NEW HAMPSHIRE INSURANCE DEPARTMENT

MARKET CONDUCT TARGETED EXAMINATION

OF

ANTHEM HEALTH PLANS OF NEW HAMPSHIRE, INC., NAIC #53759

MATTHEW THORNTON HEALTH PLAN, INC., NAIC #95527

1155 ELM STREET, SUITE 200

MANCHESTER, NEW HAMPSHIRE 03101

FOR THE PERIOD OF JANUARY 1, 2016 THROUGH JULY 31, 2017

REGARDING MENTAL HEALTH PARITY AND SUBSTANCE USE DISORDER BENEFIT TREATMENTS

DOCKET NO. INS 17-046-MC

FINAL

AS OF

January 22, 2020

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SCOPE

Pursuant to RSA 400-A:37, the New Hampshire Insurance Commissioner (hereinafter, "Commissioner") issued an examination warrant for the purpose of examining Anthem Health Plans of New Hampshire, Inc. and Matthew Thornton's Health Plans, Inc.'s (collectively, "the Company") administration of benefits for Mental Health Parity and Substance Use Disorder and Addiction treatment services (hereinafter, "MH/SUD") in comparison to Medical/Surgical services (hereinafter, "Med/Surg").

The goal of the examination was to ascertain how companies regulated by the New Hampshire Insurance Department (hereinafter, "Department" or "NHID") are providing coverage for MH/SUD treatments and to ensure that benefits are consistently applied within the requirements of state and Federal laws and are not subject to more stringent requirements than for Medical/Surgical benefits during the examination period of January 1, 2016 through July 31, 2017.

Specifically, this examination encompassed all regulatory requirements under RSA Title XXXVII that apply to the health carrier's practices for the handling of MH/SUD services, including, but not limited to:

- RSA 417-E:1, V and RSA 420-B:8-b, V, which authorize the Commissioner to enforce the provisions of the federal Mental Health Parity Addiction Equity Act of 2008, codified at 29 U.S.C. § 1185a (hereinafter, "MHPAEA") that relate to the business of insurance, including federal regulations adopted under MHPAEA, 45 CFR § 146.136, Parity in mental health and substance use disorder benefits (federal parity rule)[1];
- RSA 420-N:5, which authorizes the Commissioner to enforce the consumer protections and market reforms set forth in the Affordable Care Act (hereinafter, "ACA") including the ACA's amendments to MHPAEA;
- RSA 415:18-a, requiring coverage for mental or nervous conditions and treatment for chemical dependency under group health plans;
- RSA 420-B:8-b, requiring Health Maintenance Organizations (hereinafter, "HMOs") to provide coverage for mental and nervous conditions and chemical dependency;

[1] This Examination applied the federal parity rule rather than New Hampshire's parity rule, N.H. Code of Admin. R. Ins. Part 2702, as the federal rule is more comprehensive. As noted below, the Examination applied state law requirements in addition to federal requirements when the state requirements were stricter and/or more protective of the consumer.

- RSA 417-E:1, requiring coverage for certain biologically-based mental illnesses that is in parity with coverage for physical illness; and
- Provisions of New Hampshire's Managed Care Law, including RSA 420-J:5 through 5-e, governing appeals; RSA 420-J:7, regarding network adequacy; RSA 420-J:8-a, requirements for prompt pay; RSA 420-J:4 governing provider credentialing; and RSA 420-J:6, regarding utilization review.

Please note that for purposes of this report, the terms "mental health" and "behavioral health" are used interchangeably. Both terms include substance use disorder. Many company documents use the term "behavioral health" rather than "mental health." Behavioral health is used as an all-encompassing term that not only includes promoting wellbeing by preventing or intervening in mental illness such as depression or anxiety, but also has an aim of preventing or intervening in substance use disorder. However, because the term "mental health" is used in MHPAEA, the term "mental health" is most often used in this report.

REVIEWS

The examination was conducted in two phases. Phase I included sending interrogatories to obtain initial information regarding the following areas: Company Operations and Management, Quantitative Reviews, Financial Limitations, Non-Quantitative Reviews, Discriminatory Benefit Designs, and Other Considerations. Phase II included a series of data requests for MH/SUD and Med/Surg health and prescription drug claim file review to verify Medication Assisted Treatment (hereinafter "MAT") practices and overall compliance with both quantitative and non-quantitative requirements of the MHPAEA.

For the purposes of this examination, the Department contracted with the following as outside examiners: (1) mental health parity experts to assist with the review of company policies and procedures and sample claim files, and (2) mental health parity experts and other health professionals to assist with the review of the American Society of Addiction Medicine (hereinafter "ASAM") criteria and provider reimbursement methodology and rates.

Phase I

On February 15, 2018, the Department sent interrogatories to the Company. The Department requested that the Company provide a detailed response to interrogatory questions as they related to the top ten most common plans in New Hampshire, including the premium assistance program (hereinafter, "PAP") membership. The Company's top ten most common plans in New Hampshire include:

Segment	Product – 2016	Membership Dec 2016
IND	Silver Pathway X Enhanced 4200/0% (PAP)	9,427
IND	Silver DirectAccess, Multi-State Plan	4,490
LG	HMO Blue New England	3,952
IND	Silver Pathway X Enhanced HMO 10% for HAS	2,956
IND	Silver Pathway X Enhanced HMO 4000/0%	2,734
SG	Access Blue New England HMO	2,212
LG	Access Blue New England Large Group HMO	1,905
IND	Gold Pathway X Enhanced HMO 1000/10%	1,866
IND	Bronze Pathway X Enhanced HMO 5400/20%	1,739
IND	BlueDirect	1,543

Segment	Product – 2017	Membership Dec 2017
IND	Silver Pathway X Enhanced 4200/0% (PAP)	11,342
LG	HMO Blue New England	4,085
SG	Access Blue New England Gold	2,986
IND	Silver DirectAccess, Multi-State Plan	2,904
IND	Silver Pathway X Enhanced HMO 5300/25%	2,430
IND	Silver Pathway X Enhanced HMO 4000/0%	1,977
LG	Preferred Blue PPO HAS	1,930
IND	Silver Pathway X Enhanced HMO 10% for HAS	1,754
SG	Access Blue New England Silver	1,737
IND	Gold Pathway X Enhanced HMO 1000/10%	1,188

The Department's primary objective in conducting Phase I of the examination was to evaluate whether the Company is covering MH/SUD benefits no less favorably than Med/Surg benefits. The Company was required to provide information relative to the following areas:

- Company Operations and Management:
  - Internal and External Audits
  - Third Party Entities/Service Providers

    - Record Retention
    - Insurance Management
    - NHID Data Reporting Compliance
- Quantitative Reviews:
    - Aggregate Limitations
        - Aggregate Lifetime Limitations
        - No Lifetime Limitations
        - Lifetime Limitations
    - Annual Limitations
    - Treatment Limitations
- Financial Limitations:
    - 2/3 substantially all requirements
    - Deductibles
    - Co-payments
    - Coinsurance
    - Out-of-Pocket Maximum Expenses
- Non-Quantitative Reviews:
    - Benefit Classifications
        - In-patient/In-network
        - In-patient/Out-of-network
        - Out-patient/In-network
        - Out-patient/Out-of-network
        - Emergency
        - Prescription Drugs
    - Medical Management Standards
        - Utilization Review and Case Management
        - Prior-authorization/pre-certifications
    - Complaints
    - Discriminatory Benefit Designs
        - Producer incentives to deny applicants because of medical history
        - Written treatment plans
        - Formulary Designs for Prescription Drugs
        - Fail First and Step Therapy requirements
    - Network Designs
        - Standards for provider admissions into the network including reimbursement rates
        - Coverage for Out-of-Network Providers
        - Coverage for Out-of-Network Emergency Services
        - Restrictions based on geographic locations, facility type, or specialist type
    - Usual and Customary Charges and Reasonable Charges
    - Provider Reimbursement
    - Grievance and Appeals and Disclosures
    - Claims
        - Data and claims manuals

        - Claims Paid (Health and Prescription Drug)
        - Claims Denied (Health and Prescription Drug)
        - Claims Denied with Prior Authorization (Health)
    - Other considerations
        - Availability of Plan Information
        - Clinical Trials
        - Coverage of Autism as defined by RSA 417-E, RSA 415:6-n and RSA 415:18-s
        - ASAM Guidelines
        - Delegated Service Contracts
        - Medication Assisted Therapies/Treatment

To achieve the goal of the examination, review elements included but were not limited to the following:

- Evaluate the Company's Quantitative limitations imposed on MH/SUD benefits compared to the Quantitative limitations imposed on Med/Surg benefits to ensure that parity is provided.
- Evaluate the Company's financial limitations imposed on MH/SUD benefits compared to the financial limitations imposed on Med/Surg benefits to ensure:
    - That the 2/3 Substantially all requirements are met; and
    - That financial limitations are not more stringently applied to MH/SUD benefits than those of Med/Surg benefits.
- Consistent with 45 CFR 146.136 (c)(4), evaluate the Company's Non-Quantitative limitations imposed on MH/SUD benefits compared to the Non-Quantitative limitations imposed on Med/Surg benefits to:
    - Evaluate if the Company is considering benefits in all six market segments identified in 45 CFR §146.136 (b)(5):
        i. In-patient/in-network;
        ii. In-patient/out-of-network;
        iii. Out-patient/in-network;
        iv. Out-patient/out-of-network;
        v. Emergency services; and,
        vi. Prescription drug benefits
    - Identify any variations for coverage or benefits for these market segments and ensure that any identified variances are in compliance with the appropriate statutes and regulations, including 45 CFR §146.136 (b)(5).
    - Evaluate the Company's Medical Management Standards, such as Utilization Reviews and Case Management, to ensure that the Company is not imposing more restrictive requirements and determinations on MH/SUD treatments than on Med/Surg.

- Evaluate the Medical Management Standards to ensure that the guidelines are clearly outlined and presented to consumers in a format compliant with all applicable statutes and regulations.
- Review and test the Company's website for ease of use and accuracy of on-line directory.
- Evaluate the Company's pre-certification/pre-authorization policies and procedural requirements to ensure that the Company is not imposing more restrictive requirements and determinations on MH/SUD treatments than on Med/Surg.
- Evaluate the Company's complaint volume for MH/SUD complaints versus Med/Surg complaints.
- Detect and identify discriminatory benefit designs.
- Evaluate the Company's formulary designs for prescription drugs to ensure access to appropriate drugs was not more restrictive for MH/SUD than for Med/Surg.
- Evaluate the Company's network adequacy and provider admission requirements for MH/SUD providers and Med/Surg providers.
- Evaluate benefits when treatment is received through an out-of-network provider for services related to MH/SUD and Med/Surg.
- Evaluate the Company's reimbursement practices to determine if they are consistent between MH/SUD and Med/Surg, and to determine that any fee schedule updates are consistently applied to both MH/SUD and Med/Surg providers.
- Evaluate the Company's Usual and Customary allowances to determine that benefit reductions are not applied more strictly to MH/SUD than to Med/Surg benefits.
- Ensure that adverse benefit determination letters included information regarding any right to external review and all required contact information.
- Ensure that policyholder correspondence includes all appropriate information and disclosures for both MH/SUD and Med/Surg treatments.
- Ensure that plan information is readily available for both MH/SUD and Med/Surg benefits.
- Ensure that appropriate coverage is provided for Clinical Trials for both MH/SUD and Med/Surg benefits.
- Ensure Autism coverage is provided according to RSA 417-E, RSA 415:6-n and RSA 415:18-s and the NH Bulletin: Guidance on administration of Autism Benefits.
- Ensure that ASAM criteria are being followed as required by RSA 420-J:16 (Levels of Care Criteria).
- Determine the oversight of Delegated Service Contracts for both MH/SUD and Med/Surg Third-Party Administrators (hereinafter, "TPAs").
- Review Medication Assisted Treatment (MAT) criteria.

During the entrance conference held on February 22, 2018, examiners stated that responses to interrogatories must be comprehensive in nature. For example, if a narrative response referenced or described the Company's policies, practices and/or procedures, then those policies, practices and/or procedures must also be submitted for review. The Company's initial responses to interrogatories were due within thirty (30) days from February 22, 2018. The Company was instructed to upload its responses on a rolling basis per the Department's interest in certain priority areas (i.e., Company Operations and Management, Non-Quantitative Reviews, and Discriminatory Benefit Designs).

Interrogatory responses were requested, received and reviewed by the Department's examiners and contracted examiners. The examiners interacted with the Company for any follow-up questions or identified deficiencies. Examiners also held monthly status conference calls with the Company to discuss the examination and answer any questions that the Company may have. The Company and examiners also spoke and corresponded throughout the duration of the examination.

Phase II

In addition to performing a review of company processes and procedures, examiners also reviewed sample claim files. Sample claim files reviewed included both health and prescription drug services.

Examiners used ACL sampling methodology for MH/SUD diagnosis-based claims. ACL is statistical sampling. A sample drawn by ACL is statistically valid, or representative, because it is planned, drawn, and evaluated using accepted statistical formulas. The formulas are based on probability distributions. ACL sample sizes are based upon total universe population.

Examiners used random sampling limited to twenty-five (25) Med/Surg claims per bucket no matter the total universe population. Examiners limited Med/Surg sample claim review to twenty-five (25) claims per bucket given the mental health parity (hereinafter, "MHP") focus of this examination.

On May 8, 2018, the Company received the following four (4) claim universe requests from examiners for purposes of sampling:

- MH/SUD Health claims – paid, denied, and denied with prior authorization
- Med/Surg Health claims – paid, denied, and denied with prior authorization
- MH/SUD Prescription Drug claims – paid and denied
- Med/Surg Prescription Drug claims – paid and denied

Examiners requested that the Company classify each health claim by using one of the six sub-classifications:

- Inpatient in-network

- Inpatient out-of-network
- Outpatient in-network
- Outpatient out-of-network
- Emergency
- Prescription drug, if applicable

MH/SUD health claim universes were determined by the International Classification of Diseases (hereinafter, "ICD10" or "ICD9"). Examiners provided the Company with a list of all MH/SUD ICD9 and ICD10 codes for claim use querying; the list is available upon request. The MH/SUD health claim universes were restricted to claims with ICD10 and ICD9 diagnosis codes as the first and second diagnoses (e.g., ICD10 and ICD9 codes in the primary and/or secondary diagnosis field(s)).

Examiners requested that the Company classify each prescription drug claim by using one of the seven sub-classifications:

- Retail in-person in-network
- Retail mail order in-network
- Retail in-person out-of-network
- Inpatient in-network
- Inpatient out-of-network
- Office-based Treatment in-network
- Office-based Treatment out-of-network

Med/Surg prescription drugs were limited to those prescription drugs prescribed for pain management only because some of the same prescription drugs used for Med/Surg pain management are also used for SUD treatment, which allowed examiners to make MH/SUD and Med/Surg prescription drug comparisons.

The Department's primary objective in conducting the examination was to evaluate whether the Company is covering MH/SUD benefits no less favorably than Med/Surg benefits. As such, examiners reviewed sample claim files for MHPAEA compliance related to non-quantitative treatment limitations (hereinafter, "NQTL") and quantitative treatment limitations (hereinafter, "QTL"). Examiners utilized Company medical necessity, utilization review/management, prior authorization, and Medication Assisted Treatment policies while reviewing sample claim files.

COMPANY PROFILE

Anthem Health Plans of New Hampshire, Inc. ("AHPNH") and Matthew Thornton Health Plan, Inc. ("MTHP") are New Hampshire domiciled insurance companies. Anthem Health Plans of New Hampshire, Inc. is a wholly-owned subsidiary of ATH Holding Company, LLC ("ATH Holding"), and Matthew Thornton Health Plan, Inc. is a wholly-owned subsidiary of Anthem Health Plans of New Hampshire, Inc. Lines of business sold include individual, small group and

large group HMO and point-of-service (hereinafter, "POS") products, in addition to specialty products (life, vision and dental).

ATH Holding is a wholly-owned subsidiary of Anthem, Inc., a publicly traded company (NYSE: ANTM) and one of the largest health benefits companies in terms of membership in the United States.

The Companies' Financial Statements reflect the following information:

Re: MTHP	**2016**	**2017**
NH Covered Lives	94,084	95,828
Net Admitted Assets	$202,357,512	$199,420,213
Liabilities	$108,286,779	$103,749,988

Re: AHPNH	**2016**	**2017**
NH Covered Lives	135,547	133,571
Net Admitted Assets	$316,005,277	$322,686,200
Liabilities	$173,333,366	$167,415,498

EXECUTIVE SUMMARY

The following summary of the targeted market conduct examination of the Company is intended to provide a high-level overview of the examination results. The report includes sections that detail the scope of the examination, tests conducted, findings and observations. Appendices include the Interrogatories, Data Requests and Claim Universe File Layout sent to the Company, and the Provider Reimbursement Analysis Report.

The examination focused on the following areas of review: Parity in Quantitative, Financial, and Non-Quantitative benefit considerations, as well as other considerations that may impact parity. Based upon the examiners' review of the information received from the Company, the following is a summary of examiner findings:

Company Operations and Management:

Internal and External Audit Reports:

The examiners found no exceptions in terms of internal and external audit reports under parity procedures.

Management of Insurance Information and Record Retention:

The examiners found no exceptions in terms of management of insurance information and record retention under parity procedures.

Accurate MH/SUD Information Reported to NHID:

The examiners found no exceptions in terms of completeness and accuracy in company MH/SUD information required to be reported to the NHID under parity procedures.

Quantitative Limitations:

Aggregate Limitations:

The examiners found no exceptions in terms of inclusion of aggregate limitations under parity procedures.

Aggregate Lifetime Limitations:

The examiners found no exceptions in terms of inclusion of aggregate lifetime limitations under parity procedures.

No Lifetime Limitations:

The examiners found no exceptions in terms of inclusion of no lifetime limitations under parity procedures.

Lifetime Limitations:

The examiners found no exceptions in terms of inclusion of lifetime limitations under parity procedures.

Annual Limitations:

The examiners found no exceptions in terms of inclusion of annual limitations under parity procedures.

Treatment Limitations:

The examiners found no exceptions in terms of inclusion of treatment limitations under parity procedures.

Financial Limitations:

2/3 Substantially All Requirements:

The examiners found no exceptions in terms of inclusion of 2/3 substantially all requirements under parity procedures.

Deductibles:

The examiners found no exceptions in terms of inclusion of deductibles under parity procedures.

Co-payments:

The examiners found no exceptions in terms of inclusion of co-payments under parity procedures.

Coinsurance:

The examiners found no exceptions in terms of inclusion of coinsurance under parity procedures.

Out-of-Pocket Maximum Expenses:

The examiners found no exceptions in terms of inclusion of out-of-pocket maximum expenses under parity procedures.

Non-Quantitative Limitations:

Benefit Classifications:

Examiners reviewed the markets for both MH/SUD and Med/Surg coverage to ensure there were no disparities or gaps in coverage in all six market segments identified in 45 CFR §146.136 (b)(5):

i. In-patient/in-network;
ii. In-patient/out-of-network;
iii. Out-patient/in-network;
iv. Out-patient/out-of-network;
v. Emergency services; and,
vi. Prescription drug benefits

The examiners found no exceptions in terms of inclusion of all relevant markets under parity procedures.

Medical Management Standards:

The examiners found no exceptions in terms of inclusion of Medical Management Standards under parity procedures.

Complaints:

The examiners found no exceptions in terms of Complaints under parity procedures.

Discriminatory Benefit Designs:

The examiners found no exceptions in terms of Discriminatory Benefit Designs under parity procedures.

Formulary Designs for Prescription Drugs:

The examiners found no exceptions in terms of inclusion of Formulary Designs for Prescription Drugs under parity procedures.

Network Design:

The examiners found no exceptions in terms of Network Design under parity procedures.

Out-of-Network Providers:

The examiners found no exceptions in terms of out-of-network providers under parity procedures.

Usual, Customary and Reasonable (UCR) Charges:

The examiners found no exceptions in terms of Usual, Customary and Reasonable charges under parity procedures.

Provider Reimbursement:

Contract examiners from Regulatory Insurance Advisors (hereinafter, "RIA") and Berry, Dunn, McNeil & Parker (hereinafter, "BerryDunn") completed distinct reviews relative to Provider Reimbursement.

Examiners found exceptions in terms of Provider Reimbursement under parity procedures. Specifically, MH/SUD providers are reimbursed at lower rates than Med/Surg providers, and the Company was unable to provide a clear explanation for said provider reimbursement disparities. Please refer to the *Examination Details and Findings* section for additional information.

Grievance and Appeals:

The examiners found no exceptions in terms of inclusion of Grievance and Appeals under parity procedures. However, the examiners found four (4) exceptions in Med/Surg appeals related to appeal handling and unfair claim settlement practices. Please refer to the *Examination Details and Findings* section for additional information.

Claims:

Data, Policies and Procedures:

Samples: HEALTH CLAIMS PAID

The examiners found no exceptions in terms of MH/SUD health claims paid under parity procedures and claim handling procedures.

The examiners found no exceptions in terms of Med/Surg health claims paid under claim handling procedures.

MH/SUD Total Universe Population	202,701
Med/Surg Total Universe Population	3,530,213

MH/SUD Health Sample Size	109
Med/Surg Health Sample Size	25

Claim type	**MH/SUD Sample Size**	**Med/Surg Sample Size**
In-patient/In-Network	5	2
In-patient/Out-of-Network	1	0
Out-patient/In-Network	95	23
Out-patient/Out-of-network	8	0
Emergency Services	0	0
Prescription Drug Services	0	0

Samples: HEALTH CLAIMS DENIED

The examiners found no exceptions in terms of MH/SUD health claims denied under parity procedures and claim handling procedures.

However, the examiners found one (1) exception in terms of Med/Surg claims denied under claim handling procedures. Specifically, the Company failed to acknowledge one

claim submission in a timely manner. Please refer to the *Examination Details and Findings* section for additional information.

MH/SUD Total Universe Population	78,942
Med/Surg Total Universe Population	167,181

MH/SUD Health Sample Size	109
Med/Surg Health Sample Size	25

Claim type	**MH/SUD Sample Size**	**Med/Surg Sample Size**
In-patient/In-Network	3	0
In-patient/Out-of-Network	2	1
Out-patient/In-Network	42	21
Out-patient/Out-of-network	61	3
Emergency Services	1	0
Prescription Drug Services	0	0

Samples: HEALTH CLAIMS DENIED WITH PRIOR AUTHORIZATION

The examiners found no exceptions in terms of MH/SUD health claims denied with prior authorization under parity procedures and claims handling procedures.

However, the examiners found one (1) exception in terms of Med/Surg claims denied with prior authorization under claim handling procedures. Specifically, the Company failed to pay one claim in a timely manner. Please refer to the *Examination Details and Findings* section for additional information.

MH/SUD Total Universe Population	1,942
Med/Surg Total Universe Population	8,048

MH/SUD Health Sample Size	109
Med/Surg Health Sample Size	25

Claim type	**MH/SUD Sample Size**	**Med/Surg Sample Size**
In-patient/In-Network	63	16
In-patient/Out-of-Network	16	0
Out-patient/In-Network	26	9

Out-patient/Out-of-network	4	0
Emergency Services	0	0
Prescription Drug Services	0	0

Samples: PRESCRIPTION DRUG CLAIMS PAID

The examiners found no exceptions in terms of MH/SUD prescription drug claims paid under claim handling procedures. However, the examiners found two (2) exceptions in terms of MH/SUD prescription drug claims paid under parity procedures. Specifically, the Company required a prior authorization for SUD prescription drugs in 2016. Please refer to the *Examination Details and Findings* section for additional information.

The examiners found no exceptions in terms of Med/Surg prescription drug claims paid under claim handling procedures. However, the examiners found one (1) exception in terms of Med/Surg prescription drug claims paid under market conduct examination procedures. Specifically, the Company failed to provide complete prescription drug accumulators upon the examiners' first request. Please refer to the *Examination Details and Findings* section for additional information.

MH/SUD Rx Universe Population	327,986
Med/Surg Rx Universe Population	79,969

MH/SUD Rx Sample Size	109
Med/Surg Rx Sample Size	25

Claim type	**MH/SUD Sample Size**	**Med/Surg Sample Size**
Retail In-Network	100	25
Retail Out-of-Network	0	0
Mail Order In-Network	9	0
Other	0	0

Samples: PRESCRIPTION DRUG CLAIMS DENIED

The examiners found no exceptions in terms of MH/SUD prescription drug claims denied under claim handling procedures. However, the examiners found one (1) exception in terms of MH/SUD prescription drug claims paid under parity procedures. Specifically, the Company required a prior authorization for a SUD prescription drug in 2016. Please refer to the *Examination Details and Findings* section for additional information.

The examiners found no exceptions in terms of Med/Surg prescription drug claims denied under claim handling procedures.

MH/SUD Rx Universe Population	154,819
Med/Surg Rx Universe Population	29,849

MH/SUD Rx Sample Size	109
Med/Surg Rx Sample Size	25

Claim type	**MH/SUD Sample Size**	**Med/Surg Sample Size**
Retail In-Network	109	25
Retail Out-of-Network	0	0
Mail Order In-Network	0	0
Other	0	0

Other Considerations:

Availability of Plan Information:

The examiners found no exceptions in terms of Availability of Plan information under parity procedures.

Clinical Trials:

The examiners found no exceptions in terms of inclusion of Clinical Trials under parity procedures.

Autism Coverage:

The examiners found no exceptions in terms of inclusion of Autism Coverage under parity procedures.

ASAM Compliance:

Contract examiners from RIA and BerryDunn completed distinct reviews relative to compliance with RSA 420-J:16, which is specific to the utilization of ASAM criteria.

RIA examiners reviewed prior authorization and concurrent review notes in sample claims only. Many sample claims were for services not requiring a prior authorization and/or concurrent review. As such, the aforementioned review was limited in nature.

RIA examiners found no exceptions in terms of inclusion of ASAM Compliance under parity procedures.

BerryDunn reviewed medical management policies, clinical rosters, Company narratives in response to BerryDunn interrogatories, staffing data, and clinical review data to determine whether the Company utilized ASAM criteria in the medical necessity/utilization review process. BerryDunn also reviewed specific MH/SUD sample claim files separate and distinct from RIA sample claim files, as well as sample claim file utilization review notes.

NHID examiners found no exceptions in the Company's application of ASAM criteria during the medical necessity/utilization review process.

Delegated Service Contracts:

The Company does not delegate any services related to MH/SUD. As such, delegated service compliance does not apply.

Medication Assisted Treatment (MAT):

Examiners found three (3) exceptions in terms of inclusion of Medication Assisted Treatment under parity procedures. The three (3) exceptions are described under MH/SUD prescription drug claims paid and denied section located above. Specifically, the Company required prior authorization for generic MAT medications in 2016. The Company took corrective action measures by implementing a new policy effective January 1, 2017 no longer requiring prior authorizations for MAT medications.

Compliance with Previous Examination Recommendations:

The findings and recommendations identified in the previous examination, Ins. No. 15-072-MC, included:

- Handling network adequacy issues due to a lack of SUD providers in the area.
- Providing a sufficient online/website listing of MH/SUD providers.
- Provider directory accuracy.
- Pre-authorization and medical necessity standards for SUD being easily accessible and available for consumers online and otherwise.
- Including correct MAT drug dosing limitations.
- QTL policies and procedures addressing protocol for disparities should disparities arise.
- Medical Management policies and procedures including depression screening without cost sharing.
- Medical Necessity policies, Utilization Review policies and Clinical Guidelines being easily accessible for consumers online and upon request.

- Pre-certification and pre-authorization guidelines easily accessible online, and including information on identification cards to contact Customer Service for eligibility verification and/or PA requirements.
- Produce provider reimbursement analysis and evidence supporting that disparity in MH/SUD provider reimbursement is not a parity violation.

During the course of examination Ins. No. 17-046-MC, it was determined that the Company took the above-mentioned corrective action measures to come into compliance with previous findings and recommendations.

EXAMINATION DETAILS AND FINDINGS

Examiners requested company policies, procedures and processes, all plan documents, marketing and member materials, sample complaint and appeal files, and sample claim files for review to determine mental health parity compliance. Examiners sent out fourteen (14) Requests for Information (hereinafter, "RFI") to follow up with the Company regarding the Company's responses to interrogatories.

Company Operations and Management:

Internal and External Audit Reports:

***Testing Methodology*:**

In determining parity compliance, examiners requested that the Company provide a list of all internal and external MH/SUD-related audits conducted within the last three years and the corresponding audit reports. The Company stated in response, "Internal MH/SUD audits are not specific to NH and include other Anthem New England states." The Company provided two MH/SUD-related reports, New England Behavioral Health Audit in March 2017 and Commercial UM Compliance Program Report in August 2015, with the redaction of non-New Hampshire state information. Examiners reviewed both reports.

Examiner Findings:

Examiners found no exceptions.

Management of Insurance Information and Record Retention:

In determining parity compliance, examiners reviewed the Company's records retention schedule policies (2015-2017), records management policies (2015-2017) and records management procedures (2015-2017).

Examiner Findings:

Examiners found no exceptions.

Accurate MH/SUD Information Reported to NHID:

In determining parity compliance, examiners reviewed the Company's state and federal policies and procedures governing accurate and complete data reporting to the NHID.

Examiner Findings:

Examiners found no exceptions.

Quantitative Treatment Limitations:

In accordance with the federal mental health parity rule, 45 CFR § 146.136 (a)(3)(i)(A), examiners reviewed the Company's policies and procedures in applying both quantitative and non-quantitative limitations. Under the rule, quantitative treatment limitations are those for which the extent of benefits provided is based on accumulated amounts, such as an annual or lifetime day or visit limit.

Aggregate Limitations:

Aggregate Lifetime Limitations:

The term "aggregate lifetime limit" means, with respect to benefits under a group health plan or health insurance coverage, a dollar limitation on the total amount that may be paid with respect to such benefits under the plan or health insurance coverage with respect to an individual or other coverage unit. Does the plan include aggregate lifetime limitations (for example, is the plan discontinued if a certain dollar threshold is met, such as $2 million dollars)?

No Lifetime Limitations:

Examiners reviewed all plan limitations to ensure that the carrier consistently imposed no lifetime limitations for MH/SUD treatments and Med/Surg treatments.

Specific Lifetime Limitations:

Examiners reviewed all plan limitations to ensure that if the carrier imposed a specific lifetime limitation that it was imposed consistently for MH/SUD treatments and Med/Surg treatments.

***Testing Methodology*:**

In determining parity compliance with the **aggregate lifetime**, **no lifetime** and **specific lifetime limitations,** examiners reviewed certificates of coverage, summary of benefits and coverage, and marketing and member material documents. Examiners also reviewed company medical management (utilization management/review, prior authorization, medical necessity and experimental/investigative) policies that may limit or restrict any treatments or

services. Additionally, examiners reviewed 309 MH/SUD health (ACL sampling methodology), 75 Med/Surg health (random sampling methodology), 218 MH/SUD prescription drug (ACL sampling methodology), and 50 Med/Surg prescription drug (random sampling methodology) sample claim files to ensure company provisions in plan documents and company policies and procedures align with actual claim processing and handling practices.

Examiner Observations:

Plan documents and sample claim files did not contain aggregate lifetime, lifetime or specific service lifetime limitations.

Examiner Findings:

Examiners found no exceptions.

Annual Limitations:

Examiners reviewed all plan limitations to ensure that if the Company imposed specific annual limitations that they were consistently applied to MH/SUD treatments and Med/Surg treatments.

***Testing Methodology*:**

In determining parity compliance with annual limitations, examiners reviewed certificates of coverage, summary of benefits and coverage, and marketing and member material documents. Examiners also reviewed company medical management (utilization management/review, prior authorization, medical necessity and experimental/investigative) policies that may limit or restrict any treatments or services. Additionally, examiners reviewed 309 MH/SUD health (ACL sampling methodology), 75 Med/Surg health (random sampling methodology), 218 MH/SUD prescription drug (ACL sampling methodology), and 50 Med/Surg prescription drug (random sampling methodology) sample claim files to ensure company provisions in plan documents and company policies and procedures align with actual claim processing and handling practices.

Examiner Observations:

Plan documents and sample claim files did not contain annual limitations.

Examiner Findings:

Examiners found no exceptions.

Treatment Limitations:

Examiners reviewed all plan limitations to ensure that if the carrier imposed specific treatment limitations that they were consistently applied to MH/SUD treatments and Med/Surg treatments.

***Testing Methodology*:**

In determining parity compliance with treatment limitations, examiners reviewed certificates of coverage, summary of benefits and coverage, and marketing and member material documents. Examiners also reviewed company medical management (utilization management/review, prior authorization, medical necessity and experimental/investigative) policies that may limit or restrict any treatments or services. Additionally, examiners reviewed 309 MH/SUD health (ACL sampling methodology), 75 Med/Surg health (random sampling methodology), 218 MH/SUD prescription drug (ACL sampling methodology), and 50 Med/Surg prescription drug (random sampling methodology) sample claim files to ensure company provisions in plan documents and company policies and procedures align with actual claim processing and handling practices.

Examiner Observations:

Plan documents and sample claim files did not contain MH/SUD treatment limitations. Plan documents and sample claim files did contain treatment limitations for Med/Surg services such as physical therapy, occupational therapy, speech therapy, chiropractic care, rehabilitation care, and skilled nursing care.

Examiner Findings:

Examiners found no exceptions.

Financial Limitations:

Reviewing financial limitations included reviewing and comparing cost-share requirements for both MH/SUD benefits and Med/Surg benefits. The term cost-share means the share of costs covered by the insurance carrier that the policyholder would pay out of their own pocket.[2] This term generally includes deductibles, coinsurance, and copayments, or similar charges, but it doesn't include premiums, balance billing amounts for non-network providers, or the cost of non-covered services. Cost sharing in Medicaid and State Comprehensive Health Insurance Plans (CHIP) also includes premiums.

To provide different premium options to consumers, carriers offer various tiers of cost share requirements that meet the metal level assignments, which are Bronze, Silver, Gold and Platinum as defined by 42 U.S.C. § 18022 Section 1302 (d)(2)(A) . Usually, the greater the cost-share requirement and out-of-pocket expenses incurred by the consumer, the less

[2] "Cost Sharing," https://www.healthcare.gov/glossary/cost-sharing/

the policy premium is. As such, examiners should determine how many plans the carrier offers in the category and review the financial limitations for multiple plans in that category.

2/3 Substantially All Requirement:

If a type of financial requirement or quantitative treatment limitation applies to at least two-thirds of all Med/Surg benefits in a classification as determined under paragraph 45 CFR § 146.136(c)(3)(i)(A), the level of the financial requirement or quantitative treatment limitation that is considered the predominant level of that type in a classification of benefits is the level that applies to more than one-half of Med/Surg benefits in that classification subject to the financial requirement or quantitative treatment limitation.

If, with respect to a type of financial requirement or quantitative treatment limitation that applies to at least two-thirds of all Med/Surg benefits in a classification, there is no single level that applies to more than one-half of Med/Surg benefits in the classification subject to the financial requirement or quantitative treatment limitation, the plan (or health insurance issuer) may combine levels until the combination of levels applies to more than one-half of Med/Surg benefits subject to the financial requirement or quantitative treatment limitation in the classification. The least restrictive level within the combination is considered the predominant level of that type in the classification. (For this purpose, a plan may combine the most restrictive levels first, with each less restrictive level added to the combination until the combination applies to more than one-half of the benefits subject to the financial requirement or treatment limitation.)

***Testing Methodology*:**

In determining parity compliance with the 2/3 substantially all requirements, examiners reviewed the Company's policy, Anthem FMHP Testing & Compliance Policy and Procedures, regarding MHPAEA's financial requirements and quantitative treatment limitations.

Examiner Observations:

The eight (8) page policy outlines the Company's understanding of MHPAEA financial requirements, the FMHP Final Rule FAQs (April 2015), and the Updated FAQs (April 2016). The company policy includes company testing approaches, the Anthem Mental Health Parity Test Tool, a statement that underwriting maintains copies of all test results, examples of situations that may trigger mental health parity (hereinafter, "MHP") QTL testing, examples of situations that do not require MHP QTL testing, and recommendations of benefits to be covered and modified.

Examiner Findings:

Examiners found no exceptions.

Deductibles:

The term deductible means the amount the policyholder would pay for covered health care services before their insurance plan starts to pay.[3] Deductibles do not apply to defined covered Preventive Health Services outlined in 42 USC § 300gg-13.

Co-payments:

The term co-payment means a fixed amount ($20, for example) the policyholder would pay for a covered health care service after they've paid their deductible.[4]

Coinsurance:

The term co-insurance means the percentage of costs of a covered health care service the policyholder pays (20%, for example) after they've paid their deductible.[5]

Out-of-Pocket Maximum Expenses:

The term out-of-pocket maximum expenses means the most the policyholder must pay for covered services in a plan year. After the policyholder spends this amount on deductibles, copayments, and coinsurance, their health plan pays 100% of the costs of covered benefits.[6]

***Testing Methodology*:**

In determining parity compliance for **deductibles**, **co-payments**, **coinsurance** and **out-of-pocket maximums**, examiners reviewed certificates of coverage, summary of benefits and coverage, and marketing and member material documents. Additionally, examiners reviewed 309 MH/SUD health (ACL sampling methodology), 75 Med/Surg health (random sampling methodology), 218 MH/SUD prescription drug (ACL sampling methodology), and 50 Med/Surg prescription drug (random sampling methodology) sample claim files to ensure claims are processed according to the cost-sharing outlined in plan documents and marketing materials.

Examiner Findings:

Examiners found no exceptions.

***Non-Quantitative Treatment Limitations*:**

Examiners closely reviewed the Company's policies and procedures regarding Non-Quantitative limitations, including network admissions, reimbursement rates, and tiered benefits. Examiners

[3] "Deductible," https://www.healthcare.gov/glossary/deductible/
[4] "Copayment," https://www.healthcare.gov/glossary/co-payment
[5] "Coinsurance," https://www.healthcare.gov/glossary/co-payment/
[6] "Out-of-pocket maximum/limit," https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/

also reviewed company credentialing policies and procedures, contract templates, fee schedules and provider manuals to ensure that requirements being presented for credentialing of Mental Health specialists were not more stringently applied than the standards applied to Medical/Surgical specialists.

Non-quantitative treatment limitations included (but are not limited to) the following:

1. Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
2. Formulary design for prescription drugs;
3. Network tier design for plans with multiple network tiers (such as preferred providers and participating providers);
4. Standards for provider admission to participate in a network, including reimbursement rates;
5. Methods for determining usual, customary, and reasonable charges;
6. Refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective (also known as fail-first policies or step therapy protocols);
7. Exclusions based on failure to complete a course of treatment; and
8. Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage).

Medical Management Standards, Including Utilization Review, Case Management, and Prior Authorization/Pre-Certifications:

Medical Management standards were reviewed to determine that access to coverage, medical necessity requirements, utilization reviews, and precertification requirements for MH/SUD and Med/Surg benefits were consistently applied and did not incorporate more stringent factors for MH/SUD benefits that would limit or discourage access for treatment.

Policy Development and Updates:

Examiners also reviewed methodologies that the Company utilizes to create, amend, or update policies and procedures. The purpose of this section of the review was to determine if the Company was utilizing the most up to date policies and procedures based on current medical standards, and ensuring that the policies and procedures for MH/SUD are updated as frequently, if not more frequently than, the policies and procedures established for Med/Surg benefits.

Testing Methodology:

In reviewing the medical management standards, examiners performed a comprehensive review of internal medical policies, and clinical utilization management guidelines and a review of all medical management-medical policy and clinical utilization management guidelines applicable to MH/SUD and Med/Surg processes and procedures. The reason for this comprehensive review was to determine if the Company was imposing greater requirements for medical necessity determinations on MH/SUD benefits than were imposed on Med/Surg benefits. In addition, the review also identified the criteria for creating policies and procedures, and ensured that the appropriate expertise from credentialed professionals was taken into consideration in updating and amending any policies and procedures, and that the updates were timely and accurate according to medical standards. The review also determined if timeframes for reviewing and updating policies and procedures was consistently applied, therefore ensuring that the most current policies and procedures were taken into consideration for both MH/SUD benefits and Med/Surg benefits.

Examiners also reviewed prior authorization and pre-certification requirements for MH/SUD and Med/Surg treatments. To determine parity between prior authorization and pre-certification requirements for both MH/SUD and Med/Surg, examiners reviewed all of the Company's internal processes for both areas as well as samples of policy language from a large group, small group and individual plan.

In reviewing medical management standard requirements, examiners utilized internal process and procedure guidelines as well as the NAIC Market Regulation Handbook. The following standards were followed from the Market Regulation Handbook:

Standard 1

The health carrier shall operate its utilization review program in accordance with final regulations established by the US Department of Health and Human Services (HHS), the US Department of Labor (DOL) and the US Department of the Treasury (Treasury). *NAIC Market Regulation Handbook, Chapter 20A, page 689***.**

Standard 2

The health carrier operates its utilization review program in accordance with applicable state statutes, rules and regulations. *NAIC Market Regulation Handbook, Chapter 20, page 565*

<u>Regulatory Authority</u>

RSA 415-A:4-a Minimum Standards for Claim Review; Accident and Health Insurance. – Any carrier that offers group health plans and employee benefit plans shall establish and

maintain written procedures by which a claimant may obtain a determination of claims and by which a claimant may appeal a claim denial.

RSA 420-J:5 Managed Care Law. Grievance Procedures. Every carrier or other licensed entity shall establish and shall maintain a written procedure by which a claimant or a representative of the claimant, shall have a reasonable opportunity to appeal a claim denial to the carrier or other licensed entity, and under which there shall be a full and fair review of the claim denial. The written procedure filed with the insurance department shall include all forms used to process an appeal.

Examiner Observations:

Medical management policies appeared to be clearly drafted and comprehensive in nature. Medical management policies are updated annually, and in some circumstances, more than one time per year.

Examiner Findings:

Examiners found no exceptions.

Complaints:

Complaint logs are telling from the perspective of detecting problems as they provide indicators that may be indicative of deeper concerns. Examiners reviewed complaint logs to detect an increase in complaints in certain areas over a specific timeframe, and determined the underlying factor of the increase.

***Testing Methodology*:**

In determining parity in complaints, examiners reviewed the Company's complaint logs for 2016 and 2017. The Company's complaint logs contained all written complaints by members or a member's representative sent directly to the Company. The Company received five (5) written complaints in 2016. The Company received sixteen (16) written complaints in 2017.

Examiner Observations:

The Company received very few written complaints during the examination period. The complaints did not trend in one particular area or subject matter.

Examiner Findings:

Examiners found no exceptions.

Discriminatory Benefit Designs:

Discriminatory benefit designs are incorporated to mitigate or eliminate paying coverage benefits, or to dissuade or prevent individuals from obtaining coverage. Discriminatory benefit designs may be subtle and not easy to identify. Additionally, some discriminatory benefit designs and practices may look innocuous on the surface, but ultimately limit coverage in a way that is in fact discriminatory. Examiners reviewed the Company's processes and procedures to identify potential discriminatory benefit designs and to ascertain potential options for handling any discriminatory benefit designs that were identified.

Producer Incentives to Deny Applicants Because of Medical History:

***Testing Methodology*:**

In determining parity in application denials, examiners requested that the Company provide a listing of all applicants that applied for and were subsequently denied coverage, as well as the agent's name and carrier ID number who took the application. The Company responded by stating, "Anthem does not medically underwrite or deny individual applicants requesting coverage in accordance with the ACA and NH State Law implementing ACA provisions." Examiners also reviewed internal company policies and procedures regarding plan membership.

Examiner Findings:

Examiners found no exceptions.

Written Treatment Plans:

***Testing Methodology*:**

In determining parity in written treatment plans, examiners requested that the Company provide all policies and procedures regarding written treatment plans for both MH/SUD and Med/Surg treatments. The Company responded by stating, "Anthem BH does not produce written treatment plans. We receive clinical information and the treatment plan from the treating provider."

Examination Observations:

The Company defers to the treating provider for treatment plans.

Examiner Findings:

Examiners found no exceptions.

Formulary Designs for Prescription Drugs:

The examiners reviewed the list of prescription drugs that have been selected by the carrier to be covered due to their effectiveness, safety and costs to ensure all requirements of 45 CFR 156.122 are met.

45 CFR 156.122 provides the requirements for compliance in providing prescription drug benefits. These requirements state:

(a) A health plan does not provide essential health benefits unless it:

(1) Subject to the exception in paragraph (b) of this section, covers at least the greater of:

> (i) One drug in every United States Pharmacopeia (USP) category and class; or
>
> (ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan; and

(2) Submits its drug list to the Exchange, the State, or OPM.

(b) A health plan does not fail to provide EHB prescription drug benefits solely because it does not offer drugs approved by the Food and Drug Administration as a service described in Sec. 156.280(d) of this subchapter.

(c) A health plan providing essential health benefits must have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the health plan.

***Testing Methodology*:**

In determining parity in formulary designs for prescription drugs, examiners reviewed (i) prescription drugs included in the EHB-benchmark plans for 2016 and 2017, and (ii) then reviewed the Company's formularies for 2016 and 2017 to ensure that the formularies included either one drug in every USP category and class or the same number of prescription drugs in each category and class as the EHB-benchmark plan. Examiners also reviewed company prior authorization policies for allowing a member to receive clinically appropriate drugs not covered by the health plan.

Examiner Findings:

Examiners found no exceptions.

Fail First and Step Therapy Requirements:

Examiners reviewed all fail first and step therapy requirements to ensure that the carrier was incorporating these requirements consistently between MH/SUD treatments and Med/Surg treatments. Examiners also reviewed the fail first and step therapy requirements to ensure they were not applied more stringently to MH/SUD treatments than to Med/Surg treatments.

***Testing Methodology*:**

In determining parity in fail first and step therapy requirements, examiners reviewed plan documents such as certificates of coverage, summary of benefits and coverage, marketing and member materials, and company medical management policies and procedures. Additionally, examiners reviewed and 309 MH/SUD health (ACL sampling methodology), 75 Med/Surg health (random sampling methodology), 218 MH/SUD prescription drug (ACL sampling methodology), and 50 Med/Surg prescription drug (random sampling methodology) sample claim files to ensure fail first and step therapy requirements were applied correctly, and no more stringently to MH/SUD treatments than to Med/Surg treatments.

Examiner Findings:

Examiners found no exceptions.

Network Design:

Examiners reviewed the Company's network to determine accessibility to appropriate specialists and treatments. Examiners also reviewed the requirements for provider application and acceptance into the network to determine if there were more stringent requirements for MH/SUD providers than Med/Surg providers. Additionally, examiners reviewed the provider reimbursement rates and fee schedules within the network to identify discrepancies in reimbursements for MH/SUD and Med/Surg providers that may dissuade MH/SUD providers from joining the network. To identify this, the examiners reviewed seven CPT codes to determine the reimbursement rates for providers (methodology and analysis below under the *Provider Reimbursement* subsection).

Network Adequacy:

Standard 1

The health carrier demonstrates, using reasonable criteria, that it maintains a network that is sufficient in number and types of providers that ensure all services to covered persons will be accessible without unreasonable delay. *NAIC Market Regulation Handbook – Chapter 20, page 530*

A health carrier shall demonstrate that it monitors its providers, provider groups and intermediaries with which it contracts on an ongoing basis to ensure their ability, clinical capacity, financial capability and legal authority, including applicable licensure requirements, to furnish all contracted benefits to covered persons. *NAIC Market Regulation Handbook – Chapter 20, page 531*

Regulatory Authority

RSA 420-J:7 Network Adequacy.
I. A health carrier shall maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible without unreasonable delay.
IV. Annually, the health carrier shall submit a report to the commissioner demonstrating compliance with the rules for network adequacy.

Ins 2701.06 Standards for Geographic Accessibility.

Ins 2701.10 Enforcement. If the commissioner determines that a health carrier has not contracted with a sufficient number of participating providers to assure that covered persons have accessible health care services in a geographic area or that a health carrier's health care certification of compliance report does not assure reasonable access to covered benefits, the commissioner shall issue an order requiring the health carrier to institute a corrective action, or shall use other enforcement powers under RSA 420-J to ensure that covered persons have access to covered benefits.

***Testing Methodology*:**

In determining parity in network designs, examiners reviewed the Company's 2016 and 2017 network adequacy filings with the NHID, which included the following information:

- Broad and Pathway products
    - Certification
    - Cover Letter
    - Network Adequacy Exception Letter
    - Anthem New Hampshire Health Care Access Report
        - Membership Figures
        - Provider and Facility Lists
        - Geo Access Reports and Analysis
        - Out-of-network Referral Desktop
        - CAHPS Results
        - Provider Access Standards
        - Enrollment Form Templates

- Care Management Information, Continuation of Care Guidelines, and Transition in Care Forms
- Out-of-network Referrals Process Guide
- Provider Rates
- Several Agreement Templates

Examiner Findings:

Examiners found no exceptions.

Usual, Customary and Reasonable (UCR) Charges:

The examiners reviewed company processes and procedures for determining UCR charges, including the timeframes that the Company updates the fee schedules, and considerations given when these updates are incorporated, such as relative value changes by Medicare, geographic and economic factors for the customers (members and employers), as well as current employer group demands and concerns.

***Testing Methodology*:**

In determining parity in UCR charges, examiners reviewed company fee schedules, policies and procedures regarding updates to fee schedules, and policies outlining the determination of rates.

Examiner Findings:

Examiners found no exceptions.

NOTE: Examiners do not consider UCR charges and provider reimbursement to be synonymous. UCR charges may be considered in determining provider reimbursement rates, but UCR charges do not solely determine provider reimbursement rates. Please see the Provider Reimbursement subsection below for additional information.

Provider Reimbursement:

The examiners reviewed company policies and procedures for determining provider reimbursement rates and fee schedules. In addition, the NHID engaged a second contract examiner, BerryDunn, to perform an in-depth review of the Company's provider reimbursement practices. This section encompasses both reviews, which were provided to the Company in combined form, and to which the Company made a combined response. However, the Department's findings rely only on the BerryDunn analysis, not the RIA analysis.

Legal Standard:

45 CFR 146.136 (c)(4): Nonquantitative treatment limitations—(i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation 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 nonquantitative treatment limitation 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.

(ii) Illustrative list of nonquantitative treatment limitations. Nonquantitative treatment limitations include— . . .

(D) Standards for provider admission to participate in a network, including reimbursement rates; [and]

(E) Plan methods for determining usual, customary, and reasonable charges;...

***RIA Review*:**

In determining parity in provider reimbursement, examiners reviewed the Anthem Fee Schedule Development Policy regarding the Company's provider reimbursement practices. The Company also explained that it considers factors such as licensure, education, training, market share, and geographic and economic considerations in determining provider reimbursement rates. Additionally, examiners reviewed and compared reimbursement rates for the following seven CPT codes in MH/SUD and Med/Surg sample claim files. RIA examiners found one (1) exception in terms of provider reimbursement under parity procedures. However the NHID examiner findings (discussed below) do not rely on the RIA findings. This review is mentioned only in order to provide a complete description of the exam process.

***Testing Methodology – BerryDunn Review*:**

BerryDunn conducted a quantitative analysis of the Company's provider reimbursement levels using 2016 data from the New Hampshire Comprehensive Health Information System (hereinafter, "NHCHIS"). Specifically, BerryDunn compared the ratios of the Company's commercial MH/SUD provider reimbursement rates and Med/Surg provider reimbursement rates, as reported by the Company to the NHCHIS, to Medicare reimbursement rates for the same services.[7]

[7] The methodology and results are explained in further detail in the analysis report issued by BerryDunn dated December 7, 2018, which is attached to this report.

BerryDunn selected this methodology because Medicare's method of developing payment methods is resource-based and applies a consistent standard to both MH/SUD and Med/Surg reimbursement calculations. Medicare uses the Resource Based Relative Value Scale (hereinafter, "RBRVS") to apply relative weights to payment levels, and the weights are based on the resources associated with the providers' work, practice expense, and professional liability insurance. In order to conduct the analysis, BerryDunn identified specific services in the Inpatient, Outpatient, Emergency, and Pharmacy service categories for comparison.

In addition to the quantitative review, BerryDunn examiners propounded interrogatories regarding the Company's provider reimbursement policies and procedures, and reviewed the responses in light of the quantitative findings. The focus of BerryDunn's review of the policies and procedures was whether there was evidence to support a finding that, even if the quantitative analysis revealed differential reimbursement levels, the Company's processes, strategies, and evidentiary standards used to set provider reimbursement rates, as written and in operation, were nevertheless being applied in a manner that was comparable between MH/SUD and Med/Surg services.

***Examiner Observations – BerryDunn Review*:**

Both the inpatient and professional claims analyses showed a large discrepancy in commercial-to-Medicare payment ratios between Med/Surg services and MH/SUD services, with MH/SUD inpatient episodes showing a much lower commercial-to-Medicare reimbursement ratio (1.32 for MH/SUD episodes vs. 2.30 for Med/Surg episodes) and MH/SUD professional services showing the lowest commercial-to-Medicare reimbursement ratio, 1.06, among all professional specialties. By comparison, the BerryDunn analysis found a Med/Surg primary care ratio of 1.97, a Med/Surg evaluation and management services ratio of 1.53, and a neurological surgery ratio of 2.31.

BerryDunn noted that the Company's provider reimbursement practices could still be found to be consistent with MHPAEA, despite the discrepancies in MH/SUD and Med/Surg services reimbursements, if the Company's processes, strategies, evidentiary standards, and other factors used to arrive at the fees were consistent between MH/SUD and Med/Surg.

In an attempt to measure the comparability of the processes used to determine provider fee schedules for MH/SUD versus Med/Surg, as well as the stringency with which the factors are applied, BerryDunn asked the Company to provide any analytical framework or formula it used for the factors the Company uses to set reimbursement rates, such as the Company's competitive position in the marketplace, feedback directly from providers, comparative data from the competitive market in which prices reflect resource requirements (professional education and technical skill, equipment and facility usage, etc.). BerryDunn noted that all Medicare payment systems are updated

annually by the Centers for Medicare and Medicaid services (hereinafter "CMS") and undergo public comment in Notices of Public Rulemaking before being published in the federal Register as Final Rules.

The Company's response did not demonstrate that, as applied, its methodology for applying the factors was comparable as required under MHPAEA given the "red flag" of greatly disparate reimbursement rates for MH/SUD providers.

BerryDunn also provided evidence in its report that a national assessment of providers per capita in different specialties appears consistent with the Company's payment of higher rates for Med/Surg providers, as New Hampshire ranks near the top of the country in its supply of surgeons, OB/GYNs and pediatricians, while the per capita supply of MH/SUD providers is notably below national averages.

Company Position:

The Company disagreed with the contract examiners' observations and findings, and provided both an initial response, which was discussed during the exit conference, and a supplemental response, which was reviewed by the NHID following the exit conference. The Company also submitted a written rebuttal to NHID's May 1, 2019 Verified Report and a supplement to its rebuttal in order to address new MHPAEA guidance on NQTLs issued on September 5, 2019 by the Departments of Labor, Health and Human Services and Treasury.[8]

The Company reiterated that the process used to develop Anthem fee schedules is the same across all specialties and for Med/Surg and MH/SUD treatment providers. The Company described its use of the same seven steps in its process for determining reimbursement rates for its statewide fee schedules for both Med/Surg and MH/SUD providers. The Company referenced provider-specific negotiating leverage, specifically that hospital-affiliated providers are in a better position to negotiate higher fees. The Company noted that differences based on licensure status – i.e., care delivered by non-physician practitioners – are consistent between Med/Surg and MH/SUD services. The Company also expressed concern regarding BerryDunn's methodology for analyzing compliance with MHPAEA.

The Company asserted that BerryDunn's methodology was flawed because BerryDunn did not focus on the reimbursement rates in the Company's statewide fee schedules. The Company asserted that BerryDunn did not account for large hospital systems that have superior bargaining power and leverage to negotiate higher reimbursement rates. The Company contends that any disparity in reimbursement rates for Med/Surg and MH/SUD providers is attributable to such market forces, not the lack of comparable

[8] The Company's rebuttal and supplement to its rebuttal are attached to this report.

processes for setting reimbursement rates or more stringent application of these processes to MH/SUD providers.

The Company disputes that it failed to provide sufficient documentation to the NHID examiners regarding the processes, strategies, evidentiary standards and other factors it uses to set reimbursement rates. The Company's responses to information requests by the examiners included an interrogatory response in which it stated that for both Med/Surg and MH/SUD providers, it considers a variety of factors when determining whether the Company will pay a higher reimbursement rate to a provider, including the volume and breadth of services provided to Anthem members, geographic reach of the practice, availability of the same or similar services by other similar providers in a comparable geography, and state regulated network adequacy guidelines. Part of the Company's submissions to the examiners included, among other things, a three-page document entitled "Anthem Fee Schedule Methodology and Development Policy for Participating Professional Providers" which describes how the Company develops its statewide fee schedules, the factors influencing actual reimbursement and the timing of fee schedule updates.

Examiner Findings:

Having reviewed the reports of contract examiners as well as the Company's initial and supplemental responses, the NHID examiners make the following findings.

First, examiners find that the large disparity between the weighted averages of Anthem's reimbursement for certain categories of Med/Surg and MH/SUD providers as compared to Medicare rates is not conclusive evidence of noncompliance with MHPAEA, under federal guidance, but it does constitute a red flag or warning sign that the Company may be imposing an impermissible NQTL, and requires further review of the processes, strategies, evidentiary standards or other factors used in applying the NQTL in order to determine operational parity compliance. A large disparity in outcomes such as this constitute a strong indicator of potential non-compliance with MHPAEA's NQTL requirements with respect to provider reimbursement practices.

Second, in view of this strong indicator of potential non-compliance, the Department examined whether the Company was in compliance with MHPAEA's requirement that the Company be able to demonstrate that the processes, strategies, evidentiary standards and other factors it uses to set provider reimbursement rates for MH/SUD services and M/S services are comparable. The examiners find that the Company did not produce sufficient documentation during the examination regarding the processes, strategies, evidentiary standards or other factors it uses to set reimbursement rates or otherwise provide sufficient information to demonstrate that the Company applies these standards comparably to MH/SUD reimbursement and not more stringently to

MH/SUD providers than to Med/Surg providers. The Company provided insufficient detail about the process used to determine provider reimbursement using the factors provided. For example, the Fee Schedule Policy that the Company provided, by its own terms, states that the written policy is "general in nature, and Anthem may maintain and develop fee schedules which vary from the description. . ." Based upon the lack of documentation provided during the examination, the NHID examiners find that the company failed to meet MHPAEA's comparability demonstration requirement.

To the extent that the Company attributed the vast differences in commercial-to-Medicare payment ratios between Med/Surg services and MH/SUD services to differences in bargaining power between MH/SUD providers on the whole and Med/Surg providers on the whole, this explanation of its practices does not support a finding that it applied a consistent, non-arbitrary, and non-discriminatory methodology.

Examiners recommend corrective action to ensure the Company is in compliance with MHPAEA., This includes developing and documenting an analytical framework for establishing reimbursement rates and providing sufficient documentation and data to NHID to allow the Company to demonstrate, and the NHID to confirm, that the Company uses comparable processes, strategies, evidentiary standards and other factors to set reimbursement rates and that the Company does not apply them more stringently when setting reimbursement rates for MH/SUD providers.

Grievance and Appeals Disclosures:

Examiners reviewed all grievance and appeals disclosures to ensure that the Company was applying and updating all requirements consistently, utilizing personnel with the appropriate experience and expertise to make determinations, and providing the required disclosures and information to the policyholder advising of appeal and grievance rights. Additionally, examiners reviewed all grievances related to MH/SUD to ensure that the determinations were appropriate, timely and consistent with the Med/Surg grievances.

Standard 2

The health carrier shall comply with grievance procedure requirements, in accordance with final regulations by the US Department of Health and Human Services (HHS), the US Department of Labor (DOL) and the US Department of the Treasury (Treasury). *NAIC Market Regulation Handbook – Chapter 20A, page 626*

Standard 3

The carrier has implemented grievance procedures, disclosed the procedures to covered persons, in compliance with applicable statutes, rules and regulations, and files with the commissioner a copy of its grievance procedures, including all forms used to process a grievance. *NAIC Market Regulation Handbook – Chapter 20, page 515*

Regulatory Authority

RSA 420-J:5 Grievance Procedures. – Every carrier or other licensed entity shall establish and shall maintain a written procedure by which a claimant or a representative of the claimant, shall have a reasonable opportunity to appeal a claim denial to the carrier or other licensed entity, and under which there shall be a full and fair review of the claim denial. The written procedure filed with the insurance department shall include all forms used to process an appeal.

Examiners requested a list of all MH/SUD and Med/Surg appeals during the examination period. Examiners reviewed all MH/SUD appeals for the examination period. Examiners also reviewed a random sample of twenty-five (25) Med/Surg appeals for the examination period; the Company received 1847 Med/Surg appeals during the examination period. The following information was required in sample appeal files:

- Claim or policy number identifying the Appeal/Grievance
- The ICD 10 code applicable to the claim
- Method of receipt (e.g., mail, fax, telephonic or other)
- Source of the request (e.g., provider, policyholder, attorney, etc.)
- Date of receipt
- Date of 2nd level appeal request (if applicable)
- Individuals involved in performing the reviews for each level
- Date the final determination was initiated
- Date of final determination completed

Examiners requested that all supporting documentation be included in sample appeal files for review, including but not limited to:

- Copy of the initial request to include any subsequent request
- Copy of the final determination letter to include any relevant supporting documentation
- Copy of external review report, if applicable

***Testing Methodology*:**

In determining parity in grievance and appeals procedures, examiners reviewed policies and procedures for grievances and appeals. Additionally, examiners completed a 100% review of all MH/SUD grievance and appeal files during the examination period, which totaled sixty-two (62) files. Examiners performed a random sampling of Med/Surg grievances and appeals for the examination period; examiners reviewed twenty-five (25) randomly sampled Med/Surg appeal files.

***Examiner Observations*:**

Examiners observed the inconsistent application of administrative determination for appeals related to Med/Surg out-of-network ambulance transportation.

Examiner Findings:

In determining parity in MH/SUD grievances and appeals, examiners found no exceptions. However, examiners found four (4) exceptions in Med/Surg appeals related to appeal handling and unfair claim settlement practices. The two exceptions related to appeal handling are a result of failing to complete appeal determination within 30 days, and failing to include necessary information in a determination letter per statute. The two exceptions related to unfair claim settlement practices are a result of failing to pay for OON ambulance transportation when an appeal with very similar facts was, in fact, overturned per administrative decision, and failing to pay for additional units of physical therapy.

Company Position:

The Company agreed with three (3) of the exceptions, and disagreed with one (1) exception.

Examiner Recommendations:

The Company shall overturn the appeal decision related to OON ambulance transportation, and pay the claim in full. The Company shall overturn the appeal decision related to physical therapy, and pay the claim in full. The Company shall ensure that (i) determination letters include necessary information as required by statute, and (ii) appeal determinations are made within 30 days as required per statute.

Claims:

The examiners reviewed claims data and claims manuals to identify compliance and consistencies in the claim handling process, as well as to determine MHPAEA compliance.

***Testing Methodology*:**

In determining parity in claim handling process, examiners reviewed company policies, procedures and manuals. Examiners also reviewed sample claim files to determine consistencies in the policies and procedures presented, and the application of these policies and procedures. The examiners reviewed issues with timely payments, appropriate notifications, and MHPAEA compliance. Please see examiner observations, findings and recommendations below.

Please refer to the Phase II in the Reviews section of this report for a comprehensive explanation of claim requests, sampling methodology and other review parameters.

Claims files reviewed:

Samples: HEALTH CLAIMS PAID

MH/SUD Total Universe Population	202,701
Med/Surg Total Universe Population	3,530,213

MH/SUD Health Sample Size	109
Med/Surg Health Sample Size	25

Claim type	MH/SUD Sample Size	Med/Surg Sample Size
In-patient/In-Network	5	2
In-patient/Out-of-Network	1	0
Out-patient/In-Network	95	23
Out-patient/Out-of-network	8	0
Emergency Services	0	0
Prescription Drug Services	0	0

Examiner Findings:

The examiners found no exceptions in terms of MH/SUD health claims paid under parity procedures and claim handling procedures.

The examiners found no exceptions in terms of Med/Surg health claims paid under claim handling procedures.

Samples: HEALTH CLAIMS DENIED

MH/SUD Total Universe Population	78,942
Med/Surg Total Universe Population	167,181

MH/SUD Health Sample Size	109
Med/Surg Health Sample Size	25

Claim type	**MH/SUD Sample Size**	**Med/Surg Sample Size**
In-patient/In-Network	3	0
In-patient/Out-of-Network	2	1
Out-patient/In-Network	42	21
Out-patient/out-of-network	61	3
Emergency Services	1	0
Prescription Drug Services	0	0

Examiner Findings:

The examiners found no exceptions in terms of MH/SUD health claims denied under parity procedures and claim handling procedures.

However, the examiners found one (1) exception in terms of Med/Surg claims denied under claim handling procedures. Specifically, the Company failed to acknowledge one claim submission in a timely manner.

Company Position:

The Company agreed with examiner findings.

Examiner Recommendations:

The Company shall ensure the timely acknowledgement of claim submissions in the future.

Samples: HEALTH CLAIMS DENIED WITH PRIOR AUTHORIZATION

MH/SUD Total Universe Population	1,942
Med/Surg Total Universe Population	8,048

MH/SUD Health Sample Size	109

Med/Surg Health Sample Size	25

Claim type	**MH/SUD Sample Size**	**Med/Surg Sample Size**
In-patient/In-Network	63	16
In-patient/Out-of-Network	16	0
Out-patient/In-Network	26	9
Out-patient/Out-of-network	4	0
Emergency Services	0	0
Prescription Drug Services	0	0

Examiner Findings:

The examiners found no exceptions in terms of MH/SUD health claims denied with prior authorization under parity procedures and claim handling procedures.

However, the examiners found one (1) exception in terms of Med/Surg claims denied with prior authorization under claim handling procedures. Specifically, the Company failed to pay one claim in a timely manner.

Company Position:

The Company agreed with examiner findings.

Examiner Recommendations:

The Company confirmed that it paid the provider prompt pay interest of $4566.45 on 6/4/16. As such, the Company has taken corrective action measures.

Samples: PRESCRIPTION DRUG CLAIMS PAID

MH/SUD Rx Universe Population	327,986
Med/Surg Rx Universe Population	79,969

MH/SUD Rx Sample Size	109
Med/Surg Rx Sample Size	25

Claim type	**MH/SUD Sample Size**	**Med/Surg Sample Size**
Retail In-Network	100	25
Retail Out-of-Network	0	0

Mail Order In-Network	9	0
Other	0	0

Examiner Findings:

The examiners found no exceptions in terms of MH/SUD prescription drug claims paid under claim handling procedures. However, the examiners found two (2) exceptions in terms of MH/SUD prescription drug claims paid under parity procedures. Specifically, the Company required a prior authorization for SUD prescription drugs in 2016.

The examiners found no exceptions in terms of Med/Surg prescription drug claims paid under claim handling procedures. However, the examiners found one (1) exception in terms of Med/Surg prescription drug claims paid under market conduct examination procedures. Specifically, the Company failed to provide complete prescription drug maximum out-of-pocket (hereinafter, "MOOP") accumulators upon the examiners' first request.

Company Position:

The Company disagreed with examiner findings regarding SUD prescription drug PA requirement in 2016.

The Company agreed with examiner findings regarding failure to provide complete prescription drug MOOP accumulators upon first request.

Examiner Recommendations:

The Company implemented a policy effective January 1, 2017 removing PA requirements for all MAT drugs. As such, the Company has taken corrective action.

The Company shall provide complete MOOP accumulators upon first request in future market conduct examinations.

Samples: PRESCRIPTION DRUG CLAIMS DENIED

MH/SUD Rx Universe Population	154,819
Med/Surg Rx Universe Population	29,849

MH/SUD Rx Sample Size	109
Med/Surg Rx Sample Size	25

Claim type	**MH/SUD Sample Size**	**Med/Surg Sample Size**

Retail In-Network	109	25
Retail Out-of-Network	0	0
Mail Order In-Network	0	0
Other	0	0

Examiner Findings:

The examiners found no exceptions in terms of MH/SUD prescription drug claims denied under claim handling procedures. However, the examiners found one (1) exception in terms of MH/SUD prescription drug claims paid under parity procedures. Specifically, the Company required a prior authorization for a SUD prescription drug in 2016.

The examiners found no exceptions in terms of Med/Surg prescription drug claims denied under claim handling procedures.

Company Position:

The Company disagreed with examiner findings regarding SUD prescription drug PA requirement in 2016.

Examiner Recommendations:

The Company implemented a policy effective January 1, 2017 removing PA requirements for all MAT drugs. As such, the Company has taken corrective action.

Other Considerations:

Availability of Plan Information:

Examiners reviewed the availability of plan information to ensure that policyholders could readily obtain the policy provisions for both MH/SUD and Med/Surg benefits. The examiners reviewed both on-line availability, and availability of a hard copy of the plan information upon request from the policyholder.

***Testing Methodology*:**

In determining parity in the availability of plan information, examiners reviewed policies and procedures for requesting hard copies of plan documents and medical management policies. Examiners also reviewed policy provisions for MH/SUD and Med/Surg benefits and medical management policies online.

Examiner Findings:

Examiners found no exceptions.

Clinical Trials:

Examiners reviewed coverage allowance for Clinical trials for both MH/SUD treatments to ensure parity, and also to ensure that the requirements in 42 U.S.C 300gg-8 (a)(2) which requires coverage of routine costs for clinical trials for both MH/SUD treatments and Med/Surg treatments, are incorporated. Coverage requirements include routine patient costs, including all items and services consistent with coverage provided in the plan (or coverage) that is typically covered for a qualified individual (for definition of a qualified individual, please see 42 U.S.C 300 gg-8(b) who is not enrolled in a clinical trial.

***Testing Methodology*:**

In determining parity in the coverage of clinical trials, examiners reviewed clinical trial policies and procedures.

Examiner Findings:

Examiners found no exceptions.

Autism Coverage:

Examiners reviewed the Company's processes and policy language to ensure that coverage for Autism Coverage is provided. RSA 417-E, RSA 415:6-n and RSA 415:18-s, and the NH Bulletin: Guidance on administration of Autism Benefits, which clarifies that in New Hampshire pervasive development disorders and autism are defined as biologically based mental illnesses.

***Testing Methodology*:**

In determining parity in the coverage of autism, examiners reviewed company medical management policies related to autism and policy language in plan documents. Additionally, examiners reviewed 309 MH/SUD health (ACL sampling methodology), and 75 Med/Surg health (random sampling methodology) sample claim files to ensure compliance with the NH statutes and insurance bulletin governing autism, as well as MHPAEA.

Examiner Findings:

Examiners found no exceptions.

ASAM Compliance – RIA Review:

Examiners reviewed the Company's process to ensure that it has incorporated the appropriate American Society of Addiction Medicine (ASAM) guidelines. Beginning 1/1/17, in accordance with RSA 420-J:16 (Levels of Care Criteria), carriers must rely upon

ASAM criteria when determining medical necessity and developing utilization review standards for levels of care for substance use disorder services.

***Testing Methodology*:**

In determining the incorporation of ASAM guidelines, examiners reviewed the summary of ASAM criteria that the Company provided, Anthem UM Services, Inc. (hereinafter, "AUMSI") policies and procedures, and the four (4) case samples provided by the Company demonstrating the Company's use of its ASAM tool. Additionally, examiners reviewed 309 MH/SUD health (ACL sampling methodology) sample claim files to ensure compliance with RSA 420-J:16, where applicable, as well as MHPAEA.

RIA contract examiners reviewed prior authorization and concurrent review notes in sample claim files. Not all sample claims included services requiring the application of ASAM criteria. As such, the aforementioned review was limited in nature. However, an additional vendor reviewed and analyzed the area of ASAM criteria and application in great detail.

Examiner Findings:

Examiners found no exceptions.

Use of ASAM Criteria for Medical Necessity/Utilization Review – BerryDunn Review:

To review compliance with New Hampshire law (RSA 420-J:15-17) requiring use of the American Society of Addiction Medicine (ASAM) criteria when determining medical necessity and developing utilization review standards for levels of care for substance use disorder (SUD) services for medical necessity determinations, the NHID engaged a second contract examiner, BerryDunn, to perform both a policies and procedures review and a claim file review of Company's practices in this area.

Testing Methodology:

For the policies and procedures review, examiners requested and reviewed documentation, process documents, and comments submitted by the Company in response to requests for information which included clinical policies and procedures, clinical staffing rosters, staff to member ratio for members with SUD or co-occurring disorders, and average clinical reviews conducted per day, per clinical reviewer.

For the claim file review, BerryDunn used the New Hampshire NHCHIS database to select a random sample of individuals receiving SUD treatment services. All related SUD treatment claims for these individuals were reviewed, and the Company provided case records for these individuals. Examiners reviewed all records for each individual to assess the consistency of the Company's practices with the use of ASAM criteria.

BerryDunn's reviews were performed by a practicing psychiatric nurse, with operational knowledge and expertise in aspects of service definition, clinical standards, medical necessity criteria, benefit plan implementation, credentialing standards, quality measurement/management, and network contracting for the full range of mental health and SUD treatment services.

Examiner Observations:

In the policies and procedures review, BerryDunn observed that prior authorization is required for all levels of care other than outpatient and detox cases, and requirements are clearly outlined; that the Company's electronic medical record template requires documentation related to the six ASAM dimensions, but does not require documentation of concomitant risk associated with each dimension within the template; that no policy or procedure was provided by the Company outlining an expectation for when a utilization reviewer should involve an internal (Company) physician; and that no inter-rater reliability (IRR) tool was provided to the examiners for review.

In the file review, BerryDunn observed that the Company does not use a standardized naming convention for authorized withdrawal management or residential levels of care, which made it difficult to differentiate between them during the clinical review. BerryDunn also observed that there was not always documentation of the level of risk associated with each of the six ASAM dimensions for each member, that narrative notes were not always updated and were difficult to follow, and that utilization reviewers did not appear to have synthesized the member clinical data into a cohesive clinical picture, to demonstrate the need for that specific level of care.

BerryDunn expressed concern that few cases were taken to a physician for consultation related to level of care questions, medications, or quality of care issues, and the examiners gave examples of specific cases for which referral to a physician might have led to a more appropriate placement for the member, or to Medication Assisted Treatment (MAT) being considered as a treatment option.

In sum, BerryDunn felt that while the Company generally uses ASAM during its utilization review process, the Company's practices for determining medical necessity and developing utilization review standards were not fully compliant with ASAM criteria. There were numerous examples within the sample of situations in which, in the view of BerryDunn examiners, the level of care selected was not appropriate given the full clinical profile of the member.

Company Position:

The Company largely disagreed with the contract examiners' observations, noting that BerryDunn failed to draw a "necessary and important distinction between the role of the provider and the role of the utilization reviewer." Specifically, the Company noted that providers bear the professional responsibility for making determinations on the

appropriate level of care, while utilization reviewers use established criteria to determine the medical necessity of the provider's request. The Company noted that any denials based on medical necessity require approval of a Company physician, but that it is not the role of an insurer to be actively involved in making treatment decisions.

The Company noted that it had recently updated its clinical template to allow for more thorough documentation within each ASAM dimension, and provided a copy of the updated template. The company also provided a copy of the case vignettes used for the prior year's IRR assessment. In addition, the Company corrected an error by the examiners in calculating the average number of clinical reviews per day per case manager for members with SUD.

Finally, the Company conducted its own review of the member files reviewed by the BerryDunn examiners, and noted that, for each, the utilization reviewers had performed their function appropriately and with due consideration of the ASAM criteria given the information and assessment conducted by the treating providers, who did not in all cases utilize ASAM criteria themselves.

NHID Findings:

Having reviewed the reports of the contract examiners as well as the Company's responses, the NHID examiners find that the Company's practices, while not fully consistent with all components of the ASAM criteria, do not violate New Hampshire laws regarding use of the ASAM criteria in conducting utilization review and making medical necessity determinations. In response to the examiners' observations, the Company has taken steps to better align its clinical template with the ASAM criteria, and has provided information demonstrating that its reviewer ratios and IRR practices are appropriate.

Delegated Service Contracts:

The Company does not delegate any services related to MH/SUD. Therefore, examiners did not review delegated service contracts to identify the control and oversight that the Company has for its Third Party Administrators (TPAs) handling of contractual agreements in handling MH/SUD benefits.

Regulatory Authority:

RSA 402-H:6 Responsibilities of the Insurer.

III. In cases in which an administrator administers benefits for more than 100 certificate holders on behalf of an insurer, the insurer shall, at least semi-annually, conduct a review of the operations of the administrator. At least one such review shall be an on-site audit of the operations of the administrator.

***Testing Methodology*:**

The examiners requested that the Company provide a list of all MH/SUD third-party entities and/or service providers with corresponding functions/duties/provided services, and provide copies of contracts with all third-party entities and/or service providers to determine the handling of SUD Utilization Management (UM) and operational processes and procedures. The Company responded by stating, "Anthem BH does not use third-party vendors."

Examiner Observations:

Examiners observed that the Company has its own UM servicing entity within its corporate structure and does not delegate services related to the management of behavioral health or SUD.

Examiner Findings:

Delegated service compliance does not apply.

Medication Assisted Treatment:

Examiners created a set of interrogatories designed to provide a baseline of the Company's Medication Assisted Treatment (MAT) program in New Hampshire.

MAT is defined as any opioid addiction treatment that includes an FDA approved medication for the detoxification or maintenance treatment of opioid addiction. The interrogatories that were developed reflect the most up-to-date information on opioid addiction and treatment with an understanding that opioid addiction is a chronic disease.

Formulary Design:

Examiners reviewed the pertinent sections of the Company's formularies to determine whether the carrier met the required number of medications covered in each category and class as defined by the United States Pharmacopeia (USP) and measured by the Essential Health Benefits (EHB) benchmark plan.

Examiner Findings:

Examiners found no exceptions.

Age Limitations:

Examiners reviewed the availability of prescriptions to ensure that inappropriate age limitations were not imposed through discriminatory benefit designs.

Examiner Findings:

Examiners found no exceptions.

Formulary Exception Process:

Examiners performed a review of policy language provided to the enrollee that describes the process for an enrollee to request an exception for coverage of medications that are not covered under the formulary.

Examiner Findings:

Examiners found no exceptions.

Dosage and Refill Limit:

Examiners reviewed the dosage and refill of prescriptions to ensure that inappropriate limitations were not imposed through discriminatory benefit designs.

Examiner Findings:

Examiners found no exceptions.

Pre-authorization for MAT Drugs:

Examiners reviewed pre-authorization requirements for MAT drugs to ensure that inappropriate limitations were not imposed through discriminatory benefit designs.

Examiner Findings:

Please see "Samples: Prescription Drug Paid" and "Samples: Prescription Drug Denied" in the Claims section of this report regarding the three (3) exceptions that examiners found for requiring PAs for MAT/SUD prescription drugs in 2016. The Company has taken corrective action measures by implementing a policy effective January 1, 2017 no longer requiring PAs for MAT/SUD drugs.

Medical Necessity Standards for Methadone and Buprenorphine:

Examiners reviewed the medical necessity standards applied for MAT prescription drugs to ensure that inappropriate limitations were not imposed through discriminatory benefit designs.

Examiner Findings:

Examiners found no exceptions.

SUMMARY OF RECOMMENDATIONS

Vendor Review	Area of Examination	Examiner Findings	Company Position	Examiner Recommendations	NHID Response
RIA	Sample Prescription Drug Claims – PA required for SUD drugs in 2016.	3 exceptions found (NQTL).	Company disagreed.	The Company has taken corrective action measures by implementing a policy effective January 1, 2017 no longer requiring PAs for MAT/SUD drugs.	No further Company action is required.
RIA	Sample Prescription Drug Claims – MOOP accumulators not provided upon first request.	1 exception found	Company agreed.	Provide complete MOOP accumulator information upon the first request for future examinations.	No further Company action is required.
RIA	Appeals – Inconsistent application of administrative determination regarding ambulance transportation appeal.	1 exception found	Company agreed.	Overturn decision, and pay claim in full.	No further Company action is required.
RIA	Appeals and Grievances – Appeal handling issues.	2 exceptions found	Company agreed.	Ensure that determination letters include necessary information as required by statute, and that appeal determinations are made within 30 days as required by statute.	No further Company action is required.

RIA	Appeal – incorrect denial of claim related to physical therapy benefits.	1 exception found	Company disagreed.	Overturn decision, and pay claim in full.	No further Company action is required.
RIA	Claim Handling/Sample Claims – Acknowledgment not timely.	1 exception found	Company agreed.	Ensure timely acknowledgement of claim submissions in the future.	No further Company action is required.
RIA	Claim Handling/Sample Claims – Claim not paid timely (prompt pay).	1 exception found	Company agreed.	The Company confirmed that it paid the provider prompt pay interest of $4566.45 on 6/4/16. As such, the Company has taken corrective action measures.	No further Company action is required.
RIA and BerryDunn	Provider Reimbursement Practices – Company did not provide sufficient documentation to demonstrate comparility	RIA Review Findings - 1 exception found. (NQTL) NHID Findings based upon BerryDunn Review - 1 exception found. (NQTL)	Company disagreed.	The Company shall take agreed upon action to address this issue, subject to ongoing NHID oversight and reporting.	The Company shall provide the Department with a compliance assurance plan.

EXAMINER'S SIGNATURE AND ACKNOWLEDGEMENT

The examiners would like to acknowledge the cooperation and assistance extended by Anthem during the course of the examination. Specifically, the examiners would like to acknowledge Mr. Stephen Buchanan, Anthem's Compliance Director for New Hampshire. Mr. Buchanan's consideration and respect for others demonstrates a commitment to professionalism. Mr. Buchanan was highly responsive throughout the examination, and displayed significant knowledge regarding company operations and products.

In addition to myself, the following individuals participated in the examination:

Holly Blanchard, AIE, FLMI, INS, ACP, CCP, MCM
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Cynthia Fitzgerald, CIE, AIRC, MCM, ACS, AIAA, CICSR, CFE, PAHM
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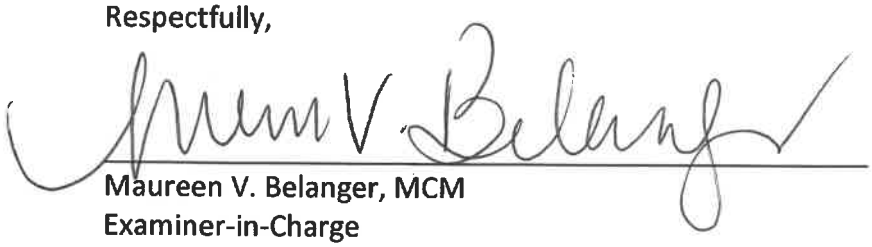
Respectfully,



Maureen V. Belanger, MCM
Examiner-in-Charge
LAH Market Conduct Division
New Hampshire Insurance Department

THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

21 South Fruit Street Suite 14
Concord, New Hampshire 03301

APPENDIX A: Letter to Commissioner Regarding Examination and Anthem Rebuttal

John Elias
Commissioner

Alexander K. Feldvebel
Deputy Commissioner

June 14, 2019

The Honorable John Elias
Commissioner of Insurance
State of New Hampshire Insurance Department
21 South Fruit Street, Suite 14
Concord, NH 03301

Dear Commissioner Elias,

In accordance with RSA 400-A:37, IV (a), on May 31, 2019, Anthem Health Plans of New Hampshire, Inc. (NAIC# 95527) and Matthew Thornton Health Plan, Inc. (NAIC# 83759) submitted a rebuttal (Rebuttal) to the Mental Health Parity examination Verified Report that was issued on May 1, 2019.

I recommend that the full text of the Rebuttal be appended to the Report, along with this memorandum. Department examiners have reviewed the Rebuttal and offer the following responses (*in italics*). Department examiners do not recommend that any changes be made to the Verified Report, other than to update the Summary of Recommendations table to reflect the rebuttal and to note the findings for which the Department examiners agree that the Company has taken appropriate corrective action. Recommendation numbers below correspond to the Summary of Recommendations table.

1. Company assertion: The Company has taken appropriate corrective action regarding Recommendations No. 1, 2, 4, 6 and 7.

   Department examiners agree.

2. Company assertion: The Company has supplied evidence that, with respect to Recommendation No. 3, the Company has paid the member the amount balance billed by the out-of-network provider.

   Department examiners agree that the Company has provided sufficient evidence of corrective action with respect to Recommendation 3.

3. Company assertion: With respect to Recommendation No. 5, the member had exhausted their plan's covered services, including their benefit maximums and plan

limitations, so no additional coverage would have been available under the plan even if the Company had made a determination that additional services were medically necessary.

Having reviewed the evidence supplied with respect to Recommendation 5, Department examiners agree that the member had exhausted their benefits, so no corrective action is required.

4. Company assertion: The Company's provider reimbursement practices do not violate the Mental Health Parity and Addiction Equity Act (MHPAEA).

Department examiners disagree. Within 90 days of the effective date of the Final Order and Final Adopted Report, the Company shall submit a corrective action plan to make its provider reimbursement practices consistent with MHPAEA.

In addition to the findings in the Verified Report, Department examiners offer the following responses to the arguments made in the Company's rebuttal with respect to provider reimbursement practices:

a. The RIA analysis did not account for different provider types.

Department examiners acknowledge that RIA's analysis had methodological limitations; it was BerryDunn's analysis the Department relied on in reaching its conclusions, not RIA's analysis.

b. BerryDunn is not a fair and objective examiner.

The findings and conclusions in the exam report are those of Department examiners. BerryDunn was hired to perform a quantitative analysis in a manner specified by Department staff and examiners. The methodology BerryDunn used for the exam analysis was distinct from methodology used in earlier BerryDunn analyses, including the work underlying the June 2018 slide presentation referenced by the Company. Footnote 2 of the Company's rebuttal underscores the fact that the exam analysis was distinct from earlier BerryDunn analyses.

c. BerryDunn's methodology is not an acceptable way to measure compliance with MHPAEA.

Neither MHPAEA, the Final Parity Rule, nor any federal guidance, limits or specifies acceptable methodologies for measuring compliance with NQTL requirements. As explained in the Verified Report, BerryDunn compared the ratios of the Company's commercial MH/SUD provider reimbursement rates and Med/Surg provider reimbursement rates, as reported by the Company to New Hampshire's all-payer claims database, to Medicare reimbursement rates for the same services.

This analysis was designed to go beyond a simple review of statewide fee schedules (a review that was also included separately in the exam), to look at the Company's actual reimbursement practices. This specific basis of comparison was selected because Medicare's method of developing payment levels is resource-based and applies a consistent standard to both MH/SUD and Med/Surg reimbursement calculations.

d. BerryDunn applied faulty logic/failed to understand market dynamics.

For non-quantitative treatment limitations such as provider reimbursement practices, MHPAEA requires that any processes, strategies, evidentiary standards, or other factors, as written and in operation, be comparable to and applied no more stringently to MH/SUD than to Med/Surg benefits. While reimbursement rates need not be identical, a consistent pattern of reimbursing MH/SUD providers at a lower level as compared to a standard resource-based payment methodology is evidence that a more stringent treatment limitation is being applied to MH/SUD services. The Company's position is that MH/SUD providers are less likely to be affiliated with a large practice group, and thus have less bargaining leverage, leading these providers to accept lower rates. This position implies that market forces require the carrier to contract with large group practices, but that demand for MH/SUD providers and their services is comparatively weak. The Company did not provide evidence supporting this position. Instead, a hypothetical example of a consolidated neurosurgeon practice is given, without recognizing the high demand for MH/SUD services at a local level and the Company's ability to contract with neurosurgeons at a regional level.

e. BerryDunn misstates or ignores information provided by Anthem.

MHPAEA requires the use of objective criteria in order to meet parity requirements, but much of the information provided to BerryDunn and the Department was highly subjective, and therefore had limited value as evidence.

The Company indicates that network adequacy is one of the factors it considers when it sets reimbursement rates, but does not distinguish between network adequacy regulatory minimums, parity in access, or network development efforts that exceed regulatory minimums and differ by provider specialty.

Thank you for your consideration of these recommendations.

Sincerely,

Jennifer J. Patterson, Esquire
Life & Health Director

/mvb

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May 31, 2019

By Electronic Mail and U.S. Mail

Maureen Belanger
Examiner-in-Charge
State of New Hampshire Insurance Department
21 South Fruit Street
Suite 14
Concord, New Hampshire 03301

Re: Verified Report of Examination – Anthem Health Plans of New Hampshire, Inc. and Matthew Thornton Health Plan, Inc. – Docket No. INA-17-046-MC

Dear Ms. Belanger:

I have been retained to represent Anthem Health Plans of New Hampshire, Inc. and Matthew Thornton Health Plan, Inc. (collectively "Anthem") in the above referenced market conduct examination.[1] Anthem submits the following rebuttal to the Verified Report that the New Hampshire Insurance Department ("NHID") issued on May 1, 2019. For reference purposes, Anthem has numbered the eight (8) recommendations appearing on pages 51-52 of the Verified Report as Recommendation Nos. 1-8.

For the reasons that follow, Anthem respectfully requests that the Commissioner enter an order rejecting the findings in the Verified Report and finding instead that Anthem is compliant with all applicable departmental policies, rules, regulations and laws pertaining to this matter, or, solely in the alternative, call for an investigatory hearing pursuant to RSA 400-A:37(IV)(3).

- **Recommendation Nos. 1, 2, 4, 6 and 7**

Anthem has taken appropriate corrective action regarding Recommendation Nos. 1, 2, 4 6 and 7.

- **Recommendation No. 3 (Criticism #003, Sample No. 2)**

As per the Examiner's Recommendation, Anthem adjusted the member claim referenced in Criticism #0003, Sample No. 2, upon completion of a re-review of the appeal. Anthem paid the member the amount balance billed by the out-of-network provider. The appeal decision letter dated May 7, 2019 is attached hereto as Exhibit A. A copy of the EOB and member check dated May 10, 2019 is attached hereto as Exhibit B.

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[1] I am a licensed attorney in the State of Illinois. I will be filing an appearance with NHID later this week as soon as I receive my Certificate of Good Standing from Illinois Supreme Court. Michael K. Brown, Anthem's other representative in this examination, is a licensed attorney in the State of New Hampshire.

- **Recommendation No. 5 (Criticism #0003, Sample No. 15)**

Anthem disagrees with the Examiner's finding and recommendation. In this case, a medical necessity determination would be irrelevant and unnecessary. The member exhausted their plan's covered services, including their benefit maximums and plan limitations. There are no additional benefits available under t the terms of their plan, and the services would be considered non-covered. In other words, even if Anthem agreed with a finding of medical necessity, there would be no additional coverage available under the plan.

The member's Certificate of Coverage, attached hereto as Exhibit C, states in relevant part:

> (a) Covered Services are subject to all the terms and conditions listed in this Booklet, including, but not limited to, **Benefit Maximums**, Deductibles, Copyaments, Coinsurance, Exclusions and medical Necessity requirements.
>
> (b) All Covered Services are subject to the conditions, Exclusions, **limitations**, and terms of this Booklet including any endorsements, amendments or riders.
>
> (c) Anthem will not provide any reimbursement for non-Covered Services. You may be responsible for the total amount billed by your Provider for non-Covered Services, regardless of whether such services are performed by an In-Network Provider. Non-covered services include services specifically excluded from coverage by the terms of your Plan and received **after benefits have been exhausted**. Benefits may be exhausted by exceeding, for example, **benefit caps or day/visit limits**.

(Emphasis added.) Anthem based its appeal decision on a plan benefit limitation where the member had exhausted the benefits available under the plan for physical therapy. When plan benefit limits for therapies have been exhausted, Anthem does not review for medical necessity, as any services after the 20 visit physical therapy limit would be considered a non-Covered Service. Non-review for medical necessity of a non-Covered Service does not constitute an Unfair Claim Settlement Practice by Anthem, as Anthem would have no liability for the payment of benefits under the terms of the plan when benefits have been exhausted.

- **Recommendation No. 8 (Criticism #011)**

NHID retained two Contract Examiners – Regulatory Insurance Advisors ("RIA") and BerryDunn ("BD") – to analyze whether Anthem's reimbursement rates for mental health/substance use disorder ("MH/SUD") services complied with the requirements of the Mental Health Parity and Equity Addiction Act ("MHPAEA"). Based on the reports of the two Contract Examiners, the NHID Examiners concluded that Anthem's provider reimbursement practices "do not comply with MHPAEA." Verified Report at 36. There is no basis for such a finding.

I. The standard for NQTLs under the MHPAEA

The MHPAEA requires that for plans that provide benefits for M/S and MH/SUD services, the treatment limitations applicable to such MH/SUD benefits must be "no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan." 29 U.S.C. § 1185a(a)(3)(A). The MHPAEA further prohibits separate treatment limitations that are applicable only to MH/SUD benefits. *Id.* The MHPAEA defines a "nonquantitative treatment limitation" ("NQTL") as a "limit [on] the scope or duration of benefits for treatment" that is not expressed numerically. *See* 45 CFR §§ 146.136(a), (c)(4)(ii). The MHPAEA does not prohibit all NQTLs. *Welp v. Cigna Health & Life Ins. Co.*, 2017 WL 3263138, at *7 n.11 (S.D. Fla. July 20, 2017). An NQTL complies with the MHPAEA if the "processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation 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." *Id.*, § 146.136(c)(4)(i) (emphasis added).

II. The RIA Report

RIA asserts that its review of Anthem's claims data purportedly shows that "Med/Surg ***physicians*** receive favorable reimbursement rates compared to MH/SUD ***non-physician*** providers." RIA Report at 2 (emphasis added). The result of this apples to oranges comparison by RIA is not a violation of the MHPAEA. The MHPAEA does not require a health plan to pay identical reimbursement rates to medical/surgical ("M/S") and MH/SUD providers. *See* 78 Fed. Reg. 68246 ("Again, disparate results alone do not mean that the NQTLs in use fail to comply with these requirements."); Department of Labor, Proposed FAQs About Mental Health And Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part XX, April 23, 2018 ("a plan is not required to pay identical provider reimbursement rates for medical/surgical and MH/SUD providers..."). Even RIA concedes as much. RIA Report at 3. Moreover, the MHPAEA does not require health plans to pay M/S ***physicians*** and MH/SUD ***non-physicians*** the same reimbursement rates. To the contrary, the commentary to the Final Rules under the MHPAEA expressly authorizes health plans to pay different reimbursement rates based on the "training, experience and licensure of providers." 78 Fed. Reg. 68426. Here, the differences between reimbursement rates for M/S physicians and MH/SUD non-physicians are "significantly driven by licensure status." Anthem Response to Criticism #011, at 7.

RIA also asserts that Anthem reduces reimbursement rates for non-physician practitioners providing MH/SUD services, but "does not use a comparable process with respect to reimbursement of non-physician providers of medical/surgical services." RIA Report at 3. RIA, however, cites no evidence to support this assertion, which is factually incorrect. Anthem does in fact use a stepdown process for reimbursement for providers of M/S services based on licensure and qualifications, which is industry standard. *See* Anthem Supplemental Response to Criticism #11, at 6; *see also* Anthem Response to Criticism #011, at 7.

III. The BD Report

Anthem has significant concerns that BD is not a fair and objective Examiner. Six months before BD issued its final report in Anthem's examination, BD made a PowerPoint presentation to a working group created by the New Hampshire Department of Health and Human Services entitled "NH Behavioral Health 10 Year Plan." *See* PowerPoint Presentation, attached hereto as Exhibit D. BD's presentation asserted there was a "funding problem for BH in New Hampshire." *Id.*, Slide 7. According to BD, the rates that New Hampshire Medicaid and commercial insurers pay for MH/SUD services "are not sufficient to support or attract an adequate workforce or sustain BH practices." *Id.*, Slide 9. BD proposed "raising fee levels" as the solution to this perceived problem. *Id.*, Slide 24. BD projected that "[i]f BH Commercial fees were 160% of Medicare like other specialties, ***potentially correcting a MHPAEA issue***, it would add roughly $65 million into the BH system annually[.]" *Id.* (emphasis added). Two days after BD made this presentation, Anthem received notice that NHID had appointed BD as the Examiner for the portion of Anthem's market conduct examination regarding compliance with the MHPAEA. The same individual from BD who made the presentation to the Department of Health and Human Services was also the principal author of BD's final report in Anthem's examination.

Examiners in market conduct examinations must be fair and objective and must present their findings in a factual and unbiased manner. *See* National Association of Insurance Commissioners, Market Conduct Examiners Handbook at 12-B (2018). BD is neither a fair nor objective Examiner. BD's conclusion in June of 2018 – six months before BD issued its final report in Anthem's examination – that there was an "MHPAEA issue" regarding commercial payors' reimbursement rates for MH/SUD services demonstrates two things. First, it appears that BD had already decided that Anthem and other commercial insurers had violated the MHPAEA before BD even reviewed any of the evidence regarding the processes, strategies and evidentiary standards that Anthem uses to set reimbursement rates. Second, it appears that BD's predetermined conclusion that commercial insurers' reimbursement rates for MH/SUD services violated the MHPAEA was based solely on BD's subjective belief that reimbursement rates for MH/SUD services should be at least "160% of Medicare like other specialties," even though there is no such mandate under the MHPAEA.[2]

BD's methodology for determining compliance with the MHPAEA is unprecedented and fundamentally flawed.

BD's bias manifests itself throughout the final report, but the most glaring example of BD's bias is its use of a fundamentally flawed methodology for determining Anthem's compliance with the

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[2] BD's presentation relied on a flawed analysis of reimbursement rates that the presenter had conducted for NHID in August 2016 when he was affiliated with Compass Health Analytics. This analysis incorrectly concluded that *all* of the commercial insurers in New Hampshire paid *substantially less* than Medicare rates for SUD services. *See* Ex. D, Slide 7, referring to Analysis of New Hampshire Commercial Insurance Claim Data Related to Substance Use Disorder: Reimbursement Rates (August 2016). BD's final report in Anthem's examination did not replicate these prior findings. Compass Health Analytics used incomplete data and failed to account for step-down reimbursement due to education, licensure and scope of practice.

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MHPAEA that is not endorsed or accepted by any existing guidance or authority. The Final Rules under the MHPAEA identify "standards for provider admission to participate in a network, including reimbursement rates" as an example of an NQTL under the MHPAEA. 45 CFR § 146.136(c)(4)(ii)(D). Anthem reimburses 79% of all in-network MH/SUD providers in New Hampshire based on the rates contained in its Behavioral Health Statewide Fee Schedule. Examiner's Handbook, § E.24(d).[3] BD, however, did not analyze those reimbursement rates offered to any MH/SUD provider willing to participate in Anthem's network – or any actual reimbursement rates for that matter – when determining whether Anthem has complied with the MHPAEA. Instead, BD used aggregate claims data from the NH Comprehensive Health Care Information System ("CHIS") database to create "weighted averages" for reimbursement rates by specialty and then compared these "weighted averages" for each specialty relative to existing Medicare rates. BD Final Report at 11-12. According to BD, this comparison shows that Anthem pays a significantly higher percentage of Medicare reimbursement rates for M/S services than it does MH/SUD services. *Id.*

BD's Final Report cites no authority that identifies its methodology as an acceptable way to measure compliance with the MHPAEA. BD's methodology is not even remotely similar to existing guidance on how to measure whether NQTLs comply with the MHPAEA such as the Department of Labor's self-compliance tool[4] or NAIC's recently adopted examination standard for the MHPAEA.[5] BD's methodology is anomalous and completely disconnected from the requirements of the MHPAEA in at least three crucial ways.

First, BD does not compare any actual reimbursement rates for specific CPT codes included in Anthem's statewide fee schedules for M/S and MH/SUD services or in individually negotiated contracts with providers. Instead, BD bases its analysis entirely on "weighted averages" for reimbursement rates by specialty that it created using aggregate claims data.

Second, BD's methodology treats any differences in reimbursement rates as *prima facie* evidence of a violation of the MHPAEA that must be "ameliorated" by Anthem, despite the fact that differences in reimbursement rates are not enough to establish a violation of the MHPAEA, a point BD readily admits in its report. *See* BD Final Report at 3-4, 14, 16. BD does not explain how much of a difference must exist between reimbursement rates in order to constitute a violation of the MHPAEA. BD's methodology is completely arbitrary and appears to be based on an undisclosed subjective value judgment about the appropriate level of reimbursement for MH/SUD services. BD's methodology has no basis in the MHPAEA.

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[3] Anthem also reimburses a substantial majority of the M/S providers in its network based on its statewide fee schedule. *See* Anthem's Response to Criticism #011, at 7. For example, Anthem reimburses 79.3% of all primary care physicians based on its Medical Statewide Fee Schedule. *See* Examiner's Handbook, § E.24(c).

[4] *See* https://www.dol.gov/agencies/ebsa/employers-and-advisers/plan-administration-and-compliance/health-plans/hbec/checksheets.

[5] *See* https://www.naic.org/meetings1904/d_cmte.pdf.

Third, health plans "may consider a ***wide array*** of factors in determining provider reimbursement rates for both medical/surgical and mental health and substance use disorder services, such as service type, geographic market; demand for services; supply of providers; provider practice size; Medicare reimbursement rates; and training, experience and licensure of providers." Preamble, Final Rules, 78 Fed. Reg. 68246 (emphasis added). BD's methodology, on the other hand, uses Medicare rates as the primary and predominant basis for determining compliance with the MHPAEA.

BD's decision to ignore Anthem's actual reimbursement rates for specific CPT codes and instead use weighted averages of reimbursement rates by specialty inevitably produces distorted results. BD's methodology does not account for large hospital and provider groups that have superior bargaining power and leverage, and therefore are able to negotiate substantially higher reimbursement rates than other providers. Anthem's Supplemental Response to Criticism #011 at 5; Examiner's Handbook, § E.23(b). Anthem provided a specific example of this dynamic in its submissions for this examination. Anthem produced data to the Examiners which shows that a hospital system with significant leverage and bargaining power in New Hampshire was able to negotiate reimbursement rates that in some cases are nearly double the rates on Anthem's statewide fee schedule. *See* Exhibit 3 to Anthem's Supplemental Response to Criticism #011. BD did not account for these outliers or conduct any analysis to control for this variable, which significantly skews the "weighted averages" by specialty that BD derived from Anthem's aggregate claims data. *See* Anthem's Supplemental Response to Criticism #011, at 5.

BD uses faulty logic to support its findings.

Instead of actually doing the analysis necessary to create an accurate picture of Anthem's reimbursement rates, BD uses highly questionable logic to explain away the market dynamics that account for the differences in reimbursement rates between M/S and MH/SUD services. BD admits that "[m]arket dynamics might compel commercial carriers to pay differentially higher rates to certain specialties to maintain an adequate network[.]" BD Final Report at 4. But, BD asserts that "the low supply of MH/SUD and abundant supply of M/S providers" in New Hampshire "seem to contradict" or "appear to be inconsistent with" Anthem's consideration of market dynamics when setting reimbursement rates. BD Final Report at 2, 15. That is the entirety of BD's discussion of market dynamics in its report. Further, BD's assertion of a "low supply" of MH/SUD providers in New Hampshire is wrong and does not comport with known market availability.

BD's faulty logic simply does not withstand even the slightest scrutiny. The number of specialists in New Hampshire does not provide any insight into what processes, strategies and evidentiary standards Anthem did or did not use when setting reimbursement rates. The mere fact that there are more M/S providers than MH/SUD providers in New Hampshire on a per capita basis does not disprove that Anthem relies on market factors when negotiating reimbursement rates with providers or that such market factors may explain the differences in reimbursement rates identified in BD's claims analysis. Moreover, the purported low number of MH/SUD providers in New Hampshire is not evidence of a violation of the MHPAEA, particularly when the NHID Examiners have concluded that Anthem has an adequate network of MH/SUD providers. *See* Verified Report at 31-33.

BD's logic also demonstrates a profound misunderstanding of market factors and how they impact reimbursement rates. BD merely assumes that MH/SUD providers should have greater bargaining power and leverage to negotiate rates with Anthem than M/S providers because there are fewer MH/SUD providers in New Hampshire than M/S providers. Scarcity alone, however, does not even remotely begin to explain all of the market dynamics that impact reimbursement rates. There are any number of other market dynamics in addition to scarcity – such as consolidation, utilization and geographic location – that have an even greater impact on reimbursements rates. *See* Anthem Supplemental Response to Criticism #11 at 6; Examiner's Handbook, § E.23(d).[6]

Take for example, a hypothetical where there are 10 neurosurgeons and 10 psychiatrists in New Hampshire. Using BD's logic, these two groups of providers should have equal bargaining power when negotiating reimbursement rates with Anthem because they are equally scarce. This logic, however, fails to account for the possibility that all, or substantially all, of the neurosurgeons may work for the same hospital system or practice group (consolidation), or a hospital system where a large percentage of Anthem's members receive services (utilization) or a hospital system that is essential for Anthem's network (location). In each of these scenarios, the neurosurgeons would likely have substantially more leverage and bargaining power than the same number of psychiatrists. BD's overly simplistic response to market dynamics, however, utterly fails to account for these other important factors.

BD invented requirements that do not exist under the MHPAEA.

In order to justify its preordained conclusion that Anthem has violated the MHPAEA, BD simply invents requirements that do not exist under the MHPAEA. For example. BD faults Anthem for not having an "objective analytic framework/formula" for the factors it uses to determine whether an individual provider may be entitled to higher reimbursement rates above those in the statewide fee schedule. BD Final Report at 14. The MHPAEA does not require health plans to develop a one-size-fits-all algorithm or formula that automatically calculates many different inputs and data which Anthem takes into account when setting reimbursement rates. The commentary to the Final Rules expressly acknowledge that the process for setting reimbursement rates is already complex. *See* 78 Fed. Reg. at 68256. Requiring health plans to develop and use such an algorithm or formula would make setting reimbursement rates impossibly complex, overly rigid and inflexible. This is contrary to the standard the MHPAEA applies to NQTLs, which is expressly designed to give health plans flexibility. *See* 78 Fed. Reg. at 68245. The processes, strategies and evidentiary standards Anthem uses to set reimbursement rates for M/S and MH/SUD services need only be comparable, not exactly the same or "uniform" as BD suggests. BD Final Report at 14.

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[6] *See also* Emily Gee and Ethan Gurwitz, Center for American Progress, Provider Consolidation Drives Up Health Care Costs, December 5, 2018 (concluding consolidation and concentration among hospitals and physician groups leads to higher health care costs); Leemore Dafny *et al.*, The Price Effects of Cross Market Hospital Mergers, March 18, 2016 (concluding cross-market, within-state hospital mergers increase hospitals' leverage when negotiating reimbursement rates with insurers); Steve Norton, New Hampshire Center for Public Policy Studies, Community Benefit and Market Changes in New Hampshire, at 18-20 (2017) (summarizing studies concluding hospital consolidation leads to increased prices).

Moreover, BD's insistence that Anthem must have an "objective analytic framework/formula" for setting reimbursement rates in order to be compliant with the MHPAEA would be completely unworkable in practice. As BD itself admits, Anthem "do[es] not have the force of law to set [reimbursement] rates like the Medicare program does for participating providers[.]" BD Final Report at 4. Anthem's reimbursement rates that depart from the statewide fees schedules are the product of individual ***negotiations*** with providers. What reimbursement rates are appropriate, and ultimately what reimbursement rates a provider is willing to accept, cannot be reduced to a mathematical formula.

BD misstates or ignores information provided by Anthem.

BD's bias and lack of objectivity manifest themselves throughout BD's report, including when BD repeatedly misstates or ignores evidence submitted by Anthem. For example, BD asserts that Anthem "provided no details about the process used to determine provider reimbursement using the factors provided[.]" BD Final Report at 14. This assertion is patently incorrect. With respect to formulation of statewide fee schedules, Anthem provided to the Examiners a three-page description of the process and standards Anthem uses to develop and maintain its statewide fee schedules for both M/S and MH/SUD services. *See* Anthem Response to Criticism #11 dated January 18, 2019, at 5-7. Anthem uses this same process for setting reimbursement rates for both M/S and MH/SUD services. *Id.* at 5. Anthem also submitted a copy of its Fee Schedule Methodology and Development Policy for Participating Professional Providers which describes how Anthem develops fee schedules and determines when to update the rates in these fee schedules. Anthem also provided the following response regarding reimbursement rates that are negotiated with hospitals and physicians on an individual basis:

> If a provider, regardless of specialty (medical, surgical or BH/SUD) approaches Anthem and seeks an increase in reimbursement, Anthem considers a variety of factors including volume and breadth of services provided to Anthem members, geographic reach of the practice, availability of the same or similar services by other similar providers in a comparable geography, and state-regulated network adequacy guidelines. Depending on the results of this analysis and where the provider's reimbursement level is today versus its peers for the same or similar services, an increase [in reimbursement] may be warranted.

See Anthem Response to BerryDunn RFI, § 1(e). The fact that Anthem's process for setting reimbursements rates cannot be reduced to a single, one-size fits all algorithm or formula does not mean that Anthem provided no information regarding how Anthem sets reimbursement rates.

Anthem stated in its submissions to the Examiners that network adequacy is one of the factors Anthem considers when it sets reimbursement rates. *See* Examiner's Handbook, § E.23(d); Anthem Response to BerryDunn RFI, § 1(e). BD concedes that this is an appropriate consideration. BD Final Report at 13-14. BD, however, asserts that Anthem purportedly failed to provide any information regarding "how the adequacy of a network was measured for both MH/SUD and M/S and what the results of that measurement were." *Id.* at 4. BD's assertion is demonstrably false. How Anthem measures the adequacy of its networks is hardly a mystery, especially since BD's predecessor – Compass Health Analytics – previously served as the consultant to NHID on network adequacy requirements. Anthem

files an annual report regarding its compliance with the NHID's network adequacy requirements. As part of this examination, the NHID Examiners reviewed Anthem's network adequacy filings for 2016 and 2017. Verified Report at 32-33. Based on this information, the NHID Examiners found no exceptions regarding the adequacy of Anthem's networks. *Id.* at 33. It appears that BD did not review any of this information, but it was part of the record in this examination. It is unreasonable for BD to penalize Anthem for BD's own failure to review readily available information.

BD also asserts that Anthem failed to provide its "strategy" for setting reimbursement rates for M/S and MH/SUD services. BD Final Report at 14. Anthem did provide its strategy regarding setting of reimbursement rates. In response to interrogatories issued by the Examiner, Anthem stated that its goal is to establish "consistent, competitive and reasonable provider payment rates for all of its M/S and MH/SUD providers across its network. *See* Examiner's Handbook, §§ E.23(b), 24(c). Anthem's strategy is expressly stated in the Fee Schedule Methodology and Development Policy for Participating Professional Providers it submitted in this examination – set reimbursement rates high enough to guarantee an adequate network, but not so high that they negatively impact Anthem's members. Anthem Fee Schedule Methodology and Development Policy for Participating Professional Providers, § IV. BD faults Anthem for purportedly failing to identify the reasons *why* it chooses to consider each of the factors it uses to set reimbursement rates. BD Final Report at 14. This, however, cannot possibly be a violation of the MHPAEA when BD itself concedes that the factors Anthem uses are compliant with the MHPAEA. *Id.* ("[T]he factors listed by [Anthem] are likely in alignment with the Final Rule.").

BD also asserts that Anthem failed to provide any information which shows that it does not apply its processes, strategy and evidentiary standards more stringently when setting reimbursement rates for MH/SUD services. BD Final Report at 2, 14. BD, however, ignored powerful evidence submitted by Anthem which confirms that Anthem does not apply its processes, strategies and evidentiary standards more stringently when setting reimbursement rates for MH/SUD services. There are 148 CPT codes that appear on Anthem's statewide fee schedules for both M/S services and MH/SUD services. Anthem's Supplemental Response to Criticism #011 and Exhibit 1 thereto. The reimbursement rates for 145 of the 148 overlapping CPT codes (over 97%) are identical on both statewide fee schedules. BD's final report does not even mention this evidence.

BD fails to identify any evidence to support its finding that Anthem violated the MHPAEA.

BD's Final Report ultimately does not cite any evidence that would support a finding that Anthem's reimbursement rates for M/S and MH/SUD services violate the MHPAEA. BD cites no evidence that Anthem fails to use comparable processes, strategies and evidentiary standards for setting reimbursement rates for M/S and MH/SUD services. To the contrary, the evidence shows Anthem uses the same processes, strategies and evidentiary standards for setting reimbursement rates for both types of M/S and MH/SUD services, and BD concedes that the factors Anthem uses to set rates are compliant with the MHPAEA. BD also cites no evidence that Anthem applies its processes, strategies and evidentiary standards more stringently when it sets reimbursement rates for MH/SUD services. To the contrary, the evidence shows that Anthem does not apply these factors more stringently to MH/SUD services. Out of 148 overlapping CPT codes that appear on the statewide fee schedules for both M/S and MH/SUD services, Anthem pays the same rates on both statewide fee schedules for 145 of these codes (97%).

BD concedes that a mere disparity in reimbursement rates between M/S and MH/SUD services alone is insufficient to establish a violation of the MHPAEA. Lacking evidence to support a finding that Anthem sets reimbursement rates in a manner that violates the MHPAEA, BD nevertheless reaches that conclusion through nothing more than sleight of hand. BD does so by treating the differences in reimbursement rates it identified in its flawed claims analysis as *prima facie* evidence of a violation of the MHPAEA, which somehow shifts the burden to Anthem to disprove that it applies its processes, strategies and evidentiary standards more stringently when setting reimbursement rates for MH/SUD services. *See* BD Final Report at 1-2, 4, 16. This allows BD to find a violation of the MHPAEA based on the mere *absence* of evidence, which is inconsistent with any fair reading of the MHPAEA, the Final Rules or the guidance interpreting those rules.

Even worse, this approach allows BD to find a violation of the MHPAEA, as it did in this examination, based on the absence of evidence that BD never even requested from Anthem in the first place. For example, BD asserts that Anthem may have identified the factors that it uses to set reimbursement rates, and explained that it applies these factors in the same manner to both M/S and MH/SUD services, but Anthem purportedly failed to produce any evidence regarding how it used the evidence related to these factors to set the reimbursement rates for each of the CPT codes on the statewide fee schedules or when it individually negotiated different reimbursement rates with a provider. *See* BD Final Report at 4, 14. BD never asked Anthem for this type of information or level of detail for the thousands of codes on the statewide fee schedules and the hundreds of individually negotiated provider agreements. If BD did not have sufficient information on a particular topic or issue, BD should have requested additional information or clarification from Anthem.[7] It did not do so. Instead, it weaponized this purported lack of information and used it as "evidence" of a violation of the MHPAEA.

None of this is particularly surprising, given BD's preordained conclusion that Anthem's reimbursement rates violated the MHPAEA and its stated goal of increasing reimbursement levels for MH/SUD services in order to achieve the policy goal of attracting more MH/SUD providers to New Hampshire. The MHPAEA, however, was never intended to be the mechanism for achieving these goals. The commentary to the Final Rules reassured both health plans and consumers that "there will not be significant increases in plan expenditures and premiums as a result of the increased access to mental health and substance use disorder services that are expected to result from these final regulations." 78 Fed. Reg. 68259. If the Commissioner adopts the findings in BD's Final Report, the inevitable result will be a substantial increase in the cost of care and premiums for Anthem's members.

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For all the reasons noted above, Anthem respectfully requests that the Commissioner enter an order (1) rejecting the findings in the Verified Report and finding instead that Anthem is compliant with all applicable departmental policies, rules, regulations and laws pertaining to this matter; or, in the alternative, (2) calling for an investigatory hearing pursuant to RSA 400-A:37(IV)(3). Anthem reserves, and does not

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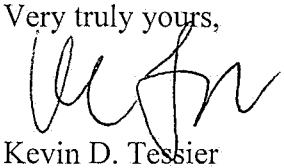
[7] BD did not become involved in Anthem's examination until fairly late in the process, and BD had very little direct contact with Anthem throughout the course of the examination.

waive all of its rights, arguments and positions under applicable law regarding the Verified Report and the findings contained therein.

Very truly yours,



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Enclosures

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September 19, 2019

By Electronic Mail and U.S. Mail

Maureen Belanger
Examiner-in-Charge
State of New Hampshire Insurance Department
21 South Fruit Street
Suite 14
Concord, New Hampshire 03301

Re: Verified Report of Examination – Anthem Health Plans of New Hampshire, Inc. and Matthew Thornton Health Plan, Inc. – Docket No. INA-17-046-MC

Dear Ms. Belanger:

Anthem Health Plans of New Hampshire, Inc. and Matthew Thornton Health Plan, Inc. (collectively "Anthem") submit the following supplement to their rebuttal to the Verified Report the New Hampshire Insurance Department ("NHID") issued on May 1, 2019.

On September 5, 2019, the Departments of Labor, Health and Human Services and the Treasury issued additional guidance regarding compliance with the Mental Health Parity and Addiction Equity Act ("MHPAEA"). *See* FAQs About Mental Health and Substance use Disorder Parity Implementation and the 21st Century Cures Act Part 39. This new guidance confirms that both BerryDunn's methodology for analyzing Anthem's compliance with MHPAEA and the findings BerryDunn made based on that methodology are contrary to MHPAEA.

The new FAQs emphasize that the analysis regarding whether a nonquantitative treatment limitation ("NQTL") violates MHPAEA "does not focus on whether the final result (for example, coverage denial rates) is the same for MH/SUD benefits and medical/surgical benefits; instead compliance depends on parity in development and application of the underlying processes and strategies." FAQs at 4. The new FAQs stress that dissimilar outcomes "are NOT determinative of compliance." *Id.* (emphasis in original). Dissimilar outcomes are merely "warning signs" that may warrant further investigation. *Id.* Similarly, the new FAQs repeatedly emphasize that the MHPAEA does not require equality of outcomes or results. For example, the FAQs state that MHPAEA does not require a plan "to ensure that the numbers of MH/SUD and medical/surgical providers in the plans network are comparable" or "to pay identical provider reimbursement rates for medical/surgical and MH/SUD providers[.]" *Id.* at 9.

Nothing in the new FAQs validates BerryDunn's incomplete and deeply flawed analysis of Anthem's reimbursement rates in this examination. BerryDunn based its findings entirely on outcomes and results – the purported differences between the weighted averages of reimbursement rates for MH/SUD and medical/surgical providers as compared to Medicare reimbursement rates. BerryDunn did not meaningfully examine Anthem's processes for setting reimbursement rates. The new FAQs confirm

that BerryDunn *ended* its investigation precisely where the investigation of Anthem's processes for setting reimbursement rates should have *started.* The guidance in neither of these questions validates BD's methodology for evaluating Anthem's reimbursement rates or supports BD's ultimate finding that Anthem's reimbursement rates violate MHPAEA.

Two of the questions in the new FAQs address hypothetical scenarios regarding stepdowns in reimbursement rates for non-physicians and network adequacy. Neither of these scenarios, however, is remotely similar to the examination record here. To the contrary, the differences between these hypothetical scenarios and the examination record merely highlight the deficiencies in BerryDunn's analysis and underscore why there is no basis for finding that Anthem's processes for setting reimbursement rates violate MHPAEA.

Question 6

Question 6 addresses stepdowns in reimbursement rates for non-physicians. In this hypothetical scenario, the plan automatically reduces reimbursement rates for all non-physician practitioners for every MH/SUD service by 15%, but does not do so for non-physician practitioners for medical/surgical services. FAQs at 9. Instead, the plan applies a variety of different factors to determine the reimbursement rates for non-physicians. *Id.* The FAQs conclude that this is not permissible under MHPAEA because the plan does not use comparable processes to determine reimbursement rates for non-physician practitioners who provide MH/SUD and medical/surgical services. *Id.* at 9-10.

In this examination, by contrast, NHID made no such findings regarding Anthem's processes for reimbursement rates for non-physician. Neither of NHID's contract examiners (RIA and BerryDunn) actually analyzed Anthem's processes for determining stepdowns in reimbursement rates for non-physicians. BerryDunn did not address the stepdown issue at all. RIA merely asserted in conclusory fashion, without any evidentiary support, that Anthem does not have a comparable process for stepdowns for reimbursement rates for M/S services performed by non-physicians. In its rebuttal, Anthem challenged the absence of any support for RIA's conclusions and pointed out that Anthem does in fact have an industry standard stepdown process for reimbursement rates for providers of medical/surgical services based on licensure and qualifications. *See* Anthem Rebuttal at 3.[1] In response to this rebuttal, NHID abandoned RIA's findings. NHID's memorandum response states in relevant part: "Department examiners acknowledge that RIA's analysis had methodological limitations; it was BerryDunn's analysis the Department relied on in reaching its conclusions, not RIA's analysis." June 14, 2019 Memorandum at 2. BerryDunn, however, did not address any stepdown issues. At a minimum, NHID should clarify that the Commissioner's June 26, 2019 order adopting the Verified Report does not include the findings NHID has abandoned related to RIA's review and analysis of stepdown issues included in the Verified Report. *See* Verified Report at 33-34.

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[1] Anthem's rebuttal also highlighted the obvious shortcomings in RIA's comparison of Anthem's reimbursement rates for M/S physicians and MH/SUD non-physician practitioners for certain services. *See* Anthem Rebuttal at 3.

Question 7

Question 7 addresses the factors a plan considers to ensure that it has an adequate network. FAQs at 10-11. In this hypothetical scenario, the plan required that a member should be able to schedule an appointment with a network provider within 15 days for non-urgent care and increased reimbursement rates to attract a sufficient number of providers to meet that requirement. *Id.* at 10. The plan, however, did not take any comparable measures to attempt to ensure an adequate network of MH/SUD providers. *Id.* The FAQs conclude that this is not permissible under MHPAEA. *Id.* The FAQs emphasize, however, that the focus under MHPAEA is on process and that disparate results – such as greater numbers of medical/surgical providers than MH/SUD providers in the network – are not a violation of MHPAEA so long as the processes for setting standards for admission to the network and ensuring an adequate network are comparable. *Id.* at 10-11.

Unlike this hypothetical scenario, Anthem's processes for ensuring adequate networks of both MH/SUD and medical/surgical providers are identical. *See* Anthem Rebuttal at 8-9. Moreover, Anthem's processes for setting reimbursement rates for both MH/SUD and medical/surgical services expressly provide that Anthem will increase negotiated reimbursement rates if necessary in order to satisfy state-regulated network adequacy guidelines. *Id.* at 8. Neither NHID nor its contract examiner BerryDunn made any findings that Anthem failed to take comparable measures to ensure an adequate network of MH/SUD providers. To the contrary, the Verified Report includes a finding by NHID that Anthem's network of MH/SUD providers is adequate and complies with the requirement of MHPAEA. The Commissioner adopted this finding. *See* June 20, 2019 Order.

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For all the reasons noted above, Anthem respectfully requests that the Commissioner (1) reconsider his June 20, 2019 order adopting the Verified Report in light of the additional guidance provided by the September 5, 2019 FAQs; (2) reject the findings in the Verified Report and find instead either that Anthem has complied with MHPAEA or that additional investigation beyond this examination is needed before NHID can determine whether Anthem's processes for setting reimbursement rates violate MHPAEA. Solely in the alternative, if the Commissioner adopts the findings in the Verified Report even after reconsideration of this additional guidance regarding MHPAEA, Anthem respectfully requests that the Commissioner call for an investigatory hearing pursuant to RSA 400-A:37(IV)(3). Anthem reserves, and does not waive all of its rights, arguments and positions under applicable law regarding the Verified Report and the findings contained therein.

Very truly yours,

Kevin D. Tessier

APPENDIX C: Mental Health Parity Examination Interrogatories

	COMPANY OPERATIONS AND MANAGEMENT
Request No.	**Request**
A.1	Provide a list of all internal and external MH/SUD-related audits conducted within the last three years and the corresponding audit reports.
A.2	Provide a list of all MH/SUD third-party entities and/or service providers with corresponding functions/duties/provided services, and provide copies of contracts with all third-party entities and/or service providers.
A.3	Provide policies and procedures to demonstrate the Company is adequately monitoring MH/SUD third party entities
A.4	Provide the Company's records retention policies and procedures.
A.5	Written overview of Company operations including management structure, type of carrier, etc.
A.6	Provide policies and procedures required to respond to requests from the examiners in a timely manner.
A.7	Provide documentation that the Company has developed and implemented written policies, standards and procedures for management of insurance information.
A.8	Provide policies and procedures demonstrating that the Company (MH/SUD) data required to be reported to the insurance department is complete and accurate.
	QUANTITATIVE REVIEWS
Request No.	**Request**
B.1	***Aggregate limitations:*** a. Does the plan include lifetime limits for MH/SUD treatments? b. Does the plan include lifetime limits for Med/Surg treatments?
B.2	***Aggregate limitations:*** a. What are the aggregate lifetime limits for MH/SUD treatments? b. What are the aggregate lifetime limits for Med/Surg treatments?
B.3	***Aggregate limitations:*** a. Does the plan include lifetime limits for specific MH/SUD diagnosis and treatments? b. Does the plan include lifetime limits for specific Med/Surg diagnosis and treatments?
B.4	***Annual limitations:*** a. Does the plan impose annual dollar limitations on treatments for MH/SUD benefits? b. Does the plan impose annual dollar limitations on treatments for Med/Surg benefits?
B.5	***Treatment limitations:*** a. Does the plan impose treatment limitations for the number of visits, days of coverage, or other similar limits on the scope or duration of MH/SUD benefits? • If yes, what is the benefit type and limitation in days or frequency?

	b. Does the plan impose treatment limitations for the number of visits, days of coverage, or other similar limits on the scope or duration of Med/Surg benefits? • If yes, what are the benefit type and limitations in days or frequency?
	FINANCIAL LIMITATIONS
Request No.	**Request**
C.1	***2/3 Substantially all requirements:*** How does the carrier ensure that the 2/3 substantially all requirements are met?
C.2	***Deductibles:*** Please provide a listing of the deductibles for the ten most popular major medical plans.
C.3	***Deductibles:*** a. Does the carrier have separate collective deductible(s) for MH/SUD benefits? b. Does the carrier have separate collective deductible(s) for Med/Surg benefits?
C.4	***Deductibles:*** a. Does the carrier have separate individual deductible(s) for MH/SUD benefits? b. Does the carrier have separate individual deductible(s) for Med/Surg benefits?
C.5	***Deductibles:*** a. Does the carrier have a separate aggregate deductible (s) for MH/SUD benefits? b. Does the carrier have a separate aggregate deductible (s) for Med/Surg benefits?
C.6	***Copayments:*** a. What are the in-network copayment amount(s) for MH/SUD Office Visits? b. What are the in-network copayment amount(s) for Med/Surg Office Visits? c. What are the out-of-network copayment amount(s) for MH/SUD Office Visits? d. What are the out-of-network copayment amount(s) for Med/Surg Office Visits?
C.7	***Copayments:*** a. What are the copayment amounts for treatments by a MH/SUD Specialist? b. What are the copayment amounts for treatments by a Med/Surg Specialist?
C.8	***Copayments:*** a. What are the copayment amounts for laboratory services for MH/SUD treatments? b. What are the copayment amounts for laboratory services for Med/Surg treatments?
C.9	***Copayments:*** a. What are the copayment amounts for X-ray services for MH/SUD treatments? b. What are the copayment amounts for X-ray services for Med/Surg treatments?
C.10	***Copayments:*** a. What are the various copayment amounts for Emergency Room services or MH/SUD treatments? b. What are the various copayment amounts for Emergency Room services for Med/Surg treatments?
C.11	***Copayments:*** a. What are the copayment amounts for therapy services such as Physical Therapy, Occupational Therapy, and Speech/Language Pathology for MH/SUD treatments?

	b. What are the copayment amounts for therapy services such as Physical Therapy, Occupational Therapy, and Speech/Language Pathology for Med/Surg treatments?
C.12	***Copayments:*** a. What are the copayment amounts for Urgent Care services for MH/SUD treatments? b. What are the copayment amounts for Urgent Care services for Med/Surg treatments?
C.13	***Copayments:*** a. What are the copayment amounts for inpatient services for MH/SUD treatments? b. What are the copayment amounts for inpatient services for Med/Surg treatments?
C.14	***Copayments:*** a. What are the copayment amounts for Generic Prescription drugs for MH/SUD treatments? b. What are the copayment amounts for Generic Prescription drugs for Med/Surg treatments?
C.15	***Copayments:*** a. What are the copayment amounts for Formulary Prescription drugs for MH/SUD treatments? b. What are the copayment amounts for Formulary Prescription drugs for Med/Surg treatments?
C.16	***Copayments:*** a. What are the copayment amounts for Non-Formulary Prescription drugs for MH/SUD treatments? b. What are the copayment amounts for Non-Formulary Prescription drugs for Med/Surg treatments?
C.17	***Copayments:*** a. Are there any other copayments imposed for Prescription Drugs used to treat MH/SUD conditions? b. Are there any other copayments imposed for Prescription Drugs used to treat Med/Surg conditions?
C.18	***Coinsurance:*** a. What are the Coinsurance rates for MH/SUD treatments for the ten most common plans? b. What are the Coinsurance rates for Med/Surg treatments for the ten most common plans?
C.19	***Out-of-pocket Maximum Expenses:*** a. What are the Out-of-pocket Maximum Expenses for In-Network MH/SUD benefits for the ten most common plans? b. What are the Out-of-pocket Maximum Expenses for In-Network Med/Surg benefits for the ten most common plans?
C.20	***Out-of-pocket Maximum Expenses:*** a. What are the Out-of-Pocket Maximum Expenses for Out-of-Network MH/SUD benefits for the ten most common plans?

	b. What are the Out-of-Pocket Maximum Expenses for Out-of-Network Med/Surg benefits for the ten most common plans?
	NON-QUANTITATIVE REVIEWS
Request No.	**Request**
D.1	***Benefit Classifications:*** a. Does the carrier provide coverage for all six categories for MH/SUD treatments? • If no, which categories are excluded and why? b. Does the carrier provide coverage for all six categories for Med/Surg treatments? • If no, which categories are excluded and why?
D.2	***Benefit Classifications:*** a. Are there any limitations or exceptions imposed on any of the six categories for MH/SUD treatments? • If yes, what are the limitations and exceptions? b. Are there any limitations or exceptions imposed on any of the six categories for Med/Surg treatments? • If yes, what are the limitations and exceptions?
D.3	***Medical Management Standards:*** a. Describe the policy development processes for Medical Management Standards for MH/SUD. b. Describe the policy development processes for Medical Management Standards for Med/Surg.
D.4	***Medical Management Standards:*** a. Describe the processes utilized to update Medical Management Standards for MH/SUD. b. Describe the processes utilized to update Medical Management Standards for Med/Surg.
D.5	***Medical Management Standards – Utilization Review and Case Management:*** a. Please provide all utilization review and case management information and disclosures available to policyholders for the treatment of MH/SUD diagnoses and explain how this information is accessed (i.e., via website, customer service request, etc.). b. Please provide all utilization review information and case management available to policyholders for the treatment of Med/Surg diagnoses and explain how this information is accessed (i.e., via website, customer service request, etc.).
D.6	***Medical Management Standards – Utilization Review:*** a. Please provide internal utilization review guidelines for determining allowable MH/SUD benefits. b. Please provide internal utilization review guidelines for determining allowable Med/Surg benefits.
D.7	***Medical Management Standards – Utilization Review:*** a. How frequently, and with what stringency is utilization review required for MH/SUD benefit determinations?

	b. How frequently, and with what stringency is utilization review required for Med/Surg benefit determinations?
D.8	***Medical Management Standards – Utilization Review:*** a. Please provide the qualifications of individuals performing utilization reviews to determine allowable MH/SUD benefits. b. Please provide the qualifications of individuals performing utilization reviews to determine allowable Med/Surg benefits. c. Are utilization review and concurrent care review for MH/SUD services performed by attending physicians, or internal (carrier) reviewers? d. Are utilization review and concurrent care review for Med/Surg services performed by attending physicians, or internal (carrier) reviewers?
D.9	***Medical Management Standards – Utilization Review and Case Management:*** 1. Utilization Review files – A separate request will be submitted for presenting utilization review files under Section DR (Data Requests). 2. Case Management files – A separate request will be submitted for presenting case management files under Section DR (Data Requests).
D.10	***Prior-authorization/pre-certification:*** a. Please provide all prior-authorization/pre-certification information and disclosures available to policyholders for the treatment of MH/SUD diagnoses and explain how this information is accessed (i.e., via website, customer service request, etc.). b. Please provide all prior-authorization/pre-certification information and disclosures available to policyholders for the treatment of Med/Surg diagnoses and explain how this information is accessed (i.e., via website, customer service request, etc.).
D.11	***Prior-authorization/pre-certification:*** a. Please provide internal prior-authorization/pre-certification guidelines for determining allowable MH/SUD benefits. b. Please provide internal prior-authorization/precertification guidelines for determining allowable Med/Surg benefits.
D.12	***Prior-authorization/pre-certification:*** a. How frequently are prior-authorization/pre-certification requirements updated for MH/SUD treatments? b. How frequently are prior-authorization/pre-certification requirements updated for Med/Surg benefits?
D.13	***Complaint Logs:*** Please provide the internal complaint logs for the timeframe from [insert date range].
	DISCRIMINATORY BENEFIT DESIGNS
Request No.	**Request**
E.1	***Denied Applicants:*** Please provide a listing of all applicants that applied for and were subsequently denied coverage as well as the agent's name and carrier ID number who took the application.
E.2	***Written Treatment Plans:*** Please provide all policies and procedures regarding written treatment plans for both MH/SUD and Med/Surg treatments.

E.3	***Written Treatment Plans:*** a. How frequently are the policies and procedures regarding written treatment plans updated for MH/SUD benefits? b. How frequently are the policies and procedures regarding written treatment plans updated for Med/Surg treatments?
E.4	***Written Treatment Plans:*** a. What is the experience and expertise required for the individuals creating and updating the written treatment plans for MH/SUD benefits? b. What is the experience and expertise required for the individuals creating and updating the written treatment plans for Med/Surg benefits?
E.5	***Formulary designs for prescription drugs:*** a. Please provide a list of formulary drugs for all plans for MH/SUD specific prescriptions. b. Please provide a list of formulary drugs for all plans for Med/Surg specific prescriptions.
E.6	***Formulary designs for prescription drugs:*** Please provide the dates the carrier last submitted its formulary list to the NHID.
E.7	***Formulary designs for prescription drugs:*** a. Please provide the copayment amounts for all categories of drugs (Generic, Tier 1 Brand-Name, Tier 2 Brand-Name, Formulary, Non-Formulary, any additional co-payments imposed) for MH/SUD specific prescriptions. b. Please provide the copayment amounts for all categories of drugs (Generic, Tier 1 Brand-Name, Tier 2 Brand-Name, Formulary, Non-Formulary, any additional co-payments imposed) for Med/Surg specific prescriptions.
E.8	***Formulary designs for prescription drugs:*** Please provide a list of all plans with separate deductible amounts for Prescription Drug services, and include the amount(s) of the deductible.
E.9	***Formulary designs for prescription drugs:*** Please provide a listing of all plans with a separate out-of-pocket (OOP) maximum amount for Prescription Drug services, and include the specific amounts for each plan.
E.10	***Formulary designs for prescription drugs:*** Please provide all documentation regarding requirements and frequency allowances for prescription drug refills.
E.11	***Formulary designs for prescription drugs:*** Please provide all information and supporting documentation for allowing enrollees to request and gain access to clinically appropriate MH/SUD drugs not covered by the health plan, including policy language and disclosure notices presented to enrollees regarding this access.
E.12	***Fail-first policies or step therapy protocols:*** In detail, please provide all processes for "Fail First" or step therapy treatment requirements for MH/SUD Treatments, Med/Surg and Pharmacy benefit considerations.
E.13	***Fail-first policies or step therapy protocols:***

	Are benefit exclusions imposed for failure to complete a course of treatment in the fail-first, or step therapy requirements?
E.14	***Fail-first policies or step therapy protocols:*** Please provide documentation on options to bypass fail first or step therapy requirements when these requirements may jeopardize the health of the policyholder.
E.15	***Network Design – Network Adequacy:*** Please identify what professional provider specialties included in the Company's network(s) participate on an "any willing provider" basis, as long as the provider accepts some form of a statewide fee schedule and standard contract requirements. Identify the network(s) that this finding applies to if the policy differs by network. *Note:* the Company may also identify the provider specialties that are not included in this category if the list is shorter.
E.16	***Network Design – Network Adequacy:*** Identify all primary care and MH/SUD treatment providers practicing in NH who have requested participation in your network(s), but were not granted in-network status. The provider does not need to have submitted a formal application to be included in the response to this inquiry.
E.17	***Network Design – Network Adequacy:*** Please identify what percentage of primary care providers are covered under an arrangement that delegates credentialing to the provider entity.
E.18	***Network Design – Network Adequacy:*** Please identify what percentage of MH/SUD providers are covered under an arrangement that delegates credentialing to the provider entity.
E.19	***Network Design – Network Adequacy:*** Please provide the website link to access the provider directory.
E.20	***Network Design – Network Adequacy:*** How frequently is the provider directory updated?
E.21	***Network Design – Network Adequacy:*** How frequently does the carrier perform disruption analysis to determine if additional providers could be added to the network(s)?
E.22	***Network Design – Network Adequacy and Provider Credentialing:*** a. Please provide the application, and requirements for a MH/SUD provider to be accepted into the network. b. Please provide the application and requirements for a primary care provider to be accepted into the network. c. How many MH/SUD providers requested to join the Company's network during the examination period successfully meeting credentialing requirements (please indicate type of provider requesting to join network subsequently meeting credentialing requirements – e.g., psychologist, psychiatrist, licensed clinical social worker, licensed substance abuse counselor, etc.)? d. Conversely, how many MH/SUD providers requested to the join the Company's network during the examination period failing to meet credentialing requirements (please indicate type of provider failing to meet credentialing requirements)?

	e. How many primary care providers requested to join the Company's network during the examination period successfully meeting credentialing requirements (please indicate type of provider requesting to join network subsequently meeting credentialing requirements – e.g., internal medicine, family medicine, OB/GYN, pediatrician or geriatrician, and MD, NP, PA, DO or ND)? f. Conversely, how many Med/Surg providers requested to the join the Company's network during the examination period failing to meet credentialing requirements (please indicate type of provider failing to meet credentialing requirements)?
E.23	***Network Design – Network Reimbursement rates:*** a. How does the carrier determine the appropriate reimbursement rates for MH/SUD providers in the network? b. How much does provider specific negotiating leverage influence MH/SUD provider payment rates? c. How does the carrier determine the appropriate reimbursement rates for Med/Surg providers in the network? d. How much does provider specific negotiating leverage influence Med/Surg provider payment rates?
E.24	***Network Design – Network Reimbursement rates:*** a. How frequently are the fee schedules updated for MH/SUD providers in the network? b. How frequently are the fee schedules updated for Med/Surg providers in the network? c. Approximately what percentage of primary care providers are paid at a statewide fee schedule, and what percentage are paid above that statewide schedule? Include as payments above the statewide schedule any medical management fees, payments process or outcome measures of quality, and potential upside risk arrangements. Count providers as individuals, not a group practice as one provider. d. Approximately what percentage of MH/SUD providers is paid at a statewide fee schedule, and what percentage is paid above that statewide schedule? Include as payments above the statewide schedule for any medical management fees, measures of quality, and potential upside risk arrangements that may be provided to a subset of providers. Count providers as individuals, not a group practice as one provider. e. Are the Company's provider payment levels based on the Medicare fee schedule and do they fully utilize Medicare payment policies? If provider payments are based on the Medicare system, please identify whether the conversion factor the Company uses (when applied to the RBRVS) differs between NH MH/SUD and NH Med/Surg providers.
E.25	***Network Design – Out-of-Network providers:*** Please provide all information regarding coverage for and access to out-of-network providers/specialists, including all penalties imposed for utilizing an out-of-network provider.
E.26	***Network Design – Out-of-Network providers:***

	Please provide all information including processes and procedures for allowing services to be performed at an out-of-network provider/specialist when an in-network provider/specialist is not available.
E.27	***Network Design – Out-of-Network providers:*** Please provide all information including plan language, disclosures, and EOB notifications that are presented to the policyholder to explain the exceptions presented for obtaining services from an out-of-network provider/specialist when an in-network provider/specialist is not available.
E.28	***Network Design – Coverage for Out-of-Network Emergency Services:*** Please provide all information regarding coverage for and access to out-of-network Emergency providers/specialists, including all penalties imposed for utilizing an out-of-network provider.
E.29	***Network Design – Coverage for Out-of-Network Emergency Services:*** Please provide all information including processes and procedures for allowing services to be performed at an out-of-network Emergency provider/specialist when an in-network provider/specialist is not available.
E.30	***Network Design – Coverage for Out-of-Network Emergency Services:*** Please provide all information including plan language, disclosures, and EOB notifications that are presented to the policyholder to explain the exceptions presented for obtaining services from an out-of-network Emergency provider/specialist when an in-network provider/specialist is not available.
E.31	***Network Design – Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage:*** a. Please provide all information regarding limitations and restrictions on geographic locations (such as treatments must be received within a certain number of miles of the policyholders residence) for MH/SUD services. b. Please provide all information regarding restrictions on geographic locations (such as treatments must be received within a certain number of miles of the policyholders residence) for MH/SUD services.
E.32	***Network Design – Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage:*** Please provide all information regarding limitations or restrictions on facility types.
E.33	***Grievance, Appeals and Disclosures:*** Please provide internal documents regarding grievance and appeals procedures.
E.34	***Grievance, Appeals and Disclosures:*** Please provide documentation and procedures that are available to the policyholders regarding the grievance and appeals process, including policy language and other guidance. If this information is presented through a secure website, please provide a username and password to allow access to the information.
E.35	***Grievance, Appeals and Disclosures:***

	Please provide documentation and procedures that are presented to the policyholders regarding expedited appeals.
E.36	***Grievance, Appeals and Disclosures:*** Please provide any additional disclosures that are available to the policyholders regarding filing a grievance and appeal.
E.37	***Grievance, Appeals and Disclosures:*** a. How frequently are the grievance and appeals procedures updated for MH/SUD treatments? i. Please provide an excel spreadsheet reporting all upheld/reversed and overturned appeals/grievances for MH/SUD treatments. <u>The spreadsheet should contain at a minimum the following information:</u> ii. Claim or policy number identifying the Appeal/Grievance; iii. The ICD 10 code applicable to the claim; iv. Include how the request was presented such as mail, fax, telephonic or other (if other, please specify); v. Identify who made the request, such as provider, policyholder, attorney, etc.; vi. The date the request was received; vii. Dates for second and level appeal or grievance if applicable; viii. Individuals involved in performing the reviews for each level; ix. The dates the final determination was initiated; and, x. The date the final determination was completed. b. Also attach the following: i. An electronic copy of the initial request to include any subsequent request; ii. An electronic copy of the final determination letter to include any relevant supporting documentation; iii. Please provide within the Appeals/Grievance spreadsheet an indicator of those appeals that an external review was requested, include the final status of the external review and the final notification letter(s); and iv. If a separate report on external reviews is available, please provide a copy.
E.38	***Grievance, Appeals and Disclosures:*** a. How frequently are the grievance and appeals procedures updated for Med/Surg treatments? i. Please provide an excel spreadsheet reporting all upheld/reversed and overturned appeals/grievances for Med/Surg treatments. The spreadsheet should contain at a minimum the following information: ii. Claim or policy number identifying the Appeal/Grievance; iii. The ICD 10 code applicable to the claim; iv. Include how the request was presented such as mail, fax, telephonic or other (if other, please specify); v. Identify who made the request, such as provider, policyholder, attorney, etc.; vi. The date the request was received;

	vii. Dates for second and level appeal or grievance if applicable; viii. Individuals involved in performing the reviews for each level; ix. The dates the final determination was initiated; and, x. The date the final determination was completed. b. Also attach the following: i. An electronic copy of the initial request to include any subsequent request; ii. An electronic copy of the final determination letter to include any relevant supporting documentation; iii. Please provide within the Appeals/Grievance spreadsheet an indicator of those appeals that an external review was requested, include the final status of the external review and the final notification letter(s); and iv. If a separate report on external reviews is available, please provide a copy.
E.39	***Claims:*** Please explain the claims handling process from receipt of claim, both electronic and hard copy, to the processing and closing of a claim. This should include all departments involved, and the timeframes for handling in each department.
E.40	***Claims:*** Please provide the carrier's claim training manuals.
E.41	***Claims:*** How frequently does the carrier perform an internal audit on the claims process as a whole?
E.42	***Claims:*** Please provide the most current internal claim audit report.
E.43	***Claims:*** Please provide copies of the claims forms utilized for health claims.
E.44	***Claims:*** Please provide the carrier's claims form manual.
E.45	***Claims:*** Claims files – A separate request will be submitted for presenting claims files under Section DR (Data Requests).
	OTHER CONSIDERATIONS
Request No.	**Request**
F.1	***Availability of Plan Information:*** a. Please provide links to plan information regarding MH/SUD provisions and benefits. b. Please provide links to plan information regarding Med/Surg provisions and benefits.
F.2	***Availability of Plan Information:*** a. Please provide information regarding policyholder access to hard copies of plan information regarding MH/SUD benefits for those that do not have access to not obtain an electronic copy. b. Please provide information regarding policyholder access to hard copies of plan information regarding Med/Surg benefits for those that do not have access to not obtain an electronic copy.

F.3	***Availability of Plan Information:*** a. How frequently does the carrier review and update plan information for MH/SUD benefits? b. How frequently does the carrier review and update plan information for Med/Surg benefits?
F.4	***Availability of Plan Information:*** a. Please provide a list of filed and approved forms, policy language, addendums and riders regarding MH/SUD benefits that have been approved by the NHID for plans/policies being reviewed during the examination period. This list should include the form number, the form it is replacing/updating, the date filed and date approved by the Department. b. Please provide a list of filed and approved forms, policy language, addendums and riders regarding Med/Surg benefits that have been approved by the NHID for plans/policies being reviewed during the examination period. This list should include the form number, the form it is replacing/updating, the date filed and date approved by the Department.
F.5	***Clinical Trials:*** a. Are clinical trials and/or experimental/investigative treatments allowed for MH/SUD services? b. Are clinical trials and/or experimental/investigative treatments allowed for Med/Surg services?
F.6	***Clinical Trials:*** a. Please provide the requirements and considerations for clinical trials for MH/SUD treatments. Please include any limitations or restrictions for these requirements. b. Please provide the requirements for consideration for clinical trials for Med/Surg treatments. Please include any limitations or restrictions for these requirements.
F.7	***Autism Coverage:*** How does the Company classify autism (e.g., medical benefit, MH benefit or both)? Please provide the Company's specific autism definition and classification in Company documentation.
F.8	***Autism Coverage:*** Please provide processes and procedures for providing Autism Coverage.
F.9	***Autism Coverage:*** Please provide the policy language outlining coverage for Autism services.
F.10	***ASAM:*** Do you currently use ASAM screening and assessment tools for prevention of, or early intervention in addiction? If so, please provide your policies and procedures for incorporating the tools, and provide four to six exhibits of the utilization of the tools.
F.11	***Delegated Service Contracts:*** Please provide a copy of all Third-Party Administrator (TPA) contracts and Service agreements in effect for the examination period for all Utilization Review, pre/post authorizations, claims processing or any support functions presently delegated to other entities relative to MH/SUD.

F.12	***Delegated Service Contracts:*** Please provide a brief summary of each contract defining the delegated service.
F.13	***Delegated Service Contracts:*** If the carrier provides services, then please provide a diagram/flow chart of the internal process associated with the handling of MH/SUD.
F.14	***Delegated Service Contracts:*** If the process differs for MH/SUD from the standard process, then please provide a full explanation of any deviations from the standard process.
F.15	***Medication Assisted Therapy (MAT):*** Please provide information on how the carrier provides coverage for: a. Methadone b. Buprenorphine c. Buprenorphine/Naloxone d. Naloxone e. Naltrexone
F.16	***Medication Assisted Therapy (MAT):*** For what FDA approved indications does the carrier cover these medications?
F.17	***Medication Assisted Therapy (MAT):*** What dose and/or refill limitations are applied to these covered medications?
F.18	***Medication Assisted Therapy (MAT):*** Please provide all information regarding annual or lifetime limits on MAT for Methadone and/or Buprenorphine.
F.19	***Medication Assisted Therapy (MAT):*** Are there pre-authorization, re-authorization or step therapy processes or other utilization management requirements (limitations on drug screenings, requirements that a physical examination be performed, etc.) applicable to MAT for methadone and/or buprenorphine?
F.20	***Medication Assisted Therapy (MAT):*** Does the Company impose any penalty or exclusion of coverage for the failure to complete a course of treatment applicable to MAT for methadone and/or buprenorphine?
F.21	***Medication Assisted Therapy (MAT):*** What medical necessity or medical appropriateness standard is applied to the coverage of MAT for methadone and/or buprenorphine?
F.22	***Medication Assisted Therapy (MAT):*** Does the Company provide Office-based Opioid Therapy (OBOT) and Opioid Treatment Program (OTP)? • If so, what is the level of OBOT and/or OTP coverage, the process for receiving OBOT and/or OTP, and the requirements for treatment? • If OBOT and/or OTP are excluded services, please provide exclusion language and rationale behind the exclusion.
	DATA REQUESTS
Request No.	**Request**

D.9	*Medical Management Standards – Utilization Review and Case Management:* 1. Utilization Review (UR) files for sampled MH/SUD, Med/Surg and Pharmacy claims. 2. Case Management (CM) files for sampled MH/SUD, Med/Surg and Pharmacy claims. ***Once examiners have sampled the total claims universe lists provided under Request No. E.45, then examiners will request all utilization review and case management files and/or documentation associated with the sampled claims.**
E.45	*Claims:* Provide a list of all paid, denied, and denied with prior authorization claims for the examination period: a. MH/SUD health claims b. Med/Surg health claims c. MH/SUD pharmacy claims in retail, inpatient and outpatient (e.g., Office-based Opioid Treatment "OBOT" and Opioid Treatment Program "OTP" settings). d. Med/Surg pharmacy claims in retail, inpatient and outpatient setting (including methadone for pain management).

APPENDIX D: Claim Universe File Layout

PAID HEALTH CLAIMS:

Field Name	Description
Subclass	Sub-classification type or environment
ClmNo	Claim Number
InsLast	Last Name of Insured
InsFirst	First Name of Insured
InsDOB	Insured Date of Birth (MMDDYYYY)
CertNo	Certificate Number, If Applicable
PolNo	Policy Number
ClmIncDt	Claim Incurred/Service Date (MMDDYYYY)
ClmRecDt	Claim Received Date (MMDDYYYY)
ClmAckDt	Date Claim Acknowledged (MMDDYYYY)
ICD10PRM	ICD 10 Primary Diagnosis Code
ICD10Sec1	ICD 10 Secondary Diagnosis Code One, If Applicable
ICD10Sec2	ICD10 Secondary Diagnosis Code Two, If Applicable
CPTCODE	CPT Code
ClmBillAmt	Claim Billed Amount
ClmAllAmt	Claim Allowed Amount
ClmCopay	Claim Copayment, If Applicable
ClmCoins	Claim Co-insurance, If Applicable
ClmDeduct	Claim Deductible Applied, If Applicable
ClmPdAmt	Claim Amount Paid
ClmPdDt	Claim Paid Date (MMDDYYYY)
ClmEOBDt	Date Explanation of Benefits Sent to Member
EHB	Essential Health Benefit, Yes or No
PriorAuth	Prior Authorization Required, Yes or No
CaseMgmt	Case Management Applicable, Yes or No
UtilRev	Utilization Review Applicable, Yes or No

DENIED HEALTH CLAIMS:

Field Name	Description
Subclass	Sub-classification type or environment
ClmNo	Claim Number
InsLast	Last Name of Insured
InsFirst	First Name of Insured
InsDOB	Insured Date of Birth (MMDDYYYY)
CertNo	Certificate Number, If Applicable
PolNo	Policy Number
ClmIncDt	Claim Incurred/Service Date (MMDDYYYY)
ClmRecDt	Claim Received Date (MMDDYYYY)
ClmAckDt	Date Claim Acknowledged (MMDDYYYY)
ICD10PRM	ICD 10 Primary Diagnosis Code
ICD10Sec1	ICD 10 Secondary Diagnosis Code One, If Applicable
ICD10Sec2	ICD10 Secondary Diagnosis Code Two, If Applicable
CPTCODE	CPT Code
ClmBillAmt	Claim Billed Amount
ClmAllAmt	Claim Allowed Amount
ClmCopay	Claim Copayment, If Applicable
ClmCoins	Claim Co-insurance, If Applicable
ClmDeduct	Claim Deductible Applied, If Applicable
ClmDenDt	Date Claim Denied (MMDDYYYY)
DenRsnCo	Denial Reason Code
ClmEOBDt	Date Explanation of Benefits Sent to Member
EHB	Essential Health Benefit, Yes or No
PriorAuth	Prior Authorization Required, Yes or No
CaseMgmt	Case Management Applicable, Yes or No
UtilRev	Utilization Review Applicable, Yes or No

DENIED WITH PRIOR AUTHORIZATION HEALTH CLAIMS:

Field Name	Description
Subclass	Sub-classification type or environment
ClmNo	Claim Number
InsLast	Last Name of Insured
InsFirst	First Name of Insured
InsDOB	Insured Date of Birth (MMDDYYYY)
CertNo	Certificate Number, If Applicable
PolNo	Policy Number
ClmIncDt	Claim Incurred/Service Date (MMDDYYYY)
ClmRecDt	Claim Received Date (MMDDYYYY)
ClmAckDt	Date Claim Acknowledged (MMDDYYYY)
ICD10PRM	ICD 10 Primary Diagnosis Code
ICD10Sec1	ICD 10 Secondary Diagnosis Code One, If Applicable
ICD10Sec2	ICD10 Secondary Diagnosis Code Two, If Applicable
CPTCODE	CPT Code
ClmBillAmt	Claim Billed Amount
ClmAllAmt	Claim Allowed Amount
ClmCopay	Claim Copayment, If Applicable
ClmCoins	Claim Co-insurance, If Applicable
ClmDeduct	Claim Deductible Applied, If Applicable
ClmDenDt	Date Claim Denied (MMDDYYYY)
DenRsnCo	Denial Reason Code
ClmEOBDt	Date Explanation of Benefits Sent to Member
EHB	Essential Health Benefit, Yes or No
PriorAuth	Prior Authorization Required, Yes or No
CaseMgmt	Case Management Applicable, Yes or No
UtilRev	Utilization Review Applicable, Yes or No

PAID PRESCRIPTION DRUG CLAIMS:

Field Name	Description
Subclass	Sub-classification type or environment
ClmNo	Claim Number
InsLast	Last Name of Insured
InsFirst	First Name of Insured
InsDOB	Insured Date of Birth (MMDDYYYY)
CertNo	Certificate Number, If Applicable
PolNo	Policy Number
ClmIncDt	Claim Incurred/Service Date (MMDDYYYY)
ClmRecDt	Claim Received Date (MMDDYYYY)
ClmAckDt	Date Claim Acknowledged (MMDDYYYY)
DrgNme	Drug Name
Dosage	Dosage Prescribed
Quan	Quantity Prescribed
Type	Liquid/Tablet/Capsule/Etc.
Pharm	Pharmacy
ClmBillAmt	Claim Billed Amount
ClmAllAmt	Claim Allowed Amount
ClmCopay	Claim Copayment, If Applicable
ClmCoins	Claim Co-insurance, If Applicable
ClmDeduct	Claim Deductible Applied, If Applicable
ClmPdAmt	Claim Amount Paid
ClmPdDt	Claim Paid Date (MMDDYYYY)
ClmEOBDt	Date Explanation of Benefits Sent to Member
Brand	Generic, Preferred, Non-Preferred, Specialty
PriorAuth	Prior Authorization Required, Yes or No
CaseMgmt	Case Management Applicable, Yes or No
UtilRev	Utilization Review Applicable, Yes or No

DENIED PRESCRIPTION DRUG CLAIMS:

Field Name	Description
Subclass	Sub-classification type or environment
ClmNo	Claim Number
InsLast	Last Name of Insured
InsFirst	First Name of Insured (MMDDYYYY)
InsDOB	Insured Date of Birth
CertNo	Certificate Number, If Applicable
PolNo	Policy Number
ClmIncDt	Claim Incurred/Service Date (MMDDYYYY)
ClmRecDt	Claim Received Date (MMDDYYYY)
ClmAckDt	Date Claim Acknowledged (MMDDYYYY)
DrgNme	Drug Name
Dosage	Dosage Prescribed
Quan	Quantity Prescribed
Type	Liquid/Tablet/Capsule/Etc.
Pharm	Pharmacy
ClmBillAmt	Claim Billed Amount
ClmAllAmt	Claim Allowed Amount
ClmCopay	Claim Copayment, If Applicable
ClmCoins	Claim Co-insurance, If Applicable
ClmDeduct	Claim Deductible Applied, If Applicable
ClmDenDt	Date Claim Denied (MMDDYYYY)
DenRsnCo	Denial Reason Code
ClmEOBDt	Date Explanation of Benefits Sent to Member
Brand	Generic, Preferred, Non-Preferred, Specialty
PriorAuth	Prior Authorization Required, Yes or No
CaseMgmt	Case Management Applicable, Yes or No
UtilRev	Utilization Review Applicable, Yes or No

BerryDunn

New Hampshire Insurance Department

Market Conduct Exams
Provider Reimbursement Strategy Analysis
Behavioral Health Parity
Anthem Blue Cross Blue Shield of New Hampshire
Final Report

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Table of Contents

1.0 Executive Summary

The New Hampshire Insurance Department (NHID) contracted with the BerryDunn Health Analytics Practice Area (BerryDunn) to analyze Anthem of New Hampshire's (the Carrier's) provider reimbursement practices for physical health and behavioral health services for compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA, 45 CFR § 146.136), as amended by the Affordable Care Act of 2010, and New Hampshire state laws relative to coverage for behavioral health. MHPAEA requires that carriers' processes, strategies, and evidentiary standards used to set provider reimbursement rates, as written and in operation, must be applied comparably to and no more stringently to mental health and substance use disorder (MH/SUD) provider reimbursement as they are to medical and surgical (M/S) reimbursement. Medicare payment rates are developed using a highly detailed, scientific process that is consistent across all services, and is therefore consistent with this standard and serves as a benchmark that, if adhered to, would provide adequate evidence of compliance with MHPAEA.

To examine the Carrier's compliance with MHPAEA's requirement that the factors used to determine provider reimbursement levels for MH/SUD must be developed and applied comparably to those developed and applied to M/S provider reimbursement, BerryDunn analyzed:

- The Carrier's provider reimbursement policies, procedures, and responses to interrogatories
- Ratios of the Carrier's 2016 commercial MH/SUD provider reimbursement rates and M/S provider reimbursement rates, as reported by the Carrier in the New Hampshire Comprehensive Health Care Information System (NH CHIS), to Medicare reimbursement rates for the same services

Medicare's method of developing payment methods is resource-based and applies a consistent standard to both MH/SUD and M/S reimbursement calculations. The analysis found that the Carrier reimburses MH/SUD providers at rates very near Medicare rates, but virtually all M/S provider specialties at rates much higher than Medicare. Since Medicare reimbursement rates are resource-based, this result places the burden on the Carrier to provide documentation that demonstrates its specific analysis of both MH/SUD and M/S provider reimbursement levels, supporting a conclusion that the structure complies with MHPAEA.

Specifically, in order for such disparate reimbursement results to be MHPAEA-compliant, the Carrier's processes, strategies, and evidentiary standards used to set provider reimbursement rates, as written and in operation, must be applied comparably to and no more stringently to MH/SUD provider reimbursement as they are to M/S reimbursement. In order to assess this comparability and stringency, BerryDunn asked the Carrier targeted interrogatories, requested provider reimbursement methodology policies and procedures, and reviewed the Carrier's responses. The Carrier's responses to these requests listed factors considered in setting

reimbursement rates and stated that these factors were used similarly for MH/SUD and M/S providers. However, the Carrier provided no detailed insight into how fee schedules were developed nor how stringently factors were applied when fee schedules are deviated from (e.g., providers seek an increase in reimbursement) for either service type. The application of the criteria and evidence upon which reimbursement levels were set is not documented in any way in the Carrier's responses. The responses therefore provided no evidence ameliorating the findings of the claims data analysis that the Carrier's MH/SUD and M/S reimbursement rates differ, with MH/SUD reimbursement rates being relatively lower relative to Medicare than M/S rates. Absent evidence to establish that this rate differential is compliant with the law, these results provide evidence that MH/SUD rates are set in a more stringent fashion, which would constitute a MHPAEA parity violation. Out of approximately $56 million in physician services analyzed for this report (which does not include radiology, anesthesiology, or pathology services), $59,850 was paid to psychiatrists.

Evidence from data on supply of providers per capita from the Bureau of Labor Statistics indicates that New Hampshire ranks at or below average nationally in supply of behavioral health professionals for all education levels except the lowest (mental health/substance use disorder counselors), and near the top in rankings of surgeons, OB/GYNs, and pediatricians, among others. These findings appear to be inconsistent with the Carrier's stated policy to adjust reimbursement to address market supply issues.

The report proceeds in the following sections:

- Section 2 provides an introduction with brief discussions of the purpose and context of the present study
- Section 3 discusses the study methodology and data sources
- Section 4 presents the study results for the Carrier
- Section 5 provides a brief conclusion

2.0 Introduction and Background

The NHID contracted with BerryDunn to analyze the Carrier's provider reimbursement practices for physical health and behavioral health services for compliance with the MHPAEA, 45 CFR § 146.136, as amended by the Affordable Care Act of 2010, and New Hampshire state laws relative to coverage for behavioral health. To examine the Carrier's compliance with MHPAEA's requirement that the factors used to determine provider reimbursement levels for MH/SUD must be developed and applied comparably to those developed and applied to M/S provider reimbursement, BerryDunn performed a quantitative analysis comparing the ratios of commercial reimbursement rates to Medicare reimbursement rates for MH/SUD and M/S services (e.g., the commercial-to-Medicare reimbursement ratio of MH/SUD office visits compared to the commercial-to-Medicare reimbursement ratio for M/S office visits). Comparing the two ratios allows for a high-level view of parity in provider reimbursement levels. If, as this study finds, a disparity between MH/SUD and M/S exists, this disparity identifies a potential MHPAEA non-quantitative treatment limit (NQTL) violation.

However, the existence of differing reimbursement rates between MH/SUD and M/S providers may not constitute a parity violation if processes, strategies, and evidentiary standards used to set provider reimbursement rates, as written and in operation, are applied comparably to and no more stringently to MH/SUD provider reimbursement as they are to M/S reimbursement. In order to assess this comparability and stringency, BerryDunn asked the Carrier targeted interrogatories, requested provider reimbursement methodology policies and procedures, and reviewed the Carrier's responses.

2.1 Claim Reimbursement Analysis: BerryDunn's Approach

Medicare payment systems are carefully designed, constructed, and regularly updated to be resource-based, and therefore should be similar to the prices that would be paid in a competitive market in which prices reflect resource requirements (professional education and technical skill, equipment and facility usage, etc.). For physician and other practitioner payment, Medicare uses the Resource-Based Relative Value Scale (RBRVS) first developed by William Hsiao, PhD and colleagues at Harvard University. RBRVS and other Medicare payment systems for inpatient and outpatient services are created using many years-long, well-funded research projects, and undergo extensive public comment processes in the initial launch and in annual updates. All Medicare payment systems are updated annually by the Centers for Medicare & Medicaid Services (CMS) and undergo public comment in Notices of Public Rule Making, before having comments and responses published in the Federal Register with the Final Rules. While no system is perfect, this consistent process across all specialties and services means that the processes, strategies, evidentiary standards, and other factors used to arrive at the fees are consistent between MH/SUD, M/S, and other services as required by MHPAEA.

Since Medicare follows this process to set provider rates in a consistent manner between behavioral health and M/S services, there are two ways that reimbursement rates paid by commercial carriers can be MHPAEA-compliant. One would be for commercial products to pay the same relative prices paid by Medicare—these prices might all be higher or lower than the Medicare rates, but they would be consistently so, so that the ratios of commercial-to-Medicare fees would be consistent between MH/SUD and M/S. Accordingly, as described in detail in Section 3, BerryDunn calculated the ratio of Carrier reimbursement rates to Medicare reimbursement rates for MH/SUD services, and for M/S services by specialty to ascertain whether Medicare was being followed as a standard, and how the ratios of MH/SUD services compared to the ratios for M/S services.

The second way to establish compliance with MHPAEA would be to document how the specific processes used to set MH/SUD and M/S rates are compliant with MHPAEA. Market dynamics might compel commercial carriers to pay differentially high rates to certain specialties to maintain an adequate network. Carriers do not have the force of law to set rates like the Medicare program does for participating providers (although Medicare does need to attract a sufficient supply of providers willing to participate in Medicare). However, if such variations are present, and carriers vary from Medicare by greater degrees for some specialties, then such variation from the inherently MHPAEA-compliant Medicare rates puts the burden on the carrier to comply with MHPAEA's requirement that the processes, strategies, evidentiary standards, and other factors used to arrive at the fees—and their resultant variation from Medicare—are consistent between MH/SUD and M/S.

If one or more M/S specialties receive fees that are a large multiple of the Medicare rates owing to market power and constrained supply, and the carrier raises fees to secure an adequate network, then the carrier must be able to demonstrate through documentation of the specific activities engaged in to set provider rates that the same processes, strategies, and evidentiary standards were used for determination of MH/SUD fees. That is, it is not sufficient to state the criteria generally applied to set reimbursement and that they were applied comparably. Rather, it is also necessary to document the specific considerations and evidence collected, and the assessment and measurement of the evidence separately for both MH/SUD and other services, in such a way that demonstrates that the specific application of the criteria can be judged comparable. For example, if recruiting and adequate network were the issue, documentation should be available describing how the adequacy of a network was measured for both MH/SUD and M/S, what the results of that measurement were, and specifically what criteria were applied and measured to weight those results in making specific fee-level determinations for each MH/SUD and M/S.

BerryDunn collected from the Carrier and reviewed any policies, procedures, and other information related to setting provider reimbursement levels.

2.2 Review of Policies and Procedures

Consistent with MHPAEA compliance, "Plans and issuers may consider a wide array of factors in determining provider reimbursement rates for both MS services and MH/SUD services, such as service type; geographic market; demand for services; supply of providers; provider practice size; Medicare reimbursement rates; and training, experience of providers."[1] These and other factors "must be applied comparably to and no more stringently than those applied with respect to MS services."[2]

As part of its review, BerryDunn reviewed Anthem's responses to the interrogatories asked by the other examination firm, as well as the documentation submitted, including policies and procedures pertaining to provider reimbursement and provider fee schedules.

In addition to the interrogatories and requests for information requested by the other examination firm, BerryDunn submitted an additional set of interrogatories, requesting responses for the following:

- Additional information regarding factors used in determining provider reimbursement and timing of fee schedule updates
- The analytical framework/formula used to apply the provider reimbursement factors under various scenarios (e.g., fee schedule development, negotiation with providers) for M/S versus MH/SUD

3.0 Data Sources and Quantitative Analysis Methodology

3.1 Data Sources

BerryDunn utilized the NH CHIS (New Hampshire's all payer claims database) commercial medical claims incurred in calendar 2016 and paid through October 2017 and medical eligibility for the 2016 calendar year updated through October 2017. The analysis included paid claims from fully insured primary health insurance policies for members less than 65 years of age at the time of service (i.e., supplemental policies were excluded).

BerryDunn matched the commercial medical claims to the commercial membership files to identify group and individual policies. Claims not matching by member, carrier, and month to the membership files were excluded from the analysis.

For the policy and procedure review, BerryDunn began by reviewing all documentation and interrogatories already received from the Carrier by the other examination consulting firm assisting NHID with this examination. This information included fee schedules, the provider reimbursement-related policies and procedures, and interrogatory responses. BerryDunn asked follow-up interrogatories and requested additional information in an attempt to better understand how the factors used to determine provider reimbursement rates translated into provider rates. BerryDunn also examined data from the federal Bureau of Economic Analysis on supply of medical and other health practitioner supply in each state.

3.2 Steps in the Claim Analysis

3.2.1 Step 1: Identifying Services for Comparison

BerryDunn focused on the MHPAEA Inpatient and Outpatient service categories. The analysis of outpatient services included the vast majority of professional M/S services. Not included were radiology, laboratory/pathology, and anesthesiology services.[i] The included services were sub-grouped into provider specialty areas, based on values of the service providers' CMS National Plan and Provider Enumeration System (NPPES) National Provider Identifier (NPI) primary taxonomy codes,[3] to allow comparisons of commercial-to-Medicare ratios by provider specialty. Medicare reimburses these professional services using the RBRVS.[4] The analysis of inpatient services focused on acute-care hospital inpatient and psychiatric inpatient claims. Medicare reimburses claims for these inpatient services using two prospective payment systems: the Inpatient Prospective Payment System (IPPS)[5] and the Inpatient Psychiatric Facility Prospective

[i] These hospital-based specialties were excluded primarily because reimbursement for them is more complex and findings for these specialties would not alter the project's conclusions given the other results generated. The inclusions were defined by Current Procedural Terminology® (CPT®) range. Claims reporting the following CPT® codes were included: 11000-69900, 99200-99999, 90791, 90792, 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90849, 90853, 90870, 96101, and 96118.

Payment System (IPF PPS),[6] respectively, which were developed with comparable methods and standards.

The MHPAEA service classification also includes Emergency and Pharmacy categories.[7] Payers typically reimburse emergency department claims without regard to the behavioral versus physical nature of the complaint (i.e., without regard to diagnosis). Therefore, payment parity between MH/SUD and M/S emergency department care should be the norm in the market. Medicare pharmacy coverage is provided to members by commercial payers, whose contracts with pharmacy benefit managers and/or pharmaceutical companies are proprietary. Further, pharmaceutical companies set the prices of drugs based on a variety of factors unrelated to the behavioral versus physical health status of the conditions their products treat. For these reasons, this study did not test reimbursement parity for Emergency and Pharmacy services.

3.2.2 Step 2: Pricing Professional Services

Professional services are generally billed on the CMS-1500 standard bill form (required by CMS) and priced by Medicare using the RBRVS.[8] In order to compute the commercial-to-Medicare reimbursement ratios, it was necessary to compute what Medicare would have paid for the same services paid for by the Carrier.

The Medicare RBRVS system assigns relative value units (RVUs) to a procedure based on physical and mental resource intensity, with greater RVUs representing a higher-intensity procedure. Other factors being equal, higher RVUs for a procedure lead to higher reimbursement. For example, an evaluation and management (E&M) procedure performed in a practitioner's office is generally assigned lower RVUs than a surgical procedure performed at a facility. In order to determine the total RVUs, RBRVS divides a procedure into three categories: Work, Practice Expense, and Malpractice Expense, each of which is assigned an RVU value.[9] The RVUs assigned to the practice expense category are dependent on whether the procedure was performed in a facility or non-facility setting.[10] All three RVU categories are then geographically adjusted using category-specific geographic pricing cost indexes (GPCIs). All of New Hampshire is considered by CMS to be the same geographic area, so there is only one value for each GPCI in this study.[11] Summing the adjusted RVUs produces the total adjusted RVUs for a procedure. The total adjusted RVUs are multiplied by a conversion factor provided from the Physician Fee Schedule Final Rule to produce a payment rate.[12]

Two Current Procedural Terminology® (CPT®) code modifier-based payment adjustments were taken into account—bilateral procedure[ii] and assistant at surgery.[iii] Bilateral procedures are

[ii] CPT® Modifiers 50, LT, and RT

[iii] Assistant at surgery services are those services rendered by physicians or non-physician practitioners who actively assist the physician in charge of performing a surgical procedure. CPT Modifiers 80, 81, 82, and AS.

reimbursed at 150% of the standard physician fee schedule rate for a unilateral procedure,[iv] while assistant at surgery procedures are reimbursed at 16% of the standard physician fee schedule rate.[13]

BerryDunn took several steps to make the analysis tractable without impacting the validity of the conclusions. BerryDunn grouped services into CMS specialties based on NPI taxonomy. This analysis modifies the CMS provider specialty taxonomy for reporting purposes. Major specialties were included, while several less-common specialties and the hospital-based specialties were excluded from the report.[v] The "Primary Care" specialty as defined for this analysis is the combination of the Pediatrics, Internal Medicine, Family Medicine, and General Practice specialties. Furthermore, only procedures performed by physicians were included for M/S services, while all services, except MH/SUD add-on codes,[vi] performed by all MH/SUD provider license types (physician, PhD psychologist, Master of Social Work (MSW), and other licensed counselors) were included. Note that the inclusion of the add-on codes would have produced far lower ratios of commercial-to-Medicare payment rates for MH/SUD services than are presented in this report. Non-physician providers are far more central to service delivery in behavioral health, and reimbursement for non-physicians in M/S services can be complicated in ways that, if not handled correctly, could bias the analysis. The importance of the non-physicians for behavioral health services led BerryDunn to report each separately in the results. Accordingly, these are presented in aggregate and by education level in the results. Medicare reimburses non-physician providers at a percentage of the RBRVS. For example, clinical social workers are reimbursed at 75% of the psychiatrist rate;[14] these discount factors are reflected in the results.

3.2.3 Step 3: Pricing Inpatient Services

Medicare reimburses inpatient facility claims using a variety of PPSs based on the type of facility providing the services. For this analysis, BerryDunn focused only on acute inpatient and psychiatric inpatient events, which fall under the IPPS and IPF PPS, respectively. Under both systems, Medicare assigns price on an episodic basis.[vii] As with procedures in the Physician Fee Schedule, inpatient events are first assigned weighted values (representing relative

[iv] That is, if a surgeon makes $5000 for a knee replacement procedure on a single knee, she makes $7500 to replace both knees during the same surgery.

[v] The following specialties were excluded from the report: Anesthesiology, Clinical Pharmacology, Electrodiagnostic Medicine, Emergency Medicine, Hospitalist, Independent Medical Examiner, Legal Medicine, Medical Genetics, Neuromusculoskeletal Medicine & OMM, Neuromusculoskeletal Medicine, Sports Medicine, Nuclear Medicine, Oral & Maxillofacial Surgery, Pain Medicine, Pathology, Phlebology, Preventive Medicine, Radiology, Transplant Surgery

[vi] Add-on codes are services that can only be performed in conjunction with another specified, primary service code (Add-on Code Edits. Updated 29 August 2018. Accessed July 2018. https://www.cms.gov/Medicare/Coding/NationalCorrectCodInitEd/Add-On-Code-Edits.html). Add-on codes were found to be reimbursed at a significantly lower rate than the constituent primary code.

[vii] An episode is an inpatient event that starts on admission and ends after the patient has been out of a hospital or SNF for 60 days ("ACUTE CARE HOSPITAL INPATIENT PROSPECTIVE PAYMENT SYSTEM." Published March 2018. Accessed July 2018. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/acutepaymtsysfctsht.pdf.

resource intensity) that are then converted to dollars by multiplying by a standard inpatient reimbursement rate assigned nationally in the respective annual Final Rule published in the Federal Register.

Under both systems, there are additional facility-specific and outlier adjustments. Neither adjustment has been included in this model due to being unrelated to compensating for the specific service and complexity, respectively. Facility-specific adjustments include disproportionate share hospital, Direct Graduate Medical Education, and Indirect Medical Education adjustments. CMS increases payment amounts based on these factors to offset the additional costs that facilities incur for providing these social goods. In contrast, private carriers only pay for the cost of services, so these factors are excluded from the calculation of the Medicare reimbursement. Outliers would be very difficult to calculate and represent approximately 5% of inpatient PPS payments on average. The results section makes clear that this small under-estimate of Medicare payments does not affect the interpretation of the results. Excluding the outlier adjustment essentially assumes that the MH/SUD and M/S inpatient episode distributions are similar with respect to the effects of outliers.

3.2.3.1 Step 3.1: Inpatient Prospective Payment System

The IPPS assigns a Medicare Severity Diagnosis-Related Group (MS-DRG) to each inpatient event. Each MS-DRG has an associated weight.[15] This weight is multiplied by the standard reimbursement rate, referred to as the Operating Standardized Amount[16] to arrive at a Medicare episode reimbursement amount. The Operating Standardized Amount encompasses both the direct and indirect cost of treatment during an episode.[17] Medicare also includes a capital amount, the Capital Standard Federal Payment Rate, which was excluded from this model,[18] under the assumption that, unlike Medicare, commercial carriers are only paying for the services performed and not for capital expenditures such as electronic health records or quality reporting incentive programs. In any case, the capital portion of the rate is approximately 3%, and this report will show that this difference is immaterial to the overall results presented.

3.2.3.2 Step 3.2: Inpatient Psychiatric Facility Prospective Payment System

During the development of the IPPS, several facility types, including psychiatric facilities, were excluded.[19] This was due to treatment costs being inadequately accounted for in the IPPS. The IPF PPS was developed as on offshoot to accurately price psychiatric inpatient episode resource requirements. The two major differences between the systems are the standard rate and the price adjustments. The standard rate under the IPF PPS is a per diem value, as opposed to an overall episodic value under IPPS, and is referred to as the Federal Per Diem Rate.[20] The IPF PPS also has additional price adjustments that are not included in the IPPS. These include length of stay (LOS), age, and DRG adjustments. LOS adjustments are made to account for higher costs in the initial phase of psychiatric episodes. IPF PPS uses MS-DRG weights, but they are supplemental and optional. An episode can be submitted from an IPF without a DRG and is assumed to have a weight of one.[21] Such an episode is reimbursed at the Federal Per Diem Rate.

IPFs are identified by Medicare using their CMS certification number (CCN).[22] This ties a facility to the services it is certified to provide under Medicare, and determines whether inpatient episodes are reimbursed under IPPS or IPF PPS. The available data do not include CCN; in this analysis, episodes to be priced under the IPF PPS are identified based on an MH/SUD DRG assignment or by the presence of an MH/SUD room and board revenue code billed during the episode.

Once Medicare rates were assigned to both professional and facility claims, commercial-to-Medicare ratios were calculated as the commercial allowed amount divided by the assigned Medicare reimbursement amount. Both professional and facility claims are split between New Hampshire providers and all other states. The results presented in the next section are for New Hampshire providers only.

4.0 Results

4.1 Examination Observations

4.1.1 Results of the NH CHIS Claim Analysis

Tables 1 and 2 below show the results of the NH CHIS claim analysis of commercial-to-Medicare payment ratios. Table 1 shows the comparison of acute physical health (M/S) inpatient episodes to inpatient psychiatric (MH/SUD) ratios. Table 2 shows the comparison of professional service reimbursement ratios by provider specialty.

Table 1: Allowed Commercial Medical Expenses, Weighted Mean Commercial-to-Medicare Reimbursement Ratios, and Median Commercial-to-Medicare Reimbursement Ratios for 2016 Inpatient M/S vs. Inpatient MH/SUD Episodes: New Hampshire Providers Only

Inpatient Episode Type	Commercial	Commercial-to-Medicare Payment Ratio	
	Allowed Medical Expense	Weighted Average	Median
Acute Physical Health Inpatient	$ 53,094,015	2.30	2.01
Inpatient Psychiatric	$ 2,957,354	1.32	0.98

Both the inpatient and professional claims analyses show a large discrepancy in commercial-to-Medicare payment ratios between M/S services and MH/SUD services, with MH/SUD inpatient episodes showing a much lower commercial-to-Medicare reimbursement ratio (1.32 for MH/SUD episodes vs. 2.30 for M/S episodes) and MH/SUD professional services showing the lowest commercial-to-Medicare reimbursement ratio, 1.06, among all professional specialties. For comparison, consider the M/S primary care ratio of 1.97, the M/S evaluation and management services ratio of 1.53, and the neurological surgery ratio of 2.31. BerryDunn notes that of the almost $56 million of service spending and $5 million of MH/SUD services summarized in Table 2, payments to Psychiatrists total $59,850.

As noted above, a finding that the Carrier's MH/SUD and M/S services reimbursements had similar ratios to Medicare reimbursement rates would be strong evidence of MHPAEA-compliant provider reimbursement practices. The Carrier's claim analysis results in the present study clearly fail that test. However, market dynamics might compel commercial carriers to pay different rates to certain specialties to maintain an adequate network.

However, if such variations are present and reimbursements vary from Medicare by greater degrees for some specialties, then MHPAEA requires that the processes, strategies, evidentiary standards, and other factors used to arrive at the fees—and their resultant variation from Medicare—are consistent between MH/SUD and M/S. The next section discusses the results of BerryDunn's review of information provided by the Carrier, including its provider reimbursement policies and procedures.

Table 2: Allowed Commercial Medical Expenses, Weighted Mean Commercial-to-Medicare Reimbursement Ratios, and Median Commercial-to-Medicare Reimbursement Ratios for 2016 Professional Services by Specialty: New Hampshire Providers Only[viii]

Professional Specialty	Commercial	Commercial-to-Medicare Payment Ratio	
	Allowed Medical Expense	Weighted Average	Median
Allergy & Immunology	$ 11,020	1.30	1.39
Colon & Rectal Surgery	$ 19,626	2.09	2.08
Dermatology	$ 367,583	1.19	1.21
Evaluation and Management	$ 31,544,262	1.53	1.46
Gasteroenterology	$ 952,502	2.14	2.34
Neurological Surgery	$ 410,070	2.31	2.73
Neurology	$ 12,436	1.47	1.41
Obstetrics & Gynecology	$ 1,339,673	1.39	1.48
Ophthalmology	$ 533,220	1.63	1.46
Oral & Maxillofacial Surgery	$ -	N/A	N/A
Orthopaedic Surgery	$ 1,944,015	1.61	1.68
Otolaryngology	$ 456,384	1.59	1.48
Physical Medicine & Rehabilitation	$ 15,153	1.41	1.29
Plastic Surgery	$ 131,972	1.15	1.20
Primary Care	$ 11,842,237	1.97	1.82
Psychiatry	$ 5,013,268	1.06	1.05
MD/DO	$ 59,850	1.02	1.00
MSW	$ 1,067,515	1.11	1.09
Other	$ 2,274,456	1.13	1.11
Psychologist	$ 1,611,447	0.95	1.00
Surgery	$ 629,528	1.64	1.48
Thoracic Surgery (Cardiothoracic Vascular Surgery)	$ 132,818	1.64	1.50
Urology	$ 273,240	1.57	1.69

4.1.2 Results of the Review of Anthem's Policies and Procedures, and Responses to Interrogatories

In order for the disparities identified in Tables 1 and 2 to be MHPAEA-compliant, the Carrier's processes, strategies, and evidentiary standards used to set provider reimbursement rates, as written and in operation, must be applied comparably to and no more stringently to MH/SUD provider reimbursement as they are to medical/surgical M/S reimbursement. In order to assess this comparability and stringency, BerryDunn asked the Carrier targeted interrogatories,

[viii] All specialties are included for E&M. Only non-E&M services are included for individual specialties.

requested provider reimbursement methodology policies and procedures, and reviewed the Carrier's responses.

The Carrier's Fee Schedule Methodology and Development Policy for Participating Professional Providers (Fee Schedule Policy) indicates that provider fee schedules are developed using accepted industry methodologies, along with consideration of local market dynamics and competitive pressures. The Fee Schedule Policy provides a description of provider fee schedule development that is "general in nature and Anthem may maintain and develop Fee Schedules which vary from the description…"

The Fee Schedule Policy indicates the foundation for the development of fee allowances is the CMS RVU table. The RVU methodology is utilized for most, but not all procedures, for which CMS publishes an RVU. The RVU for the procedure code is multiplied by a dollar conversion factor that takes into consideration market dynamics and competitive pressures for the local area. Differences in the dollar conversion factor may exist among categories of procedure codes, or between physicians and limited-license providers, reflecting the market valuation of services. For procedures that do not have a CMS RVU, the Carrier may utilize the Ingenix Essential RBRVS publication to obtain the RVU or may impute an RVU based on a review of clinically similar procedures that do have a CMS RVU.

When asked in an interrogatory how the Carrier assures that market dynamics and competitive pressures are applied comparably to MH/SUD and M/S services, the Carrier replied that its process to update medical and behavioral fee schedules is identical and considers both qualitative and quantitative data along with expert opinions and information regarding Medicare changes to develop fair, reasonable, and competitive fee schedules for all providers, regardless of type. In addition, the Carrier provided additional factors it considers when determining fee schedules. These include:

- Data regarding Anthem's competitive position based on third-party information
- Feedback directly from providers
- Comparative data from Anthem's internal databases
- Medicare fee and RVU changes
- Feedback from employer groups and brokers
- Industry publications
- Data on medical trends

The Carrier noted that an internal workgroup comprised of individuals from various disciplines regularly confers on the above data sources and adjusts the fee schedule accordingly, and the process is the same for both M/S and MH/SUD.

MHPAEA's Final Rule indicates that a wide array of factors may be considered in determining provider reimbursement rates for both M/S services and MH/SUD services, such as service type, geographic market, demand for services, supply of providers, provider practice size, Medicare reimbursement rates, and training, experience, and licensure of providers. Therefore,

the factors listed by the Carrier are likely in alignment with the Final Rule. However, the MHPAEA NQTL provisions require the factors used be applied comparably to and no more stringently to MH/SUD services than to M/S services. Disparate provider reimbursement rates (i.e., relatively higher reimbursement rates for M/S providers than MH/SUD providers) alone do not mean that the NQTLs in use fail to comply with these requirements[23] if the process used to determine the rates is comparable across service types as described above.

In an attempt to measure the comparability of the process used to determine provider fee schedules for MH/SUD versus M/S, as well as the stringency with which the factors are applied, the Carrier was asked if there is an analytic framework or formula used for the factors provided. The Carrier indicated there is not a tangible methodology to fee schedule development and provided no details about the process used to determine provider reimbursement using the factors provided, nor did the Carrier provide the strategy (i.e., the reason) the factor was chosen, nor did the Carrier provide the evidence used when considering the factor. The lack of documentation about having applied a comparable process and standards to MH/SUD and M/S constitutes a potential MHPAEA violation.

The Carrier indicated that some providers, due to volume, geographic, or services offered, are able to negotiate a provider reimbursement rate beyond what is offered to its network. When asked how Anthem assures that these factors are applied uniformly for MH/SUD and M/S services, the Carrier indicated that if a provider, regardless of specialty (MH/SUD or M/S) sees an increase in reimbursement, the Carrier considers a variety of factors including:

- Volume and breadth of services provided to Anthem members
- Geographic reach of the practice
- Availability of the same or similar services by other similar providers in a comparable geography
- State-regulated network adequacy guidelines

Depending on the results of this analysis and where the provider's reimbursement is currently versus its peers for the same or similar services, an increase may be provided. The Carrier was asked if there is an objective analytic framework/formula is used, and if so, to provide documentation. The Carrier provided no details about the process used to determine provider reimbursement using the factors provided, nor did the Carrier provide the strategy (i.e., the reason) the factors were chosen, nor did the Carrier provide the evidence used when considering the factor. The lack of documentation about having applied a comparable process and standards to MH/SUD and M/S constitutes a potential MHPAEA violation.

The Carrier's Fee Schedule Policy takes into consideration several factors, in each of the markets it serves, in assessing when a fee schedule update is warranted. These include:

- Provider network participation percentages

- The impact that updating or not updating the fee schedules may have on future provider network participation
- Professional service utilization trends
- Reimbursement programs that reward excellence in clinical quality or create value for members
- The additional contribution from programs

The Fee Schedule Policy provides that if a fee schedule(s) update is warranted then such fee schedule update is implemented for all providers who currently utilize the Fee Schedule as well as any new providers who utilize the Fee Schedule. Typically the Carrier undergoes an assessment that includes but is not limited to the factors listed above in determining if an update is warranted.

In response to an interrogatory, the Carrier responded that if a fee schedule is updated in any given year, that decision always applies consistently to the M/S and MH/SUD fee schedules. This response appears inconsistent with the Fee Schedule Policy, which notes the fee schedules may be updated at a given time for only the providers who utilize a particular fee schedule.

4.1.3 Assessment of Stated Policy Using Provider Supply Data

The appendix to this report contains an assessment across states of providers per capita for MH/SUD and common medical specialties.[24] These results do not appear to be consistent with the stated policy of the Carrier to adjust reimbursement to address market supply issues. MH/SUD providers have far lower payment levels relative to Medicare than other specialties, but the per capita supply of MH/SUD providers are notably below national averages. At the same time, New Hampshire ranks near the top of the country in supply of surgeons, OB/GYNs, and Pediatricians while their reimbursement rates far exceed Medicare levels. This would seem to contradict the Carrier's stated policies.

5.0 Conclusion

A claims analysis of commercial-to-Medicare provider reimbursement ratios show that the Carrier reimburses MH/SUD providers at rates very near the Medicare rates, but virtually all M/S provider specialties at rates much higher than Medicare. Since Medicare reimbursement rates are resource-based, this result places the burden on the Carrier to provide documentation that demonstrates its specific analysis of both MH/SUD and M/S provider reimbursement levels, supporting a conclusion that the structure complies with MHPAEA.

In order for such disparate reimbursement results to be MHPAEA-compliant, the Carrier's processes, strategies, and evidentiary standards used to set provider reimbursement rates, as written and in operation, must be applied comparably to and no more stringently to MH/SUD provider reimbursement as they are to M/S reimbursement. In order to assess this comparability and stringency, BerryDunn asked the Carrier targeted interrogatories, requested provider reimbursement methodology policies and procedures, and reviewed the Carrier's responses. The Carrier's responses to these requests listed factors considered in setting reimbursement rates and stated that these factors were used similarly for MH/SUD and M/S providers, but provided no detailed insight into the actual rate-setting process for either service type. The responses therefore provided no evidence ameliorating the claim analysis findings that the Carrier's MH/SUD and M/S reimbursement rates differ, with MH/SUD reimbursement rates being lower relative to Medicare than M/S rates, a possible MHPAEA parity violation. Finally, the low supply of MH/SUD and abundant supply of M/S providers in New Hampshire, when aligned with the results of the reimbursement analysis, seem to contradict the stated policy of the Carrier with respect to using market conditions to set payment rates.

Appendix

	Psychiatrists	Psychiatrists	Psychiatrists	MH-SA Social Workers	MH-SA Social Workers	MH-SA Social Workers	Clin. Psych.	Clin. Psych.	Clin. Psych.	MH-SA Counselors	MH-SA Counselors	MH-SA Counselors	Surgeons	Surgeons	Surgeons	OB	OB	OB	Peds	Peds	Peds
Area Name	Per 1000 Pop.	Ratio to New Hampshire	State Ranking	Per 1000 Pop.	Ratio to New Hampshire	State Ranking	Per 1000 Pop.	Ratio to New Hampshire	State Ranking	Per 1000 Pop.	Ratio to New Hampshire	State Ranking	Per 1000 Pop.	Ratio to New Hampshire	State Ranking	Per 1000 Pop.	Ratio to New Hampshire	State Ranking	Per 1000 Pop.	Ratio to New Hampshire	State Ranking
New Hampshire	0.045	1.00	35	0.195	1.00	46	0.331	1.00	23	1.323	1.00	5	0.361	1.00	3	0.105	1.00	5	0.173	1.00	6
Alabama	N/A	N/A	47	0.243	1.24	43	0.126	0.38	50	0.354	0.27	48	0.101	0.28	28	0.043	0.41	34	0.097	0.56	14
Alaska	0.095	2.10	17	0.840	4.30	4	0.380	1.15	18	1.139	0.86	12	0.054	0.15	42	0.095	0.90	11	0.068	0.39	28
Arizona	0.120	2.67	8	0.374	1.91	21	0.373	1.13	20	0.670	0.51	33	0.040	0.11	46	0.056	0.53	28	0.148	0.86	10
Arkansas	0.081	1.79	21	0.332	1.70	25	0.175	0.53	46	0.584	0.44	36	0.081	0.22	31	0.057	0.54	26	0.040	0.23	43
California	0.078	1.73	22	0.323	1.65	27	0.468	1.41	11	0.673	0.51	32	0.109	0.30	26	0.052	0.49	29	0.089	0.51	18
Colorado	0.083	1.83	20	0.363	1.86	22	0.508	1.54	8	1.301	0.98	7	0.165	0.46	12	0.103	0.98	6	0.073	0.42	26
Connecticut	0.176	3.90	5	0.533	2.73	10	0.469	1.42	10	1.244	0.94	9	N/A	N/A	48	0.167	1.59	3	0.165	0.95	8
Delaware	0.085	1.88	19	0.413	2.11	17	0.424	1.28	13	0.837	0.63	20	0.138	0.38	14	0.095	0.91	10	0.244	1.41	3
District of Columbia	0.179	3.97	4	0.776	3.97	5	0.791	2.39	1	1.223	0.92	10	0.328	0.91	4	0.179	1.70	2	0.448	2.59	1
Florida	0.049	1.10	33	0.173	0.89	49	0.147	0.44	47	0.420	0.32	45	0.074	0.21	35	0.058	0.55	25	0.052	0.30	37
Georgia	0.038	0.85	41	0.108	0.55	51	0.201	0.61	44	0.459	0.35	43	0.070	0.19	38	0.099	0.94	9	0.076	0.44	24
Hawaii	0.105	2.33	12	0.281	1.44	37	0.330	1.00	24	0.393	0.30	47	0.056	0.16	41	0.091	0.87	13	0.098	0.57	13
Idaho	0.018	0.40	45	0.381	1.95	20	0.236	0.71	39	0.901	0.68	16	0.042	0.12	45	0.024	0.23	45	0.042	0.24	42
Illinois				0.244	1.25	42	0.311	0.94	25	0.752	0.57	29	0.114	0.32	22	0.040	0.38	38	0.063	0.36	31
Indiana	0.038	0.84	42	0.299	1.53	32	0.213	0.64	42	0.534	0.40	40	0.112	0.31	24	0.092	0.88	12	0.062	0.36	32
Iowa	0.035	0.78	43	0.317	1.62	28	0.205	0.62	43	0.801	0.61	23	0.051	0.14	44	0.048	0.46	30	N/A	N/A	47
Kansas	0.041	0.92	36	0.310	1.58	30	0.409	1.24	14	0.568	0.43	37	0.072	0.20	37	0.017	0.16	47	N/A	N/A	48
Kentucky	0.038	0.85	40	0.172	0.88	50	0.267	0.81	33	0.838	0.63	19	0.185	0.51	9	0.081	0.77	17	0.093	0.54	17
Louisiana	0.011	0.24	46	0.285	1.46	36	0.105	0.32	51	0.688	0.52	31	0.051	0.14	43				0.019	0.11	45
Maine	0.135	3.00	7	0.895	4.58	3	0.188	0.57	45	N/A	N/A	52	0.135	0.38	16	0.120	1.14	4	0.120	0.70	11
Maryland	0.100	2.22	14	0.387	1.98	19	0.349	1.05	22	0.781	0.59	27	0.077	0.21	34	0.075	0.71	18	0.097	0.56	15
Massachusetts	0.150	3.33	6	0.991	5.07	2	0.585	1.77	5	1.885	1.42	1	0.312	0.87	5	0.087	0.83	16	0.233	1.35	4
Michigan	0.059	1.32	29	0.363	1.86	23	0.234	0.71	40	0.561	0.42	38	0.128	0.35	17	0.069	0.65	20	0.074	0.43	25
Minnesota	0.102	2.26	13	0.518	2.65	11	0.611	1.85	4	1.286	0.97	8	0.204	0.57	7	0.100	0.95	8	N/A	N/A	49
Mississippi	0.023	0.52	44	0.268	1.37	39	0.130	0.39	49	0.542	0.41	39	0.127	0.35	18	0.020	0.19	46	0.064	0.37	30
Missouri	0.039	0.88	39	0.495	2.53	13	0.260	0.79	35	0.760	0.57	28	N/A	N/A	49	0.033	0.31	44	0.036	0.21	44
Montana	0.097	2.15	16	0.417	2.13	15	0.407	1.23	15	1.308	0.99	6	0.174	0.48	10	0.058	0.55	24	0.058	0.34	34
Nebraska	0.074	1.64	25	0.201	1.03	45	0.285	0.86	31	0.797	0.60	24	0.174	0.48	11	0.074	0.70	19	0.079	0.46	22
Nevada	0.018	0.40	11	0.253	1.30	41	0.146	0.44	48	0.406	0.31	46	0.087	0.24	30	0.045	0.43	33	0.049	0.28	39
New Jersey	0.115	2.56	10	0.175	0.89	48	0.392	1.18	17	0.902	0.68	15	0.152	0.42	13	0.068	0.65	21	0.168	0.97	7
New Mexico	0.058	1.28	30	0.332	1.70	26	0.553	1.67	7	0.870	0.66	18	0.115	0.32	21	0.038	0.37	40	0.058	0.33	35
New York	0.187	4.15	3	0.536	2.74	9	0.576	1.74	6	0.688	0.52	30	0.088	0.24	29	0.061	0.58	23	0.094	0.54	16
North Carolina	0.047	1.04	34	0.291	1.49	34	0.298	0.90	29	0.665	0.50	34	0.111	0.31	25	0.057	0.54	27	0.086	0.50	20
North Dakota	0.092	2.05	18	0.344	1.76	24	0.370	1.12	21	0.529	0.40	41	0.106	0.29	27	0.040	0.38	39			
Ohio	0.116	2.58	9	0.416	2.13	16	0.305	0.92	26	0.628	0.47	35	0.226	0.63	6	0.068	0.65	22	0.165	0.95	9
Oklahoma	0.064	1.42	28	0.310	1.58	29	0.289	0.87	30	0.888	0.67	17	0.079	0.22	32	0.015	0.15	48	0.018	0.10	46
Oregon	0.055	1.21	31	0.539	2.76	8	0.256	0.77	38	1.195	0.90	11	0.067	0.19	40	0.035	0.33	42	0.087	0.50	19
Pennsylvania	0.077	1.72	23	0.675	3.46	6	0.375	1.13	19	1.636	1.24	3	0.126	0.35	19	0.041	0.39	36	0.045	0.26	41
Puerto Rico				0.079	0.40	52	0.103	0.31	52	0.082	0.06	51	0.009	0.02	47	N/A	N/A	49	0.050	0.29	38
Rhode Island	0.208	4.62	2	0.616	3.15	7	0.635	1.92	3	0.455	0.34	44	N/A	N/A	50				0.180	1.04	5
South Carolina	0.041	0.91	37	0.215	1.10	44	0.257	0.78	36	0.351	0.27	49				0.037	0.35	41	0.055	0.32	36
South Dakota	0.000			0.396	2.03	18	0.256	0.78	37	1.107	0.84	13	0.408	1.13	2	0.047	0.44	31	0.047	0.27	40
Tennessee	0.052	1.14	32	0.271	1.39	38	0.265	0.80	34	0.526	0.40	42	0.068	0.19	39	0.041	0.39	37	0.106	0.61	12
Texas	0.040	0.90	38	0.186	0.95	47	0.228	0.69	41	0.335	0.25	50	0.123	0.34	20	0.042	0.40	35	0.081	0.47	21
Utah	N/A	N/A	48	0.268	1.37	40	0.485	1.47	9	0.782	0.59	26	0.137	0.38	15	0.090	0.86	14	0.067	0.39	29
Vermont	0.272	6.02	1	1.965	10.05	1	0.735	2.22	2	1.853	1.40	2	0.431	1.20	1	0.224	2.12	1	0.272	1.57	2
Virginia	0.099	2.20	15	0.516	2.64	12	0.305	0.92	27	1.337	1.01	4	0.114	0.31	23	0.087	0.83	15	0.078	0.45	23
Washington	0.075	1.67	24	0.303	1.55	31	0.302	0.91	28	1.026	0.78	14	0.074	0.21	36	0.046	0.44	32	0.071	0.41	27
West Virginia	0.065	1.44	27	0.071	0.36	53	0.282	0.85	32	0.809	0.61	22				N/A	N/A	50			
Wisconsin	0.073	1.61	26	0.291	1.49	33	0.454	1.37	12	0.811	0.61	21	0.078	0.22	33	0.035	0.33	43	0.061	0.35	33
Wyoming				0.290	1.48	35	0.392	1.19	16	0.784	0.59	25	0.188	0.52	8	0.102	0.97	7			

Endnotes

[1] 45 CFR Parts 146 and 147. Final Rules Under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008; Technical Amendment to External Review for Multi-State Plan Program; Final Rule. Accessed 10 October 2018: https://www.gpo.gov/fdsys/pkg/FR-2013-11-13/pdf/2013-27086.pdf.

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[8] "RBRVS Overview." Accessed June 2018. https://www.ama-assn.org/rbrvs-overview.

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BerryDunn

New Hampshire Insurance Department

Market Conduct Examination

Analysis of Compliance With New Hampshire RSA 420-J:16 and Required Application of ASAM Criteria

Anthem Blue Cross Blue Shield of New Hampshire

FINAL Report

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1.0 Executive Summary

The New Hampshire Insurance Department (NHID) engaged BerryDunn to participate in a market conduct examination of Anthem in New Hampshire, referred to hereinafter as the "Carrier." The purpose of BerryDunn's portion of the examination was to assess the Carrier's compliance with New Hampshire (State) law[1] that requires the use of the American Society of Addiction Medicine (ASAM) criteria[2,3] when determining medical necessity for specific levels of care (LOC) and conducting utilization review, including in the prior authorization process. State RSA 420-J:16 became effective on January 1, 2017, and requires, "Whenever substance use disorder services are a covered benefit under a health benefit plan subject to this chapter, the health carrier providing such benefits shall rely upon ASAM Criteria when determining medical necessity and developing utilization review standards for level of care for substance use disorder services." [4]

The ASAM Criteria (hereafter referred to as "ASAM") are comprehensive guidelines for placement, continued stay, and transfer/discharge of patients with substance use disorders (SUDs) and co-occurring conditions.[5] ASAM uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and LOC. (See Appendices A and B.)[6]

To examine the Carrier's compliance with the use of ASAM, BerryDunn analyzed the following:

- The Carrier's responses to interrogatories, requests for information (e.g., policies and procedures), and data calls
- A review of a random sample of 126 claims representing 60 unique members to determine whether ASAM was used

Findings: Interrogatory, Request for Information, Data Call Review

The Carrier's responses and documentation indicated that it uses ASAM during utilization review processes. The Carrier provided its training presentation and evidence of The Change Company™ ASAM training for all clinical staff and new hires. Our primary findings are:

1. *Risk scoring is not in the carrier template.* Prior authorization is required for all LOC other than outpatient. BerryDunn reviewed four sample cases previously provided by the Carrier in response to the interrogatory. These cases illustrated the information collected via the electronic medical record (EMR) template. Although the template requires documentation related to the six dimensions of ASAM, it does not require the concomitant risk scores associated with each dimension—risk scores are required to formulate a utilization management determination using ASAM.
2. *Inter-rater Reliability (IRR) is not conducted separately for substance use treatment.* The Carrier combines IRR for all behavioral health. IRR scores reflect 90% correctly applied medical necessity determinations for behavioral health. The tool used to measure IRR was not included in the interrogatories and was not reviewed.

3. *The staffing ratio makes careful application of ASAM difficult.* The ratio of utilization reviewer to members is 1:9180. The Carrier indicated that utilization reviewers average approximately 79 reviews/8-hour day. This is a high number of daily reviews considering the vulnerability and risk associated with the SUD population.
4. *LOC as defined by ASAM are not explicitly determined.* The submitted materials do not clearly describe all ASAM levels of care through a crosswalk with the Carrier's LOC; particularly, residential and withdrawal management (WM) LOC are not clearly described. Utilization review policies and procedures are generic and provide staff credentials, peer review requirements, timeliness of authorizations, and the detail of the denial and appeal procedures, and did not fully describe the details that were pertinent to this review.[i]

Findings: Medical Claim Review

BerryDunn used the New Hampshire Comprehensive Health Care Information System (NHCHIS) as a data resource from which a random sample of individuals receiving substance use treatment services was selected. All related substance use treatment claims for these individuals were reviewed, and the Carrier provided case records from its systems for these individuals. BerryDunn reviewed all records for each individual to assess compliance with ASAM. Findings from this review are summarized below.

5. *Documentation of ASAM is inconsistent.* BerryDunn's medical claim review found that the Carrier uses ASAM during utilization review processes, although BerryDunn's review found utilization reviewers documented ASAM inconsistently.
6. *Risk scores are not determined*. The risk score for each ASAM dimension is a key piece of information in making the appropriate determination for LOC. Risk scores for the six dimensions were often missing, although at times, risk could be inferred in the narrative notes.
7. *There are errors in LOC determination.* Although there is evidence that utilization reviewers have been trained in the use of ASAM, it is not always applied correctly. The carrier did not identify the correct ASAM LOC in the majority of cases related to WM and residential LOC.
8. *Reviewers do not assess treatment alternatives.* BerryDunn found no documented evidence that utilization reviewers actively queried providers related to member treatment options, particularly with Medication Assisted Treatment (MAT), an evidence-based practice. For specific relevant members, MAT may have been a critical treatment option, given the history of a member's opioid use disorder (OUD). There was also no documentation that a utilization reviewer sought an internal consultation from a physician related to MAT.

[i] Anthem UM Services, Inc. AUMSI

9. *Underuse of ASAM Dimensions 4, 5, and 6*. BerryDunn identified times when a utilization reviewer posed questions or followed up with a provider related to family involvement, probation/parole involvement, or appropriate housing options. In some cases, utilization reviewers prepared follow-up questions for the next utilization review; however, there was little indication of follow-through to obtain information. Utilizing elements of ASAM Dimensions 4, 5, and 6 (see Appendix A) are critical to member recovery.
10. *Carrier staff is not engaging in outreach and follow-up*. Unless a provider notified a utilization reviewer, there was no activity or outreach on the case. When following a case, the utilization reviewer would not receive a "call back" from a provider on the due date of review. There was no documented outreach performed, and the case was closed by the utilization reviewer. One of the guiding principles of ASAM includes "focusing on treatment outcomes."[7]

More detailed information and discussion is contained in the body of the report, which proceeds in the following sections:

- Section 2.0 provides an introduction and background of the present targeted examination.
- Section 3.0 discusses the purpose and goal of the examamination.
- Section 4.0 describes the process used to conduct the examination.
- Section 5.0 presents the results of the examination.
- Section 6.0 provides a brief conclusion of the targeted examination.

Executive Summary Endnotes

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2.0 Introduction and Background

The NHID engaged BerryDunn to participate in a market conduct examination of the Carrier. The purpose of the examination was to assess compliance relative to the use of the ASAM criteria when determining medical necessity and conducting utilization review, including clinical detail related to the prior authorization process. This is required under State RSA 420-J: 16.[1]

ASAM provides a structured approach to create comprehensive and individualized treatment plans.[2] Treatment plans are developed through a multidimensional patient assessment (see Appendix A) over five broad levels of treatment: 0.5, 1, 2, 3, and 4 (see Appendix B). Levels of treatment are based on the degree of direct medical management provided, as well as the structure, safety, and security of the medical management. Decimal numbers are used to further express gradations of intensity of services (e.g., a 3.1 LOC indicates clinically managed low-intensity residential services). ASAM is intended to address the patient's needs, obstacles, and liabilities, as well as the patient's strengths, assets, resources, and support structure.

3.0 Purpose and Goal of the Examination

In the State and across the country, substance abuse is growing at a significant rate. To promote opportunities for recovery for individuals with SUDs, the State legislature collaborated with providers, associations, and insurance providers to define the LOC and prior authorization requirements to help ensure that clinical care is delivered in the right amount, at the right time, in the right setting, and for the right duration for patients.

The NHID is in the process of conducting targeted market conduct examinations of Qualified Health Plan (QHP) issuers to evaluate compliance with insurance laws relating to behavioral health services and compliance with mental health parity laws. BerryDunn conducted an in-depth analysis of the QHP issuers' compliance with the Substance Use Disorders subdivision of the State's Managed Care Law, State RSA 420-J: 15-18[3] relative to the appropriate use of ASAM to determine appropriate clinical care delivery. The purpose BerryDunn's review is to ensure that the Carrier uses ASAM as medical necessity criteria (MNC) to determine appropriate LOC placement of members in the correct ASAM LOC, and to apply ASAM MNC in the utilization review process.

4.0 Examination Process

4.1 Interrogatories, Data Calls, and Requests for Information

BerryDunn began by reviewing information already collected by the examination firm. Following this review, BerryDunn requested additional information through interrogatories, data calls, and requests for information pertaining to the time period January 1, 2017, through June 30, 2017.

4.1.1 Clinical Operations

In order to understand clinical policies, procedures, and staffing related to SUDs and co-occurring disorders, BerryDunn requested the following information and documents:

- Clinical table of organization
- Clinical policies and procedures, particularly those that outline the application of ASAM
- Clinical policies and procedures related to prior authorization, authorization determinations, documentation requirements, timeliness of authorizations, denial processes, transition and discharge processes, and physician advisor oversight
- Clinical staffing roster for those staff who perform utilization review activities, including total full-time equivalents (FTEs), FTEs allocated to members with SUDs or co-occurring disorders, credentials, licensure, certification, and educational preparation
- Staff-to-member ratio for members with SUDs or co-occurring disorders
- Average number of clinical reviews per day per utilization reviewer for members with SUDs and co-occurring disorders

4.1.2 Orientation and Training of Clinical Staff

BerryDunn requested the following orientation and training materials for all clinical staff, including physician advisors and utilization reviewers who make utilization determinations:

- Evidence of ASAM eLearning training modules available online through The Change Companies™ or other formal ASAM training
- Annual MNC training requirements for all clinical staff, particularly training requirements regarding ASAM
- Training related to the ASAM Multidimensional Assessment and Level of Risk
- Training related to the array of LOC as defined by ASAM
- Training related to network composition and availability of providers that offer all ASAM LOC

4.1.3 Quality

BerryDunn requested the following quality materials to determine the Carrier's internal process for case review of those members with SUDs or co-occurring disorders:

- Results of annual or semi-annual IRR data for the Carrier's internal physician advisors and utilization reviewers who make utilization review determinations, with a focus on SUD clinical cases
- All clinical denials related to SUD

4.2 Clinical Record Review

4.2.1 Sampling Process

Using the NHCHIS, BerryDunn extracted claims using a random sampling technique, with no member represented by more than one claim, for the LOC "intensive outpatient" (IOP) or higher. BerryDunn sent this sample of member claims to the carrier to identify the unique members and link to the entire episodes of care. BerryDunn chose the number of claims in order to attain a confidence level of 95% or greater in the results of the analysis. The review process involved multiple claims for unique members and provided the ability to review elements of clinical care over time and across clinical treatment settings. The method of review also captured coordination of care, attention to care integration opportunities, discharge practices, and evidence related to appropriate utilization of ASAM. Each sampled claim represented one LOC review, and in some instances, several LOC were relevant in the review of the care episode for that same member.

4.2.2 Clinical Evaluation Tool

BerryDunn referenced the *American Society of Addiction Medicine, Third Edition*,[4] to conduct the clinical analysis of each claim. Using this reference, needs or concerns within each of the six dimensions of ASAM were identified, and a five-point risk rating was included to identify the degree of member risk to accompany each dimension. BerryDunn assessed whether the Carrier's utilization reviewer applied the appropriate elements corresponding to each dimension in order to render a correct medical necessity determination, and the member was placed in an appropriate LOC related to clinical presentation and need.

BerryDunn collected the following information for each claim/case review:

- Member identification (ID) number
- Date of birth (DOB)
- LOC requested and LOC authorized
- Appropriateness of clinical request based upon presenting clinical information
- Results of the member's mental status examination
- Results of the provider's biopsychosocial assessment of the member
- Diagnosis
- History of substance use and co-occurring disorder, including physical health concerns
- Social determinants
- Presenting problem
- Utilization reviewer opportunities to ensure optimal outcomes of care
- Discharge planning or transition to the next appropriate LOC
- ASAM Multidimensional Assessment (six dimensions) and level of risk (including any imminent risk) for each dimension for each prior authorization

- ASAM criteria that justifies admission
- Denials
- Consultations with physician advisors
- Member recovery needs
- Overall case comments

BerryDunn used one clinical reviewer; therefore, no IRR was needed or completed. As a result, trends, strengths, and opportunities for improvement were able to be tracked throughout the sample.

5.0 Results of Examination

5.1 Interrogatories, Data Calls, and Requests for Information

BerryDunn reviewed the Carrier's responses to the interrogatories, data calls, and requests for information, as well as policies and procedures related to ASAM.

5.1.1 Clinical Operations

Prior authorization requirements are clearly outlined. Prior authorization is required for all LOC other than outpatient and detox cases that were documented as mandated by the State.

In response to an interrogatory, the Carrier provided four sample cases outlining the information collected via the EMR template (this submission was separate and unrelated to the claim review). The template requires documentation related to the six dimensions of ASAM; however, there is no requirement of documentation of concomitant risk associated with each dimension that would help formulate a care management/utilization management determination using ASAM.

5.1.2 Orientation and Training of Clinical Staff

The Carrier provided its PowerPoint presentation for ASAM training and evidence of completion (i.e., The Change Company™ certificates of completion) of the ASAM eLearning modules for all clinical staff, including new hires.

5.1.3 Quality

IRR is combined for behavioral health. There are no differentiators between mental health and substance use cases per the June 28, 2018, Interrogatories submission. IRR scores reflect 90% correctly applied medical necessity determinations for behavioral health. The actual tool was not included in the interrogatories.

The ratio of utilization reviewer to members is 1:9180. In the written interrogatory response, the Carrier indicated that utilization reviewers average approximately 79 reviews/day. This is a high number of daily reviews considering the vulnerability and risk associated with the SUD population. Because of variability in the utilization review process from carrier to carrier, a

review of the literature did not reveal the number of reviews/day a utilization reviewer should perform according to best practices for this population. However, an author[ii] of this report, based on professional experience, opines that approximately 25 reviews/day to be an appropriate number of reviews for the relevant population.

5.2 Clinical Record/Claim Review

The Carrier submitted a total of 126 claims (reviews), representing 60 unique members. Of the total claims, five were not reviewed. In three files, each contained information on two different members; one file was a duplicate file; and one file was a retrospective review that did not contain pertinent information related to the ASAM examination.

5.2.1 Provider Distribution

Members received services from 33 providers. During an episode of care, one unique member may have been in service with multiple providers as the individual moved through the continuum of care.

With regard to providers, BerryDunn found the following:

- 15 providers delivered only one level of service, ASAM LOC 2.1—IOP—to 20 unique members.
- Farnum served 18 unique members and represented 34 reviews at four distinct LOC.
- Green Mountain served 15 unique members and represented 26 reviews at four distinct LOC.
- Of the 126 claims, 60 reflected residential or WM LOC.
- Of the 60 unique members, providers served a range of from 1 to 18 unique members. Farnum served 18; Green Mountain served 15; and the remaining providers served from 1 – 5 members.

5.2.2 Care Management Documentation Summary

Table 1 shows the types of reviews in the sample.

Table 1: Types of Reviews

Overview		
	Number of Reviews	**Comments**
Total Reviews	126	There were four step-down outpatient requests in the data, but none required prior authorization.

[ii] Carole Taylor, RN, MSN

Overview		
	Number of Reviews	**Comments**
Prior Authorization	118	Members were stepped up or down to LOC within treatment episodes, so there were multiple prior authorizations related to members moving along a continuum.
Continued Stay	4	
State-Mandated Detox (WM) (No Prior Auth Required)	0	None documented as mandated by the State.

5.2.3 Documentation

The Carrier does not use a standardized naming convention for authorized WM or residential LOC. Although the Carrier provided a crosswalk (in response to an interrogatory) to identify current LOC and the relationship to ASAM standard LOC, it was difficult to differentiate these LOC during the clinical review. BerryDunn identified 35 reviews in which the utilization reviewer did not clearly identify the various levels of WM or residential LOC. Utilization reviewers should use standardized terminology for the relevant LOC.

- WM LOC were found in the 126 claim files, and documentation referred to them by the following terms: Detox, residential detox, RTC detox, hospital detox, substance abuse detox (subacute), substance use detox, IP hospital detox, SA detox withdrawal protocol, alcohol detox, IP WM 4.0, 3.7 WM, and 3.7 detox.
- Residential LOC were found in the 126 claim files, and documentation referred to them by the following terms: Residential 3.5, rehab, res, RTC residential, SA rehab, residential rehab, RTC rehab, substance abuse rehab, substance use rehab, residential RTC, and SA Rehab subacute.

In the sample reviewed, no claims related to outpatient WM, 3.2 WM, or 3.1 residential/halfway house LOC were identified. Sober living opportunities are documented but no claims were reviewed for that LOC.

Narrative notes were included in the sample. Although notes are dated at each subsequent review, the narrative notes are cumulative. The dating of sequence of events is difficult to follow; specific updates within a unique review are not contemporaneously dated. There are documentation entries that are not routinely updated, are related to the six dimensions, and strongly influence the medical necessity determination.

Documentation supported that an ASAM format is being used to collect clinical data based upon the six dimensions. It was not always clear that concomitant risk associated with the dimensions is documented. There is a field where a utilization reviewer is able to check “Met

criteria/guidelines" in the defined EMR tab, but there is no specific relationship to the tab and ASAM MNC as designed.

Utilization reviewers documented clinical information related to the six dimensions in the narrative, but the associated risk is not consistently identified as influential in making a clinical determination. There was no evidence that the utilization reviewer analyzed and synthesized the existing member clinical data, obtained through the provider, into a cohesive clinical picture, demonstrating the need for that specific LOC. As an example of the structure, using ASAM LOC 3.5[5] to demonstrate, the member must meet specifications in each of the six dimensions (for very detailed information, please see ASAM, pp. 254 – 259):[6]

- Dimension 1: No signs or symptoms of withdrawal, or withdrawal needs can be managed at the 3.5 LOC.
- Dimension 2: Must meet one of the following: a or b.
- Dimension 3: If any medical conditions are present, must meet a, and one of b, or c, or d, or e, or f.
- Dimension 4: Must meet at least one of the following: a, or b, or c, or d, or e, or f, or g.
- Dimension 5: Must meet at least one of the following: a, or b, or c, or d, or e, or f.
- Dimension 6: Must meet at least one of the following: a, or b, or c, or d, or e.

5.2.4 Utilization Review Process/Decision-Making

Unless the provider notified a utilization reviewer through a "call back," there was no activity or outreach on the case. When following a case, the utilization reviewer may not have received a "call back" from a provider on the due date of review. There was no documented outreach performed and the case was closed. One of the guiding principles of ASAM includes "focusing on treatment outcomes."[7]

It appears that few cases are taken to a physician for consultation related to LOC questions, medications, or quality of care issues. A policy and procedure was not included in the interrogatories outlining the expectations of when a utilization reviewer should involve an internal physician. Examples include:

- One member was admitted to (WM) detox on three occasions within a short period of time. There was no consult with the Carrier's physician related to clinical, care nor was there discussion related to MAT.
- One member was approved for 3.5 WM with a withdrawal history of seizures, liver involvement, and hypertension. By documented history, a 4.0 WM LOC would have been the appropriate LOC. There was no documented consultation with the Carrier's physician. After three days at this LOC, the member experienced severe medical problems and was transferred to a medically managed LOC within a hospital setting.

Specific use of ASAM Dimension 1, expanded information, may have helped to identify the correct level of WM.

- One member had two recent inpatient mental health admissions for bipolar disorder. Documentation was sparse related to this member's mental health treatment and progress over time. It was unclear if the needed medications were prescribed. There was no documented consultation with the Carrier's physician. This is pertinent within Dimension 3.
- One member had serious medical issues on Dimension 2, including insulin-dependent diabetes, history of stroke, history of pancreatic surgery, and a recent weight loss of 40 pounds. There was no documented evidence of ongoing monitoring of blood sugar levels or A1C levels (a measure of blood sugar control). A utilization reviewer documented that the member had been overeating on the treatment unit. There was no documented consultation with the Carrier's physician to review this case. The member had been in RTC and stepped down to a partial hospital program.

It was not evident that utilization reviewers actively queried providers related to member treatment options, particularly with MAT, an evidence-based practice. There was no documented evidence that for specific relevant members, MAT may have been a critical treatment option, given the history of a member's OUD. There was also no evidence that a utilization reviewer sought an internal consultation from a physician in terms of MAT (Opioid Treatment Services).[8]

There were few opportunities where a utilization reviewer posed questions or follow-up related to family involvement, probation/parole involvement, or housing. Using elements of Dimension 6 is critical to member recovery. There was often cursory information documented concerning family, significant other, or recovery supports.

- A utilization reviewer addressed Dimension 6, documenting that the member is not permitted to return home. There was no description of the family and no follow-up to determine behaviors leading to family alienation. A family meeting was scheduled, but there was no follow-up inquiry by the utilization reviewer.
- A member had been stepped down to the IOP LOC from residential. There was no evidence of documentation related to the member's work history. After several weeks, it was noted on the final IOP review that the member worked in a bar. There was no discussion of recovery supports available to the member, AA/NA, or any attempt at continued OP treatment.

Two members were referred to case management per NHHIX policy. One member was unable to be located in the database. There was no documented feedback or coordination once the referrals were made.

Clinical information and documentation of member assessments are captured during reviews; however, a clinical template that drives ASAM discussion related to the six dimensions and risk associated with each dimension may be helpful to utilization reviewers in determining ASAM MNC related to LOC appropriate to the member.

Table 2: Authorizations

Authorizations						
LOC Documented	**Number of Reviews**	**Percentage Meeting ASAM Criteria**	**LOC Indicated**	**LOC Authorized**	**Unclear LOC**	**Comments**
Detox; Hospital Detox; Inpatient Detox; S-1 Detox	6	100% met criteria for WM based upon clinical presentation.	4.0 or 3.7 WM	Detox; Hospital Detox; Inpatient Detox; S-1 Detox	6	All cases met criteria for higher LOC WM. Due to naming convention, unable to differentiate between medically monitored or medically managed WM LOC.
4.0	3	100% met criteria for WM at a lower level of WM.	Three members met criteria for 3.7 WM.	Three members were authorized 4.0.		Three members were authorized for LOC 4.0; based upon clinical presentation and documentation, members could have been managed in 3.7 WM.
Rehab Subacute Detox; Residential Detox; Rehab With Detox Protocol; SA Detox, Residential; RTC Detox	12	0%		Rehab subacute detox; Residential detox; rehab with detox protocol; SA Detox, residential; RTC detox	11	Unable to differentiate among the LOC and if LOC met 3.7 WM or 3.2 WM in a 3.5 residential setting. There are differences in level of staff, staffing requirements, and milieu intensity among these LOC.

Authorizations						
LOC Documented	**Number of Reviews**	**Percentage Meeting ASAM Criteria**	**LOC Indicated**	**LOC Authorized**	**Unclear LOC**	**Comments**
			One member met criteria for 3.7 WM or 4.0.	One member was authorized for 3.5 WM.		One member met criteria for higher level of WM related to medical history and needed a higher intensity related to medically managed or medically monitored WM.
3.7 WM	11	100%	3.7 WM	3.7 or 3.7 detox		All met criteria for 3.7 WM. The documentation clearly identified detox as the preferred LOC; however, the utilization reviewer may not have identified the WM when authorizing.
3.7						3.7 may be reflected within the line below in the various levels of residential or rehab. Both 3.7 and 3.5 are offered in the network as evidenced in prior reviews.
Residential; RTC; Residential Rehab; RTC Rehab; RTC Residential; SA Residential; SA Rehab	18	0%	3.5 or 3.7	Residential; RTC; Residential Rehab; RTC Rehab; RTC Residential; SA Rehab	18	All cases met LOC consistent with 3.5 or 3.7. Due to naming convention, unable to differentiate among these LOC.
			One denial for RTC.	One recommendation for 2.5 (as a result of the denial).		One member was denied residential care and partial was recommended. Member met criteria for residential at 3.5, although the 2.5 LOC was authorized with overnight boarding.
3.5	8	100% met criteria for 3.5.				

Authorizations						
LOC Documented	**Number of Reviews**	**Percentage Meeting ASAM Criteria**	**LOC Indicated**	**LOC Authorized**	**Unclear LOC**	**Comments**
3.5 WM	2	0% The level of WM is unclear.	3.2 WM or 3.7 WM	3.5 WM	2	Unable to determine if these cases are 3.7 WM or 3.2 WM. There is no ASAM 3.5 WM; this may mean that 3.2 WM was delivered in a 3.5 residential setting, which is acceptable practice.
2.5	30	96.6%	One denial for RTC.	One denial resulted in recommendation for 2.5.		One member was denied residential care and partial was recommended. Member met criteria for residential, although the 2.5 LOC was authorized with overnight boarding (as above).
2.1	32	96.8%	One member met criteria for 3.5.	One member authorized for IOP rather than 3.5.		One member met criteria for residential care at 3.5. IOP was authorized.
1.0	4	100% appropriate step-down to outpatient.				
Not Reviewed/Not Counted in Total Reviews	5	Errors in data submission				

5.2.5 Denials

Utilization reviewers referred three cases to the Carrier's physician, who denied the LOC requested. The physician appropriately used ASAM in two of the denial determinations. In one denial, the request was for residential care. It was unclear if the physician used ASAM in the clinical denial for residential treatment. Residential does not require that a member have a diagnosed physical health problem on Dimension 2, nor a formal mental health diagnosis on Dimension 3, in order to be treated within a residential program.

Table 3: Denials

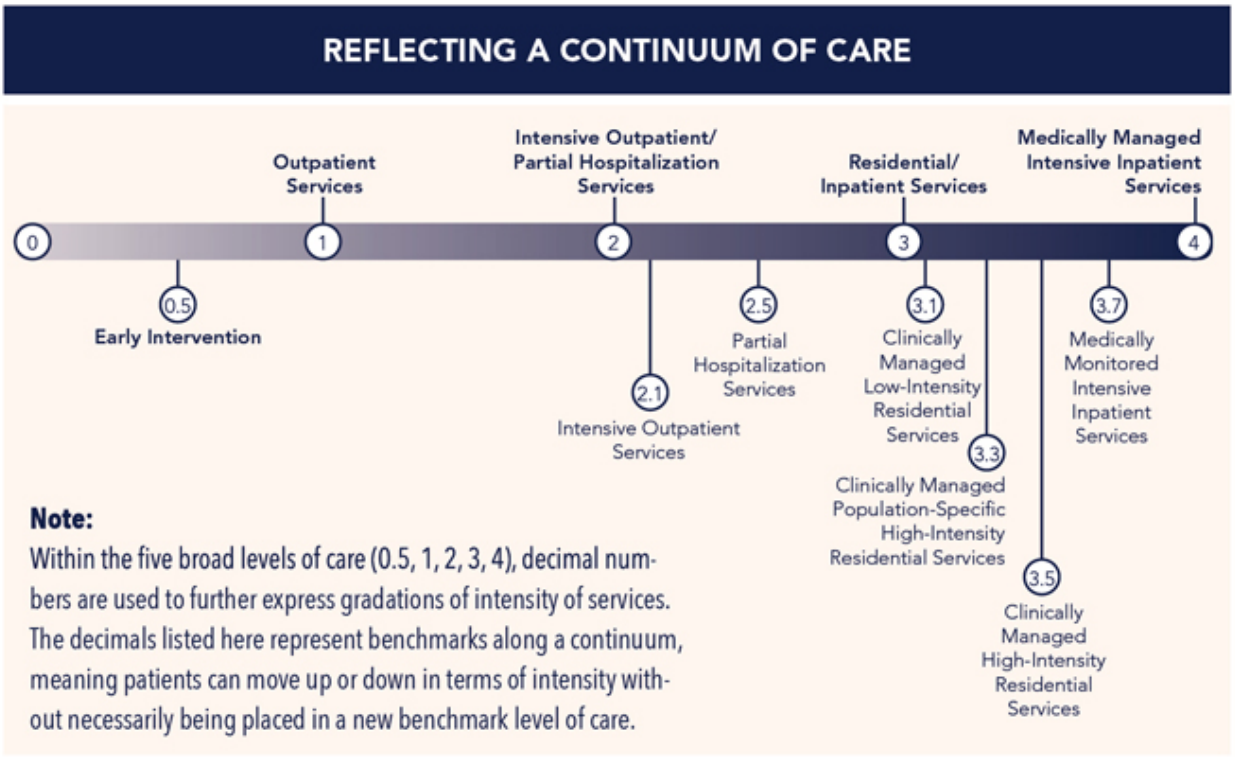
Denials					
LOC	**Total**	**Physician Review**	**Appropriate Documentation of ASAM?**	**Full/Partial Denial**	**Correct Application of ASAM**
RTC	1	Yes	No	Full	No
2.5	2	Yes	Yes	Full	Yes

6.0 Conclusion

Although BerryDunn's review found that the Carrier utilizes ASAM, the Carrier's utilization reviewers frequently apply the criteria incorrectly. The review supports additional clinical staff training of all the LOC and dimensions would be helpful. Furthermore, utilization reviewers should be encouraged to consult with Carrier physicians for more complex cases, and take a more active role in collecting missing information and following up as appropriate on information gathered during the multidimensional assessment. A clinical template that drives ASAM discussion related to the six dimensions and risk associated with each dimension would be helpful to utilization reviewers in determining ASAM MNC related to LOC appropriate for the member. Throughout the utilization review/prior authorization process, the Carrier should ascertain that standard ASAM terminology is used to facilitate proper placement of members, and that the ASAM process is used throughout the treatment episode to maximize the chances of supporting the member to recovery.

Appendix A: The Six Dimensions of Multidimensional Assessment[9]

Appendix B: ASAM Continuum of Care[10]



Appendix C: Acronyms

ASAM – American Society of Addiction Medicine

IOP – Intensive Outpatient

IP – Inpatient

IRR – Inter-rater Reliability

LOC – Level of Care

MAT – Medication Assisted Treatment

MNC – Medical Necessity Criteria

OP – Outpatient

OUD – Opioid Use Disorder

SUD – Substance Use Disorder

WM – Withdrawal Management

Endnotes

[1] NH Rev Stat § 420-J:16 (2016). http://www.gencourt.state.nh.us/rsa/html/xxxvii/420-j/420-j-mrg.htm.

[2] American Society of Addiction Medicine. Resources. What is the ASAM Criteria? Accessed 1 November 2018: https://www.asam.org/resources/the-asam-criteria/about.

[3] NH Rev Stat § 420-J:15-18 (2016). http://www.gencourt.state.nh.us/rsa/html/xxxvii/420-j/420-j-mrg.htm.

[4] Mee-Lee D, Shulman GD, Fishman MJ, Gastfriend DR, Miller MM, eds. The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions. 3rd ed. Carson City, NV: The Change Companies®; 2013.

[5] Mee-Lee D, et al., pp. 254-259.

[6] Mee-Lee D, et al., pp. 254-259.

[7] Mee-Lee D, et al., p.3.

[8] Mee-Lee D, et al., pp. 290-298.

[9] American Society of Addiction Medicine. Resources. What is the ASAM Criteria? Accessed 1 November 2018: https://www.asam.org/resources/the-asam-criteria/about.

[10] American Society of Addiction Medicine. Resources. What is the ASAM Criteria? Accessed 1 November 2018: https://www.asam.org/resources/the-asam-criteria/about.