List each financial requirement that applies to the classification for MH/SUD benefits. |  |  |  |  |  |  |
| For each type of financial requirement that applies to MH/SUD benefits, list the expected percentage of plan payments for M/S benefits in each classification that are subject to that same type of financial requirement. |  |  |  |  |  |  |
| For each level of each type of financial requirement that applies to at least 2/3rds of all M/S/ benefits in the classification, list the expected percentage of plan payments for M/S benefits subject to that financial requirement, that are subject to that level. |  |  |  |  |  |  |
| Does the plan impose a separate cumulative financial requirement or QTL for MH/SUD benefits that accumulates separately from any cumulative financial requirement or QTL for M/S benefits? |  |  |  |  |  |  |

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| **QUANTITATIVE TREATMENT LIMITATIONS** |
| Benefit Plan Design(s) Identifier(s):Submit a separate form for each benefit plan design.Plan Name: Date:Contact Name: Telephone Number: Email:Line of Business (HMO, EPO, POS, PPO):Contract Type (large group, small group, individual): Benefit Plan Effective Date: |
|  | Inpatient In-Network (if network tiers, may separate into tiers in accordance with 45 CFR 146.136(c)(3)(iii)(B)). | Inpatient Out-of- Network | Outpatient In-Network (Issuer may choose to have sub-classifications for Outpatient Office Visits, and Other Outpatient Services) (if network tiers, may separate into tiers in accordance with 45 CFR 146.136(c)(3)(iii)(B)) | Outpatient Out-of-Network (Issuer may choose to have sub-classifications for Outpatient Office Visits, and Other Outpatient Services) | Emergency Care | Prescription Drugs |
| List each QTL that applies to the classification for MH/SUD benefits. |  |  |  |  |  |  |
| For each type of QTL that applies to MH/SUD benefits, list the expected percentage of plan payments for M/S benefits in each classification that are subject to that same type of QTL. |  |  |  |  |  |  |
| For each level of each type of QTL that applies to at least 2/3rds of all M/S benefits in the classification, list the expected percentage of plan payments for M/S benefits subject to that QTL, that are subject to that level. |  |  |  |  |  |  |

**A-3 NON-QUANTITATIVE TREATMENT LIMITATIONS:**

NQTLs include but are not limited to medical management techniques such as step therapy and pre-authorization requirements. Coverage cannot impose a NQTL with respect to MH/SUD benefits in any classification unless, under the terms of the plan as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD 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 M/S benefits in the classification. Note that not every NQTL needs an evidentiary standard. There is flexibility under MHPAEA for plans to use NQTLs. The focus is on finding out what processes and standards the plan actually uses.

All plan standards that are not FRs or QTLs and that limit the scope or duration of benefits for services are subject to the NQTL parity requirements. This includes restrictions such as geographic limits, facility-type limits, and network adequacy.

The following data collection chart is modeled after a tool used in federal MHPAEA examinations. Insurers who have completed “Table 5” for NQTLs may substitute those documents for completion of this chart.

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| **NON-QUANTITATIVE TREATMENT LIMITATIONS** |
| Benefit Plan Design(s) Identifier(s):Submit a separate form for each benefit plan design.Plan Name: Date:Contact Name: Telephone Number: Email:Line of Business (HMO, EPO, POS, PPO):Contract Type (large group, small group, individual): Benefit Plan Effective Date: |
| **Area** | **Medical/Surgical Benefits***Summarize the plan’s applicable NQTLs, including any variations, by benefit.* | **Mental Health/Substance Use Disorder Benefits***Summarize the plan’s applicable NQTLs, including any variations, by benefit.* | **Explanation***Describe the processes, strategies, evidentiary standards or other factors used to apply the NQTLs. Explain how the application of these factors is consistent with 45 CFR § 146.136(c)(4). Provide the relevant pages of the documents in which the NQTLs are described and list this documentation in the space provided below.* |
| **A. Definition of Medical Necessity** *What is the definition of medical necessity?* |  |  |  |
| **B. Prior-authorization Review Process***Include all services for which prior authorization is required. Describe any step therapy or “fail first” requirements and requirements for submission of treatment request forms or treatment plans.*Inpatient, In-Network: |  |  |  |
| Outpatient, In-Network: Office Visits: |  |  |  |
| Outpatient, In-Network: Other Outpatient Items and Services: |  |  |  |
| Inpatient, Out-of-Network: |  |  |  |
| Outpatient, Out-of-Network: Office Visits: |  |  |  |
| Outpatient, Out-of-Network: Other Items and Services: |  |  |  |
| **C. Concurrent Review Process, including frequency and penalties for all services.** *Describe any step therapy or “fail first” requirements and requirements for submission of treatment required forms or treatment plans.*Inpatient, In-Network: |  |  |  |
| Outpatient, In-Network: Office Visits: |  |  |  |
| Outpatient, In-Network: Other Outpatient Items and Services: |  |  |  |
| Inpatient, Out-of-Network: |  |  |  |
| Outpatient, Out-of-Network: Office Visits: |  |  |  |
| Outpatient, Out-of-Network: Other Items and Services: |  |  |  |
| **D. Retrospective Review Process, including timeline and penalties.**Inpatient, In-Network: |  |  |  |
| Outpatient, In-Network: Office Visits: |  |  |  |
| Outpatient, In-Network: Other Outpatient Items and Services: |  |  |  |
| Inpatient, Out-of-Network: |  |  |  |
| Outpatient, Out-of-Network: Office Visits: |  |  |  |
| Outpatient, Out-of-Network: Other Items and Services: |  |  |  |
| **E. Emergency Services** |  |  |  |
| **F. Pharmacy Services***Include all services for which prior authorization is required, any step therapy or “fail first” requirements, any other NQTLs.*Tier 1: |  |  |  |
| Tier 2: |  |  |  |
| Tier 3: |  |  |  |
| Tier 4: |  |  |  |
| **G. Prescription Drug Formulary Design**Describe how formulary are decisions made for the diagnosis and medically necessary treatment of medical, mental health and substance use disorder conditions. |  |  |  |
| Describe the pertinent pharmacy management processes, including, but not limited to, cost-control measures, therapeutic substitution, and step therapy. |  |  |  |
| What disciplines, such as primary care physicians (internists and pediatricians) and specialty physicians (including psychiatrists) and pharmacologists, are involved in development of the formulary for medications to treat medical, mental health and substance use disorder conditions? |  |  |  |
| **H. Case Management**What case management services are available? |  |  |  |
| What case management services are required? |  |  |  |
| What are the eligibility criteria for case management services? |  |  |  |
| **I. Process for Assessment of New Technologies**Definition of experimental/investigational: |  |  |  |
| Qualifications of individuals evaluating new technologies:  |  |  |  |
| Evidence consulted in evaluating new technologies: |  |  |  |
| **J. Standards for Provider Credentialing and Contracting**Is the provider network open or closed? |  |  |  |
| What are the credentialing standards for physicians? |  |  |  |
| What are the credentialing standards for licensed non-physician providers?*Specify type of provider and standards; e.g., nurse practitioners, physician assistants, psychologists, clinical social workers?* |  |  |  |
| What are the credentialing/contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals? |  |  |  |
| **K. Exclusions for Failure to Complete a Course of Treatment** Does the plan exclude benefits for failure to complete treatment? |  |  |  |
| **L. Restrictions that Limit Duration or Scope of Benefits for Services** Does the plan restrict the geographic location in which services can be received; e.g., service area, within the state, within the United States? |  |  |  |
| Does the plan restrict the type(s) of facilities in which enrollees can receive services? |  |  |  |
| **M. Restrictions for Provider Specialty**Does the plan restrict the types of provider specialties that can provide certain M/S and/or MH/SUD benefits? |  |  |  |
| **List of Documents Referenced Above**List each document referenced above, including reference to exhibit number, file name, or other identifying information for examiners. |

1. "**Carrier**" means any entity that provides health insurance in this State. For the purposes of this section, "**carrier**" includes an insurance company, health service corporation, health maintenance organization, managed care organization, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation. "Carrier" also includes any third-party administrator or other entity that adjusts, administers, or settles claims in connection with a health benefit plan. “Carrier” also includes any carrier who administers a health benefit plan under 31 *Del.C.*§ 505(3). [↑](#footnote-ref-1)
2. "**Health benefit plan**" means any hospital or medical policy or certificate, major medical expense insurance, health service corporation subscriber contract, or health maintenance organization subscriber contract, as defined and qualified under 18 *Del.C.*§§ 3343 and 3578, and any assistance provided to an individual under 31 *Del.C.*§ 505(3). [↑](#footnote-ref-2)
3. *See* 18 *DE Admin. Code* § 6.1 and 6.2, which provide as follows:

6.1 Each carrier who is required to submit a mental health parity report pursuant to this regulation shall submit its initial report on or before July 1, 2019.

6.2 Each carrier who is required to submit a mental health parity report pursuant to this regulation shall submit an amended report 30 calendar days after the close of any year during which the carrier made significant changes to how it designs and applies its medical management protocols. [↑](#footnote-ref-3)
4. “**MHPAEA**” means the Mental Health Parity and Addiction Equity Act of 2008 (29 U.S.C. § 1185a) as amended and supplemented. [↑](#footnote-ref-4)
5. “**MH/SUD benefits**” means mental health and substance use disorder benefits.

 “**M/S benefits**” means medical and surgical benefits. [↑](#footnote-ref-5)