

NEW HAMPSHIRE INSURANCE DEPARTMENT
MARKET CONDUCT TARGETED EXAMINATION

OF

CELTIC INSURANCE COMPANY, NAIC #80799

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CHICAGO, ILLINOIS 60601

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

REGARDING MENTAL HEALTH PARITY AND SUBSTANCE USE DISORDER BENEFIT TREATMENTS

DOCKET NO. INS 17-045-MC



FINAL

AS OF

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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 Celtic Insurance Company’s (hereinafter, “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 Med/Surg 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 Company’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;
- 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.

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.

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 (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 ASAM criteria and provider reimbursement methodology and rates.

Phase I

On February 12, 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 included:

Segment (IND, SG, LG)	Product – 2016	FFM Membership Dec 2016	PAP Membership Dec 2016
IND	Ambetter Secure Care - 75841NH0090001-01	2	0
IND	Ambetter Balanced Care 8 - 75841NH0090002-01	3	0
IND	Ambetter Balanced Care 8 - 75841NH0090002-04	0	0
IND	Ambetter Balanced Care 8 - 75841NH0090002-05	6	0
IND	Ambetter Balanced Care 8 - 75841NH0090002-06	3	0
IND	Ambetter Balanced Care 8 - 75841NH0090002-32	0	13,109
IND	Ambetter Balanced Care 8 - 75841NH0090002-36	0	4,111
Totals		14	17,220

Segment (IND, SG, LG)	Product – 2017	FFM Membership Dec 2017	PAP Membership Dec 2017
IND	Ambetter Secure Care - 75841NH0090001-01	36	0
IND	Ambetter Balanced Care 8 - 75841NH0090002-01	15	0
IND	Ambetter Balanced Care 8 - 75841NH0090002-04	7	0
IND	Ambetter Balanced Care 8 - 75841NH0090002-05	22	0
IND	Ambetter Balanced Care 8 - 75841NH0090002-06	15	0
IND	Ambetter Balanced Care 8 - 75841NH0090002-32	0	11,882
IND	Ambetter Balanced Care 8 - 75841NH0090002-36	0	3,771
Totals		95	15,653

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, Customary and Reasonable Charges
- Provider Reimbursement
- Grievance and Appeals and Disclosures
- Claims
 - Data and claims manuals
 - Claims Paid (Health and Prescription Drug)
 - Claims Partially Paid (Health)
 - 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

The goals in conducting the Examination 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.
- 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 provider 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 used for medical necessity/utilization reviews 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 20, 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 20, 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, partially paid, denied, and denied with prior authorization
- Med/Surg Health claims – paid, partially 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 referenced Company medical necessity, utilization review/management, prior authorization, and MAT policies while reviewing sample claim files.

COMPANY PROFILE

Celtic Insurance Company is domiciled in the state of Illinois. Celtic Insurance Company is part of an insurance company holding system, and its ultimate parent is Centene Corporation, a Delaware corporation, headquartered in St. Louis, Missouri. Centene Corporation is publicly traded (NYSE: CNC). Celtic Insurance Company is licensed to write individual health insurance in all states, except New York. The Celtic Insurance Company license is currently used to underwrite Qualified Health Plans (hereinafter, “QHPs”) in six (6) states: Arkansas, Florida, Illinois, Missouri, New Hampshire and Texas.

In New Hampshire, Celtic Insurance Company holds an accident, health and life license to write preferred provider organization (hereinafter, “PPO”) or exclusive provider organization (hereinafter, “EPO”) products. Celtic Insurance Company currently underwrites the Ambetter from New Hampshire Healthy Families health insurance marketplace/QHP product in New Hampshire, which is an EPO product, with its operations generally managed by New Hampshire Healthy Families, an affiliated entity of Celtic Insurance Company.

The Companies’ Financial Statements reflect the following information:

<i>Re: Celtic Insurance Company</i>	2016	2017
NH Covered Lives	17,239	15,533
Admitted Assets	\$593,029,861	\$1,170,369, 701
Liabilities	\$539,777,964	\$1,007,868,305

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 two (2) exceptions in terms of inclusion of 2/3 substantially all requirements under parity procedures. Please refer to *Examination Details and Findings* section for additional information.

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. However, the examiners found two (2) exceptions in terms of the inconsistent language in formularies, schedule of benefits (hereinafter, “SOB”) and internal prescription drug policies as related to prior authorizations (hereinafter, “PA”). Please refer to the *Examination Details and Findings* section for additional information.

Complaints:

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

Discriminatory Benefit Designs:

The examiners found two (2) exceptions in terms of Discriminatory Benefit Designs under parity procedures. Specifically, the Evidence of Coverage (hereinafter, “EOC”) for both 2016 and 2017 excluded treatment/services due to self-harm injury. Please refer to the *Examination Details and Findings* section for additional information.

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. However, the examiners found one (1) exception in terms of Network Design in general regarding the Company’s EPO product. Additionally, the examiners found one (1) exception in terms of Network Design in general regarding balance billing language in the Company’s filing and member materials. Please refer to *Examination Details and Findings* for additional information regarding balance billing language and balance billing appeals.

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.

The examiners found no exceptions in terms of Provider Reimbursement rates under parity procedures.

Grievance and Appeals:

The examiners found no exceptions in terms of inclusion of Grievance and Appeals under parity procedures. However, the examiners found fifteen (15) exceptions in Med/Surg appeals related to balance billing (e.g., allowing balance billing, requiring that members file written requests for assistance in order to receive assistance and potential resolution, and unfair claim settlement practices). Additionally, the examiners found two (2) exceptions in general in terms of Grievances and Appeals for failure to include the Department’s mailing address and telephone number on explanation of benefit (hereinafter, “EOB”) statements with adverse benefit determinations. 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. However, the examiners found nineteen (19) exceptions in terms of MH/SUD health claims paid under claim handling procedures. Specifically, the maximum-out-of-pocket (hereinafter, “MOOP”) accumulators associated with the claims were insufficient (18 exceptions), and the Company exceeded the MOOP accumulator cap resulting in member overcharge (1 exception). Please refer to *Examination Details and Findings* for additional information.

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

MH/SUD Total Universe Population	192,602
Med/Surg Total Universe Population	601,837

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	7	0
In-patient/Out-of-Network	3	0
Out-patient/In-Network	98	17
Out-patient/Out-of-network	0	1
Emergency Services	1	7
Prescription Drug Services	0	0

Samples: HEALTH CLAIMS PARTIALLY PAID

The examiners found one (1) exception in terms of MH/SUD health claims partially paid under parity procedures. Specifically, the Company imposed a visit limitation for group psychotherapy, but also failed to provide adequate provider outreach and education regarding billing for psychotherapy. Additionally, the examiners found one (1) exception

in terms of MH/SUD health claims partially paid under claim handling procedures. Specifically, there was a MOOP accumulator overcharge. Please refer to *Examination Details and Findings* for additional information.

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

MH/SUD Total Universe Population	12,275
Med/Surg Total Universe Population	100,639

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	0	0
Out-patient/In-Network	105	16
Out-patient/Out-of-network	1	1
Emergency Services	0	8
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 three (3) exceptions in terms of MH/SUD health claims denied under claim handling procedures. Specifically, accumulator overcharge occurred (1 exception); denial due to internal payment configuration error for reimbursement rate (1 exception); and a high number of duplicate claims (1 exception). Please refer to the *Examination Details and Findings* section for additional information.

The examiners found three (3) exceptions in terms of Med/Surg claims denied under claim handling procedures. Specifically, denial due to internal payment configuration error associated with incorrect provider affiliation selection (1 exception); denial due to internal payment configuration error associated with PAs not migrating to the claim processing system (1 exception); and denial due to incorrect determination of provider appeal/reconsideration (1 exception). Please refer to the *Examination Details and Findings* section for additional information.

MH/SUD Total Universe Population	50,638
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Med/Surg Total Universe Population	218,186
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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	2	3
In-patient/Out-of-Network	1	1
Out-patient/In-Network	90	7
Out-patient/Out-of-network	16	9
Emergency Services	0	5
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. However, the examiners found twenty (20) exceptions in terms of MH/SUD health claims denied with prior authorization under claim handling procedures. Specifically, denial due to internal payment configuration error associated with denial code EX 4B (9 exceptions); a high number of duplicate claims (1 exception); claims reprocessed under a new claim number due to internal payment configuration error associated with incorrect provider affiliation selection (8 exceptions; and volume claim settlement practices with providers (1 exception). Please refer to the *Examination Details and Findings* section for additional information.

The examiners found two (2) exceptions in terms of Med/Surg claims denied with prior authorization under claim handling procedures. Specifically, the Company denied claims due to incorrect determination of provider appeal/reconsideration. Please refer to the *Examination Details and Findings* section for additional information.

MH/SUD Total Universe Population	1,995
Med/Surg Total Universe Population	16,297

MH/SUD Health Sample Size	105
Med/Surg Health Sample Size	25

Claim type	MH/SUD Sample Size	Med/Surg Sample Size
In-patient/In-Network	63	9

In-patient/Out-of-Network	21	3
Out-patient/In-Network	15	6
Out-patient/out-of-network	6	7
Emergency Services	0	0
Prescription Drug Services	0	0

Samples: PRESCRIPTION DRUG CLAIMS PAID

The examiners found eight (8) exceptions in terms of MH/SUD prescription drug claims paid under parity procedures. Specifically, the Company required a prior authorization for SUD prescription drugs. The examiners found no exceptions in terms of MH/SUD prescription drug claims paid under claim handling procedures. Please refer to the *Examination Details and Findings* section for additional information.

The examiners found nine (9) exceptions in terms of Med/Surg prescription drug claims paid under claim handling procedures. Specifically, the MOOP accumulators associated with the claims were insufficient. Please refer to *Examination Details and Findings* for additional information.

MH/SUD Rx Universe Population	131,788
Med/Surg Rx Universe Population	218,187

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

Samples: PRESCRIPTION DRUG CLAIMS DENIED

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

The examiners found three (3) exceptions in terms of Med/Surg prescription drug claims denied under claim handling procedures. Specifically, the MOOP accumulators associated with the claims were insufficient. Please refer to the *Examination Details and Findings* section for additional information.

MH/SUD Rx Universe Population	17,359
Med/Surg Rx Universe Population	31,164

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 the American Society of Addiction Medicine (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 utilization review process.

Delegated Service Contracts:

The examiners found no exceptions in terms of Delegated Service Contracts under parity procedures.

Medication Assisted Treatment (MAT):

Examiners found ten (10) exceptions in terms of inclusion of Medication Assisted Treatment under parity procedures. The ten (10) 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 April 1, 2017 no longer requiring prior authorizations for MAT medications.

Compliance with Previous Examination Recommendations:

This is the Company's first market conduct examination. Therefore, there were no previous examination 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 forty-eight (48) 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 provided one internal annual audit report completed by Envolve PeopleCare (dated September 7, 2016) and an executive summary of the annual report, both of which examiners reviewed.

Examiner Findings:

Examiners found no exceptions.

Management of Insurance Information and Record Retention:

In determining parity compliance, examiners reviewed the Company's records retention policy and procedure.

Examiner Findings:

Examiners found no exceptions.

Accurate MH/SUD Information Reported to NHID:

In determining parity compliance, examiners reviewed the Company's policy, Financial Report filings for Health Plans with the State DOI and DOM, which outlines the corporate policy for reporting complete and accurate financial statement data quarterly and annually to the NHID.

Examiner Observations:

Ambetter from New Hampshire Healthy Families is underwritten by Celtic Insurance Company, domiciled in Illinois. Therefore, the quarterly and annual financial reports are prepared in accordance with the National Association of Insurance Commissioners (hereinafter, "NAIC") guidance and are submitted to the Illinois Department of Insurance and the NAIC.

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 432 MH/SUD health (ACL sampling methodology), 100 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 evidence of coverage, summary of benefits and coverage (hereinafter, "SBC"), 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 432 MH/SUD health (ACL sampling methodology), 100 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 432 MH/SUD health (ACL sampling methodology), 100 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.

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

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 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 narrative in response to the initial interrogatory, as well as the Company's response to criticism/concern. The Company did not provide any policies or procedures related to quantitative data analysis.

Examiner Observations:

The Company acknowledged in its response to criticism/concern that the Company was not in compliance for 2016, 2017 and 2018 regarding MHPAEA's financial requirements and quantitative treatment limitations analysis.

Examiner Findings:

Examiners found two (2) exceptions (1 exception per policy year) for failure to perform quantitative analysis as required under MHPAEA.

Company Position:

The Company disagreed with all exceptions.

Examiner Recommendations:

The Company has taken corrective action measures by performing actuarial testing and quantitative analysis to ensure compliance with MHPAEA and its associated Final Rules for all plans beginning in the 2019 policy year.

NHID Response:

The Company shall provide the Department with the data and results of the actuarial testing and quantitative analysis, within 90 days of the date of the Final Order.

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

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/>

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 432 MH/SUD health (ACL sampling methodology), 100 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 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 were 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 MH/SUD and Med/Surg, examiners reviewed all of the Company's internal processes for both areas as well as samples of policy language in an 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*

Regulatory Authority

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 are updated at least every two years, and in some circumstances, every year.

Examiner Findings:

Examiners found no exceptions in terms of parity procedures. However, the examiners found two (2) exceptions (1 per policy year) in terms of the inconsistent language in formularies, SOB's and internal prescription drug policies as related to PAs.

Company Position:

The Company disagreed with all exceptions.

Examiner Recommendations:

The Company shall review all internal prescription drug policies to ensure that the internal policies match formulary and SOB language regarding prior authorization. The Company has taken corrective action measures by updating formularies and SOB's for PA policies effective for the 2019 policy year.

Company Response to Verified Draft Report:

The Company will continue to review its internal prescription drug policies for consistency between its internal policies and the formulary and SOB language regarding prior authorization.

NHID Response to Company:

The Department acknowledges that the Company has updated formularies and SOBs for prior authorization policies effective with the 2019 plan year. The Company shall immediately notify the Department of any inconsistencies found during the ongoing review process.

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 telephonic and written complaints by members or a member's representative sent directly to the Company. The Company received thirty-eight (38) complaints in 2016. The Company received twenty-five (25) complaints in 2017.

Examiner Observations:

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 for 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, "There are no denied applicants in the marketplace membership. Applicants who enroll in available plans are not denied coverage. Included with this response is policy and procedure Health Insurance Marketplace/enrollment through the exchange. Please note, there have been no off exchange applications received." Examiners reviewed the Health Insurance Marketplace/enrollment policy and procedure, as well as 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, "Policies and procedures regarding written treatment plans (care plans) for both MH/SUD and Med/Surg treatments include the following: Case Management Program Description and Care Coordination/Case Management Services. Examiners reviewed both policies.

Examination Observations:

The Company refers to written treatment plans as "care plans", and updates care plan policies and procedures at least annually.

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 Company 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. NOTE: Examiners discussed the exceptions for internal prescription drug PA policies above in *Medical Management Standards*.

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 432 MH/SUD health (ACL sampling methodology), 100 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.

Treatment Exclusions:

Testing Methodology:

In determining parity for MH/SUD treatments and services, the examiners reviewed member and marketing material documents, SBCs, EOCs and other plan documents, as well as medical management standards.

Examiner Observations:

The Company excluded treatment/services for injuries resulting from self-harm.

Examiner Findings:

Examiners found two (2) exceptions (1 per policy year).

Company Position:

The Company disagreed with the two (2) exceptions.

Examiner Recommendations:

The Company has taken corrective action measures by removing the self-harm language as an exclusion in Evidence of Coverage materials effective for the 2018 policy year.

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 design, examiners reviewed the Company's narrative response regarding MH/SUD and Med/Surg network adequacy, as well as the Company's network adequacy policy and procedure and Geo Access reports.

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.

Testing Methodology – RIA Review:

In determining parity in provider reimbursement, examiners reviewed the Company's policies and procedures for setting reimbursement rates, as well as fee schedules. The Company explained that it considers factors such as licensure and education to set 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:

CPT	Description
90832	Individual Psychotherapy - 30 minutes
90834	Individual Psychotherapy - 45 minutes
90837	Individual Psychotherapy - 60 minutes
99211	Office or Other OP Service, Established Patient, Minimal Presenting Problems - 5 minutes
99212	Office or Other OP Service, Established Patient, Self-Limited/Minor Problems - 10 minutes
99213	Office or Other OP Service, Established Patient, Low to Moderate Severity Problems - 15 minutes
99214	Office or Other OP Service, Established Patient, Moderate Severity Problems - 25 minutes
99215	Office or Other OP Service, Established Patient, Moderate to High Severity Problems - 40 minutes

Examiner Observations – RIA Review:

While reimbursement rates were relatively low in general, MH/SUD provider rates did not reveal an unexplained disparity compared to Med/Surg provider rates.

Examiner Findings – RIA Review:

Examiners found no exceptions.

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

BerryDunn selected this methodology because Medicare’s method of developing payment methods is resource-based and applies a consistent standard to both MH/SUD

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.

and Med/Surg reimbursement calculations.⁸ 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:

BerryDunn's analysis found that the Company reimburses both MH/SUD and Med/Surg providers at rates lower than Medicare. The Company's weighed average MH/SUD commercial-to-Medicare reimbursement ratio, 0.86, was very similar to the overall weighted average for professional services in the analysis, 0.88. The MH/SUD ratio was similar to those found for Med/Surg primary care and evaluation and management services. Furthermore, the Company's inpatient psychiatric commercial-to-Medicare reimbursement ratio was higher than its acute physical health inpatient reimbursement ratio.

BerryDunn did note as an area of possible MHPAEA violation that provider education/credentialing level appeared to be taken into account for MH/SUD providers, but not for Med/Surg providers.

Company Position:

The Company disagreed with both contract examiners' observations and finding with respect to a differential payment structure for midlevel providers between MH/SUD and Med/Surg. The Company provided a response indicating that its policy regarding specialty, education, and/or licensure reductions is the same for Med/Surg and MH/SUD providers, with midlevel providers including physician assistants, clinical social works, and nurse practitioners paid at 85% of physician levels, and Nutritionists/Registered Dieticians paid at 75% of physician levels.

⁸ By "resource based" BerryDunn means that Medicare rates 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.). BerryDunn noted that all Medicare payment systems are updated annually by the Centers for Medicare and Medicaid Services (CMS) and undergo public comment in Notices of Public Rulemaking before being published in the Federal Register as Final Rules.

Examiner Findings:

Having reviewed the reports of both contract examiners as well as the Company's initial and supplemental responses, the NHID examiners find that the Company's provider reimbursement practices do not violate MHPAEA. Neither RIA's nor BerryDunn's quantitative reviews showed significant disparities between reimbursement levels for Med/Surg and MH/SUD treatment services. Although there initially appeared to be a discrepancy between Med/Surg and MH/SUD services with respect to payment levels for midlevel providers, the NHID examiners are satisfied with the Company's response indicating that the same policies regarding specialty, education and licensure levels apply to both Med/Surg and MH/SUD services.

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 and Med/Surg appeals for 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 and Med/Surg grievance and appeal files during the examination period, which totaled twenty-nine (29) MH/SUD appeals and one hundred twenty-four (124) Med/Surg appeals.

Additionally, examiners requested that the Company provide all appeals and complaints related to balance billing during the examination period. The Company provided complete appeal files for seven (7) appeals and eleven (11) complaints related to balance billing. Examiners reviewed all appeal and complaint files related to balance billing.

Examiner Observations:

The Company established a policy effective December 1, 2017 stating that grievances no longer had to be written in order for the Company to assist members with a possible resolution. EOBs for partially paid and denied services/claims did not include the Department's mailing address and telephone number.

Examiner Findings:

In determining parity in MH/SUD grievances and appeals, examiners found no exceptions. However, examiners found fifteen (15) exceptions for balance billing appeals and complaints under unfair claim settlement practices as a result of failing to pay claims for OON providers at INN facilities. Examiners also found one (1) exception for the Company's failure to include the Department's mailing address and telephone number on EOBs with an adverse benefit determination.

Company Position:

The Company disagreed with the fifteen (15) balance billing appeals exceptions, and agreed with the one (1) exception for failing to include the Department's contact information on EOBs with adverse benefit determinations.

Examiner Recommendations:

The Company shall pay the claims with prompt pay interest in the above-mentioned fifteen (15) sample appeal and complaint files related to balance billing. In light of legislation prohibiting balance billing for certain services in the commercial market, the Company has taken corrective action measures effective July 1, 2018 by creating a procedure outlining member assistance for those members balance billed.

Company Response to Verified Draft Report:

The Company disagrees with the Examiner's first finding and recommendation, because (1) the Company paid the claims prior to the appeal or complaint being filed in accordance with the Company's policies, which had been approved by the Department, (2) the Company made multiple attempts to contact the affected members by letters and telephone in an attempt to collect and/or advise of the information necessary for the Company to address the appeal or complaint, and (3) both members and providers were informed at all times of the process and procedures for submitting complaints, grievances and appeals. The Company acknowledges that it has implemented additional measures to assist members who are improperly balanced billed.

NHID Response to Company:

The Department acknowledges the Company's rebuttal, but declines to modify its finding. When the Department approved the form language pertinent to this finding, the form reviewer stated that use of this language might constitute an unfair trade practice. The confusion that existed as to whether the Company's product was an HMO was

significant in the context of balance billing, because New Hampshire’s HMO law, RSA chapter 420-B, contains additional protections against balance billing, which were in effect even prior to enactment of New Hampshire’s balance billing law, 2018 N.H. Laws chapter 356. Confusion over the nature of the product hampered the Department’s ability to assist consumers who experienced balanced billing.

The Company shall provide the Department with a corrective action plan within 90 days of the date of the Final Order, which addresses the missing NHID contact information on EOBs that include adverse benefit determinations.

The Company shall provide the Department with a corrective action plan within 60 days of the date of the Final Order, that includes, but is not limited to, the identification of all consumers who may have been balance billed during the examination period, and steps for remediation.

Plan/Product Type:

Testing Methodology:

Examiners reviewed EOCs, SBCs, other plan documents, and member and marketing materials, as well as sample claim files to better understand the EPO product that the Company filed with the Department and offers to consumers.

Examiner Observations:

The EPO product operates like an HMO due to its extensive PA system, but also due to “HMO” being referenced in the claim processing system and on provider explanation of payment (hereinafter, “EOP”) statements for type of plan/product, as well as company correspondence including the “NH Healthy Families” title and/or signature block. NH Healthy Families administers the Medicaid/HMO product.

Examiner Findings:

Examiners found one (1) exception under unfair trade practices.

Company Position:

The Company disagreed with the one (1) exception.

Examiner Recommendations:

Ambetter from NH Healthy Families (EPO) and NH Healthy Families (Medicaid/HMO) are two separate and distinct products. The Company shall ensure that its EPO product is

distinctive from an HMO product, and that all Ambetter from NH Healthy Families policies, procedures, systems, and correspondence reflect an EPO product.

Company Response to Verified Draft Report:

The Company acknowledges that the Medicaid HMO product known as NH Healthy Families is separate and distinct from the Company's EPO product known as Ambetter from NH Healthy Families. The Ambetter from NH Healthy Families product is an EPO product and it is administered as an EPO product. An EPO product is expressly permitted by New Hampshire law to include prior authorization requirements. N.H. Rev. Stat. 420-J:3, V; 420-J:3, XXVIII-b. The incorrect references to "HMO" on certain materials were a minor oversight, which have been/will be corrected, and does not change an EPO product into an HMO product, or misrepresent the nature of the EPO product.

NHID Response to Company:

The Department acknowledges the Company's rebuttal, but declines to modify its finding. As noted above, the confusion that existed as to whether the Company's product was an HMO was significant in the context of balance billing, because New Hampshire's HMO law, RSA chapter 420-B, contains additional protections against balance billing, which were in effect even prior to enactment of New Hampshire's balance billing law, 2018 N.H. Laws chapter 356. Confusion over the nature of the product hampered the Department's ability to assist consumers who experienced balanced billing.

Balance Billing:

Testing Methodology:

Examiners reviewed EOCs, summary of benefits and coverage SBCs, other plan documents, and member and marketing materials, as well as sample claim files to better understand the EPO product that the Company filed with the Department and offers consumers.

Examiner Observations:

Plan documents and member materials include language stating that even if members receive a PA for in-network services, members must check that all providers are in-network prior to receiving service/treatment, otherwise the member may be responsible for charges from out-of-network providers. The Company's filing includes this language as well, which the Department warned the Company might constitute an unfair trade practice at the time the filing was approved.

Examiner Findings:

The examiners found no exceptions under parity procedures. However, examiners found one (1) exception under unfair trade practices.

Company Position:

The Company disagreed with the one (1) exception.

Examiner Recommendations:

The Company shall remove all language allowing balance billing from member materials.

Company response to Verified Draft Report:

The Company is aware that as of July 1, 2018, balance billing in the commercial insurance market is prohibited for certain services provided by out-of-network providers at an in-network facility. Since the regulation has become effective, the Company has removed all language allowing balance billing for these services from member materials and implemented additional measures to assist members who are improperly balanced billed.

NHID Response to Company:

The Department acknowledges the Company's rebuttal, but declines to modify its finding. When the Department approved the form language pertinent to this finding, the form reviewer stated that use of this language might constitute an unfair trade practice. The confusion that existed as to whether the Company's product was an HMO was significant in the context of balance billing, because New Hampshire's HMO law, RSA chapter 420-B, contains additional protections against balance billing, which were in effect even prior to enactment of New Hampshire's balance billing law, 2018 N.H. Laws chapter 356. Confusion over the nature of the product hampered the Department's ability to assist consumers who experienced balanced billing.

As noted above, the Department is requiring that the Company provide a corrective action plan within 60 days of the date of the Final Order, that includes, but is not limited to, the identification of all consumers who may have been balance billed during the examination period, and steps for remediation.

Claims:

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

Testing Methodology:

In determining parity in claim handling processes, 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 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	192,602
Med/Surg Total Universe Population	601,837

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	7	0
In-patient/Out-of-Network	3	0
Out-patient/In-Network	98	17
Out-patient/Out-of-network	0	1
Emergency Services	1	7
Prescription Drug Services	0	0

Examiner Findings:

The examiners found no exceptions in terms of MH/SUD health claims paid under parity procedures. However, the examiners found nineteen (19) exceptions in terms of MH/SUD health claims paid under claim handling procedures. Specifically, the maximum-out-of-pocket (hereinafter, “MOOP”) accumulators associated with the

claims were insufficient (18 exceptions), and the Company exceeded the MOOP accumulator cap resulting in member overcharge (1 exception).

The examiners found one (1) exception in terms of Med/Surg health claims paid under claim handling procedures. Specifically, the Company failed to pay claims in a timely manner.

Company Position:

The Company disagreed with all of the exceptions.

Examiner Recommendations:

The Company shall ensure that MOOP accumulators include sufficient information in order to recreate a claim and to properly track cost-sharing. The Company shall also ensure that cost-sharing amounts are properly applied to MOOP accumulators to avoid exceeding the maximum out-of-pocket cap.

The Company shall verify that the provider was paid prompt pay interest for claim received 2/9/16 and paid 3/10/2016.

Company Response to Verified Draft Report:

The claim was adjusted on 7/24/2017 and paid on 7/27/2017 with the appropriate prompt pay interest.

NHID Response to Company:

The Department acknowledges that the Company has confirmed that the provider was paid prompt pay interest for the claim received 2/9/16 and paid on 3/10/16.

The Department understands that quarterly MOOP requirements were associated with the premium assistance program, which expired on 12/31/18. The Company shall provide the Department with sufficient detail to demonstrate that system adjustments addressed all claims within scope of the examination period, and that the current MOOP calculations are accurate for commercial membership.

The Company shall provide evidence to the Department that the MOOP accumulator overcharge was corrected.

Samples: HEALTH CLAIMS PARTIALLY PAID

MH/SUD Total Universe Population	12,275
Med/Surg Total Universe Population	100,639

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	0	0
Out-patient/In-Network	105	16
Out-patient/out-of-network	1	1
Emergency Services	0	8
Prescription Drug Services	0	0

Examiner Findings:

The examiners found one (1) exception in terms of MH/SUD health claims partially paid under parity procedures. Specifically, the Company imposed a visit limitation for group psychotherapy, but also failed to provide adequate provider outreach and education regarding billing for psychotherapy. Additionally, the examiners found one (1) exception in terms of MH/SUD health claims partially paid under claim handling procedures. Specifically, there was a MOOP accumulator overcharge.

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

Company Position:

The Company disagreed with all exceptions. The Company provided additional information in support of denying more than one unit of CPT code 90853 (group psychotherapy) per day, but examiners did not agree with the Company's supporting documentation and explanation.

Examiner Recommendations:

The Company shall pay the claim with prompt pay interest, and ensure that providers receive the appropriate outreach and education regarding claims submission.

The Company has taken corrective action measures by refunding the member the accumulator overcharge.

Company Response to Verified Draft Report:

The Company disagrees with the Examiners' findings and recommendations regarding the denial of more than one unit of CPT code 90853 (group psychotherapy) per day. The denial of the claim was not due to a quantitative treatment limitation, but instead due to

incorrect coding of the claim, as demonstrated by the screen clip of the CMS Medicare NCCI Practitioner Medically Unlikely Edits table previously submitted to the Department. In order to bill and be reimbursed for the particular CPT code more than once per day, which would be a rare occurrence, a modifier -59 (distinct procedures/services not normally reported together) must be included with the CPT code for the second session. A description of modifier -59 and guidance on its appropriate use are set forth in the Provider Manual to educate and aid providers (see page 46 of the November 2, 2015 Manual). The Company cannot add a missing modifier or otherwise change incorrect coding on a claim it receives, but must apply its reimbursement guidelines in accordance with industry standards.

NHID Response to Company:

The Department agrees with the Company characterization of this claim, in that the CPT code of 90853 is defined by the Centers for Medicare and Medicaid Services (“CMS”) as a Medically Unlikely Edit (“MUE”) with a service value of “1”. Further, it appears that the denial of the second service billed for November 16, 2016 is an anomalous situation as opposed to a company practice.

The Company shall provide the Department with data and information sufficient to support our conclusion that this was an atypical occurrence.

The Department continues to feel that the Company should provide additional provider outreach and education regarding appropriate billing practices.

Samples: HEALTH CLAIMS DENIED

MH/SUD Total Universe Population	50,638
Med/Surg Total Universe Population	218,186

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	2	3
In-patient/Out-of-Network	1	1
Out-patient/In-Network	90	7
Out-patient/out-of-network	16	9
Emergency Services	0	5
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 three (3) exceptions in terms of MH/SUD health claims denied under claim handling procedures. Specifically, accumulator overcharge occurred (1 exception); denial due to internal payment configuration error for reimbursement rate (1 exception); and a high number of duplicate claims (1 exception).

The examiners found three (3) exceptions in terms of Med/Surg claims denied under claim handling procedures. Specifically, denial due to internal payment configuration error associated with incorrect provider affiliation selection (1 exception); denial due to internal payment configuration error associated with PAs not migrating to the claim processing system (1 exception); and denial due to incorrect determination of provider appeal/reconsideration (1 exception).

Company Position:

The Company disagreed with all exceptions.

Examiner Recommendations:

The Company shall pay the claims with the appropriate prompt pay interest for the provider appeal/reconsideration and internal payment configuration error exceptions.

The Company shall pay claims in a timely manner, and provide the necessary and appropriate provider outreach and education to avoid providers resubmitting claims multiple times to seek payment.

The Company shall ensure that its claim processing system is set up correctly to avoid system configurations errors such as the system selecting the incorrect provider affiliation resulting in claim denial, PAs not migrating to the claims processing system and incorrect reimbursement rate.

The Company has taken corrective action measures by refunding the member the accumulator overcharge.

Company Response to Verified Draft Report:

The Company will pay the claims with the appropriate prompt pay interest for the provider appeal/reconsideration and internal payment configuration error exceptions and ensure that its claim processing system is set up to avoid these system configuration errors.

NHID Response to Company:

The Company shall provide evidence to the Department that it has paid the claims, with the appropriate interest, for the provider appeal/reconsideration and internal payment configuration error exceptions.

The Company shall provide the Department with a detailed corrective action plan, within 90 days of the date of the Final Order, which will include, but not be limited to, process and procedure changes, specific system changes, quality assurance testing plans, and audits relative to the system configuration errors identified.

The Company shall provide the Department with data and information regarding duplicate claims, including but not limited to volume, frequency, and provider specialty.

Samples: HEALTH CLAIMS DENIED WITH PRIOR AUTHORIZATION

MH/SUD Total Universe Population	1,995
Med/Surg Total Universe Population	16,297

MH/SUD Health Sample Size	105
Med/Surg Health Sample Size	25

Claim type	MH/SUD Sample Size	Med/Surg Sample Size
In-patient/In-Network	63	9
In-patient/Out-of-Network	21	3
Out-patient/In-Network	15	6
Out-patient/Out-of-network	6	7
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. However, the examiners found twenty (20) exceptions in terms of MH/SUD health claims denied with prior authorization under claim handling procedures. Specifically, denial due to internal payment configuration error associated with denial code EX 4B (9 exceptions); a high number of duplicate claims (1 exception); claims reprocessed under a new claim number due to internal payment configuration error associated with incorrect provider affiliation selection (8 exceptions); and volume claim settlement practices with providers (1 exception).

The examiners found two (2) exceptions in terms of Med/Surg claims denied with prior authorization under claim handling procedures. Specifically, the Company denied claims due to incorrect determination of provider appeal/reconsideration.

Company Position:

The Company disagreed with all exceptions.

Examiner Recommendations:

The Company shall pay claims in a timely manner, and provide the necessary and appropriate provider outreach and education to avoid providers resubmitting claims multiple times to seek payment and/or volume claim settlement.

The Company shall ensure that its claim processing system is set up correctly to avoid system configurations errors.

The Company shall pay the claim with prompt pay interest associated with the provider appeal/reconsideration.

The Company has taken corrective action measures by correcting the EX 4B configuration error in July 2016 and paying all claims prior to July 2016 that denied due to the EX 4B system configuration error.

Company Response to Verified Draft Report:

The Company disagrees with the Examiner's findings regarding claim volume settlement practices, the Company strives to pay claims in a timely manner. When the Company does not meet the timeliness requirements, the Company will pay interest in accordance with applicable law. In addition, provider outreach and education are provided by the Company when billing issues or trends that impact claims payment are identified. In some cases, the education may result in a corrected billing situation or settlement should the situation call for it. Adjustments and settlements are a common industry claims processing practice. Adjustments can be the result of claims being denied for additional information, such as an explanation of benefits, or corrected billing by a provider, while settlements are used on exception basis. On the unique and rare occasions when claims are resolved through a settlement process, it is done in good faith and in collaboration with the provider on claims in which liability has been determined and agreed upon by both parties.

The Company will pay the claim with the appropriate prompt pay interest for the provider appeal/reconsideration.

NHID Response to Company:

The Company shall provide evidence to the Department that it has paid the claims, with the appropriate interest, for the provider appeal/reconsideration and internal payment configuration error exceptions.

The Company shall provide the Department with a detailed corrective action plan, within 90 days of the date of the Final Order, which will include, but not be limited to, process and procedure changes, specific system changes, quality assurance testing plans, and audits, relative to the system configuration errors.

The Company shall provide the Department with data and information regarding claim settlement practices, including but not limited to volume, frequency, and provider specialty.

The Company shall provide the Department with data and information regarding duplicate claims, including but not limited to volume, frequency, and provider specialty.

Samples: PRESCRIPTION DRUG CLAIMS PAID

MH/SUD Rx Universe Population	131,788
Med/Surg Rx Universe Population	218,187

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 eight (8) exceptions in terms of MH/SUD prescription drug claims paid under parity procedures. Specifically, the Company required a prior authorization for SUD prescription drugs. The examiners found no exceptions in terms of MH/SUD prescription drug claims paid under claim handling procedures.

The examiners found nine (9) exceptions in terms of Med/Surg prescription drug claims paid under claim handling procedures. Specifically, the MOOP accumulators associated with the claims were insufficient.

Company Position:

The Company disagreed with all exceptions.

Examiner Recommendations:

The Company shall ensure that MOOP accumulators include sufficient information in order to recreate a claim and to properly track cost-sharing.

The Company shall ensure that cost-sharing amounts are properly applied to MOOP accumulators to avoid exceeding the maximum out-of-pocket cap.

The Company has taken corrective action measures by implementing a policy effective April 1, 2017 no longer requiring PAs for MAT/SUD drugs.

Company Response to Verified Draft Report:

The Company disagrees with the Examiner's findings regarding the exceptions for MH/SUD prescription drug claims under the parity procedures, because prior authorization, in general, is required for medications that pose a risk of addiction, diversion, and abuse. The requirements for the prior authorization process are based on medical evidence and are uniformly applied across a broad range of MH/SUD and Medical/Surgical services. Prior to removal of the prior authorization process in 2017, the Company applied the process to a specific medication regardless of whether it was used for MH/SUD or Medical/Surgical benefits. The process was based on the clinical evaluation of the medication in line with practice guidance and evidence-based medicine.

In developing its prior authorization and other medical management techniques, the Company considered a wide array of factors, including recognized medical literature and professional standards and protocols, applied these factors in a comparable fashion between MH/SUD and Medical/Surgical benefits and retained documented evidence to support the development of these techniques. Pursuant to Example 8 of 45 CFR 146.136(c)(4)(iii), under these facts, the Company complies with the rules of 45 CFR 146.136(c)(4): "Under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors considered by the plan in implementing its prior authorization requirement with respect to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those applied with respect to medical/surgical benefits."

The Company acknowledges that the MOOP accumulator has been reconfigured to support quarterly MOOP per state guidelines and that the MOOP accumulators include sufficient information to recreate a claim and properly track cost-sharing. The reconfiguration ensures that cost-sharing amounts are properly applied to MOOP accumulators to avoid exceeding the maximum out-of-pocket cap.

NHID Response to Company:

The Department acknowledges the Company’s rebuttal, but declines to modify its finding. For non-quantitative treatment limitations such as prior authorization requirements, MHPAEA requires that the treatment limits be consistently applied between MH/SUD and Med/Surg, without incorporating more stringent requirements for MH/SUD benefits that would limit or discourage access to treatment. Even if the same requirements apply to use of a particular medication whether in the MH/SUD or Med/Surg context, there may still be a parity violation if the prior authorization requirement, as applied, has the effect of limiting access to treatment in a way that is more stringent for MH/SUD services.

Given that the primary use of the prescription drugs in question is to treat addiction, and that use of these drugs in the Med/Surg context is limited, the Department finds this practice imposes more stringent requirements on access to MH/SUD services, and therefore violates MHPAEA.

The Department understands that quarterly MOOP requirements were associated with the premium assistance program, which expired on 12/31/18. The Company shall provide the Department with sufficient detail to demonstrate that system adjustments addressed all claims within scope of the examination period, and that the current MOOP calculations are accurate for commercial membership.

Samples: PRESCRIPTION DRUG CLAIMS DENIED

MH/SUD Rx Universe Population	17,359
Med/Surg Rx Universe Population	31,164

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

The examiners found three (3) exceptions in terms of Med/Surg prescription drug claims denied under claim handling procedures. Specifically, the MOOP accumulators associated with the claims were insufficient.

Company Position:

The Company disagreed with all of the exceptions.

Examiner Recommendations:

The Company shall ensure that MOOP accumulators include sufficient information in order to recreate a claim and to properly track cost-sharing.

The Company shall ensure that cost-sharing amounts are properly applied to MOOP accumulators to avoid exceeding the maximum out-of-pocket cap.

The Company has taken corrective action measures by implementing a policy effective April 1, 2017 no longer requiring PAs for MAT/SUD drugs.

Company Response to Verified Draft Report:

The Company disagrees with the Examiner's findings regarding the exceptions for MH/SUD prescription drug prior authorization under the parity procedures. The Company requires prior authorization, in general, for medications that pose a risk of addiction, diversion and abuse. The requirements for the prior authorization process are based on medical evidence and are uniformly applied across a broad range of MH/SUD and Medical/Surgical services. Prior to removal of the prior authorization process in 2017, the Company applied the process for buprenorphine products equally to MH/SUD and Medical/Surgical benefits in compliance with the MHPAEA.

In developing its prior authorization and other medical management techniques, the Company considered a wide array of factors, including recognized medical literature and professional standards and protocols, applied these factors in a comparable fashion between MH/SUD and Medical/Surgical benefits, and retained documented evidence to support the development of these techniques. Pursuant to Example 8 of 45 CFR 146.136(c)(4)(iii), under these facts, the Company complies with the rules of 45 CFR 146.136(c)(4): "Under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards, and other factors considered by the plan in

implementing its prior authorization requirement with respect to mental health and substance use disorder benefits are comparable to, and applied no more stringently than, those applied with respect to medical/surgical benefits.”

The Company acknowledges that the MOOP accumulator has been reconfigured to support quarterly MOOP per state guidelines and that the MOOP accumulators include sufficient information to recreate a claim and properly track cost-sharing. The reconfiguration ensures that cost-sharing amounts are properly applied to MOOP accumulators to avoid exceeding the maximum out-of-pocket cap.

NHID Response to Company:

The Department acknowledges the Company’s rebuttal, but declines to modify its finding. For non-quantitative treatment limitations such as prior authorization requirements, MHPAEA requires that the treatment limits be consistently applied between MH/SUD and Med/Surg, without incorporating more stringent requirements for MH/SUD benefits that would limit or discourage access to treatment. Even if the same requirements apply to use of a particular medication whether in the MH/SUD or Med/Surg context, there may still be a parity violation if the prior authorization requirement, as applied, has the effect of limiting access to treatment in a way that is more stringent for MH/SUD services.

Given that the primary use of the prescription drugs in question is to treat addiction, and that use of these drugs in the Med/Surg context is limited, the Department finds this practice imposes more stringent requirements on access to MH/SUD services, and therefore violates MHPAEA.

The Department understands that quarterly MOOP requirements were associated with the premium assistance program, which expired on 12/31/18. The Company shall provide the Department with sufficient detail to demonstrate that system adjustments addressed all claims within scope of the examination period, and that the current MOOP calculations are accurate for commercial membership.

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 Company’s “Development, Review, Evaluation, and Use of Medical Necessity Criteria” policy and procedure. Additionally, examiners reviewed 432 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 relatively 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 ASAM is used for levels of care other than 4.0 (medically managed intensive inpatient service), for which InterQual criteria are used as it is a hospital-based service requiring medical management; that the Company's policies and procedures do not contain descriptions of the ASAM levels of care and clinical review protocols; and that the policies and procedures do not consistently use precise ASAM language (e.g. "detox" is used rather than "withdrawal management"). Overall, BerryDunn expressed that the policies and procedures reflected generic clinical information to be collected during the prior authorization process, but that the electronic medical record training manual did not support the scope and depth of documentation necessary for full application of the ASAM criteria.

In the file review, BerryDunn observed that the utilization reviewers correctly documented ASAM medical necessity criteria in only 11 of the 93 claims reviewed, and that in 52 reviews, utilization reviewers did not adequately identify or consider the criteria within the six ASAM dimensions relevant to the determination of the appropriate level of care.

BerryDunn expressed concern that few cases were taken to a physician for consultation related to level of care questions, and that referral to a physician might have led 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. BerryDunn examiners felt that utilization reviewers should be encouraged to consult with Company physicians for more complex cases, and take a more active role in collecting missing information and conducting follow-up as appropriate on information gathered during the multidimensional assessment.

Company Position:

The Company largely agreed with the contract examiners' observations, and explained recent system improvements it had made to more closely align its practices with the ASAM criteria.

The Company noted that in 2018 it developed a new policy on SUD treatment, which outlines ASAM level of care guidelines using objective and evidence-based criteria, and specifically identifies MAT as a strong evidence-based practice.

The Company also noted that it is in the process of updating all medical necessity policies to remove vague language related to medically necessity criteria for SUD treatment services, including specifically stating the necessary clinical information needed in the prior authorization process in order to apply ASAM criteria. This process was expected to be completed by the end of March 2019.

During the months of September and October 2018, the Company retrained its Utilization Management Team and Medical Director on the application of ASAM criteria, and will continue additional reviews and training going forward. In addition, the Company is contracting with the American Society of Addiction Medicine for access to the web-based ASAM criteria. This will allow staff to directly access and document the ASAM dimensions, medical necessity criteria, and appropriate terminology throughout their clinical reviews and denial letters, and will include training on the appropriate documentation of the six dimensions, the available levels of service, and documentation expectations.

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 during the examination period, 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 plans to continue this practice going forward.

Delegated Service Contracts:

The examiners reviewed delegated service contracts to identify the control and oversight that the carrier has for their Third Party Administrators (TPA's) handling of contractual agreements in handling MH/SUD benefits and Med/Surg 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 provided information demonstrating that it delegates behavioral health, pharmacy benefits management, and nursing assistance to subsidiaries of the Company's parent company, Centene. The Company provided agreements and amendments with Cenpatico Behavioral Health (hereinafter, "CBH"), which later become Envolve PeopleCare (hereinafter, "Envolve"). The Company provided NurseWise policies and procedures; NurseWise offers 24/7 member assistance. The Company also provided narrative in responses to interrogatories and RFIs explaining delegated responsibilities with CBH, Envolve and NurseWise. Examiners discussed the above-mentioned business relationships and delegated responsibilities during conference calls with the Company as well.

Examiner Observations:

CBH was responsible for behavioral health utilization management. Envolve then replaced CBH and became responsible for behavioral health utilization management. Envolve is also responsible for pharmacy benefits management.

Examiner Findings:

Examiners found no exceptions.

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 ten (10) exceptions that examiners found for requiring PAs for MAT/SUD prescription drugs prior to April 1, 2017. The Company has taken corrective action measures by implementing a policy effective April 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

The examiners recommend a follow-up market conduct examination in one year in order to verify and confirm that the Company has made the necessary changes and improvements outlined below, especially as related to claim handling practices.

NHID Response:

The Department will review and determine the Company's compliance through the development, implementation and evaluation of corrective action plans, and assessment of other information required as part of the Order Adopting the Verified Report. Should the Department determine, at any time during the execution and monitoring of the corrective actions, that the Company has failed to make sufficient progress deemed necessary for compliance, the Commissioner may call an examination pursuant to RSA 400-A:37, I (a).

Area of Examination	Examiner Findings	Company Position	Examiner Recommendations	NHID Response
Sample MH/SUD Prescription Drug Claims, Denied – PA required for SUD drugs in 2016.	2 exceptions found (NQTL)	Company disagreed.	The Company has taken corrective action measures by implementing a policy effective April 1, 2017 no longer requiring PAs for MAT/SUD drugs.	No further Company action is required.
Sample MH/SUD Prescription Drug Claims, Paid – PA required for SUD drugs in 2016.	8 exceptions found (NQTL)	Company disagreed.	The Company has taken corrective action measures by implementing a policy effective April 1, 2017 no longer requiring PAs for MAT/SUD drugs.	No further Company action is required.
Sample MH/SUD Health Claims, Partially Paid – visit limit and lack of provider outreach and education.	1 exception found (QTL)	Company disagreed.	The Company shall pay the claim with prompt pay interest. The Company shall ensure that providers receive the appropriate outreach and education regarding claims submission.	NHID has removed the QTL exception. The Company shall provide the Department with data and information.
Discriminatory Benefit Designs, Self-harm	2 exceptions found - 1	Company disagreed.	The Company has taken corrective	No further Company

Language in Evidence of Coverage (“EOC”) – treatment excluded for treatment/services related to self-harm injury.	exception for 2016 and 1 exception for 2017 (NQTL)		action measures by removing the self-harm language as an exclusion in Evidence of Coverage materials beginning in the 2018 policy year.	action is required.
2/3 Substantially All Requirements – failure to perform quantitative analysis.	2 exceptions found - 1 exception for 2016 and 1 exception for 2017 (FL/FR)	Company disagreed.	The Company has taken corrective action measures by performing actuarial testing and quantitative analysis to ensure compliance with MHPAEA and its associated Final Rules for all plans beginning in the 2019 policy year.	The Company shall provide the actuarial testing and quantitative analysis for the 2019 policy year to the Department.
Network Design, HMO Product versus EPO Product – the product appears to be administered as an HMO product.	1 exception found	Company disagreed.	Ambetter from NH Healthy Families (EPO) and NH Healthy Families (Medicaid/HMO) are two separate and distinct products. The Company shall ensure that its EPO product is distinctive from an HMO product, and that all Ambetter from NH Healthy Families policies, procedures, systems, and correspondence reflect an EPO product.	No further Company action is required.
Network Design, Balance Billing Language – the Company included balance billing language in member materials, and members were balance billed as a	1 exception found	Company disagreed.	The Company shall remove all language allowing balance billing from member materials.	The Company shall provide the Department with a corrective action plan.

result of the Company's balance billing policy.				
Grievances, Appeals and Complaints – members were balance billed as a result of the balance billing language included in the Company's filing and member materials.	15 exceptions found	Company disagreed.	The Company shall pay with prompt pay interest claims associated with an exception. In light of legislation prohibiting balance billing for certain services in the commercial market, the Company has taken corrective action measures effective July 1, 2018 by creating a procedure outlining member assistance for those members balance billed.	The Company shall provide the Department with a corrective action plan.
Medical Management Standards (Prior Authorization) – inconsistent language in Formularies, SOBs and Internal MH/SUD Prescription Drug PA Policies.	2 exceptions found - 1 exception for 2016 and 1 exception for 2017	Company disagreed.	The Company shall review all internal prescription drug policies to ensure that the internal policies match formulary and SOB language regarding prior authorization. The Company has taken corrective action measures by updating formularies and SOBs for PA policies effective for the 2019 policy year.	The Company shall immediately notify the Department if discrepancies are identified.
Grievance and Appeal Disclosures – the Company failed to include the NHID's address and telephone number on partially paid and denied EOBs.	2 exceptions found - 1 exception for 2016 and 1 exception for 2017	Company agreed.	The Company shall immediately begin including the NHID's address and telephone number on all EOBs containing an adverse benefit	The Company shall provide the Department with a corrective action plan.

			determination per N.H. Code Admin. R. Ins. 1001.05.	
Sample Med/Surg Prescription Drug Claims, Paid – insufficient MOOP accumulators.	9 exceptions found (claim handling)	Company disagreed.	<p>The Company shall ensure that MOOP accumulators include sufficient information in order to recreate a claim and to properly track cost-sharing.</p> <p>The Company shall also ensure that cost-sharing amounts are properly applied to MOOP accumulators to avoid exceeding the maximum out-of-pocket cap.</p>	The Company shall provide evidence to the Department regarding the system reconfiguration and accuracy of MOOP accumulators for commercial membership.
Sample Med/Surg Prescription Drug Claims, Denied – insufficient MOOP accumulators.	3 exceptions found (claim handling)	Company disagreed.	<p>The Company shall ensure that MOOP accumulators include sufficient information in order to recreate a claim and to properly track cost-sharing.</p> <p>The Company shall also ensure that cost-sharing amounts are properly applied to MOOP accumulators to avoid exceeding the maximum out-of-pocket cap.</p>	The Company shall provide evidence to the Department regarding the system reconfiguration and accuracy of MOOP accumulators for commercial membership.
Sample MH/SUD Health Claims, Paid – insufficient MOOP accumulators.	19 exceptions found (18 exceptions for insufficient MOOP accumulator and 1 exception for exceeding	Company disagreed.	The Company shall ensure that MOOP accumulators include sufficient information in order to recreate a claim and to properly track cost-sharing.	The Company shall provide evidence to the Department regarding the system reconfiguration and accuracy of

	MOOP cap) (claim handling)		The Company shall also ensure that cost-sharing amounts are properly applied to MOOP accumulators to avoid exceeding the maximum out-of-pocket cap.	MOOP accumulators for commercial membership. The Company shall provide evidence to the Department that the MOOP accumulator charge was corrected.
Sample Med/Surg Health Claims, Paid – claim not paid timely (prompt pay).	1 exception found (claim handling)	Company disagreed.	The Company shall verify that the provider was paid prompt pay interest for claim received 2/9/16 and paid 3/10/2016.	No further Company action is required.
Sample MH/SUD Health Claims, Partially Paid – accumulator overcharge.	1 exception found (claim handling)	Company disagreed.	The Company has taken corrective action measures by refunding the member the accumulator overcharge.	No further Company action is required.
Sample MH/SUD Health Claims, Denied – accumulator overcharge.	1 exception found (claim handling)	Company disagreed.	The Company has taken corrective action measures by refunding the member the accumulator overcharge.	No further Company action is required.
Sample MH/SUD Health Claims, Denied – internal payment configuration error (reimbursement rate).	1 exception found (claim handling)	Company disagreed.	The Company shall pay the claim with prompt pay interest. The Company shall ensure that its claim processing system is set-up correctly to avoid system configurations errors.	The Company shall provide the Department with a corrective action plan.

Sample MH/SUD Health Claims, Denied with Prior Authorization – internal payment configuration error (denial code EX 4B).	9 exceptions found (claim handling)	Company disagreed.	<p>The Company shall ensure that its claim processing system is set-up correctly to avoid system configurations errors.</p> <p>The Company has taken corrective action measures by correcting the EX 4B configuration error in July 2016 and paying all claims prior to July 2016 that denied due to the EX 4B system configuration error.</p>	No further Company action is required.
Sample Med/Surg Health Claims, Denied – internal payment configuration error (PA not migrating).	1 exception found (claim handling)	Company disagreed.	<p>The Company shall pay the claim with prompt pay interest.</p> <p>The Company shall ensure that its claim processing system is set-up correctly to avoid system configurations errors.</p>	The Company shall provide the Department with a corrective action plan.
Sample MH/SUD Health Claims, Denied – high number of duplicate claims.	1 exception found (claim handling)	Company disagreed.	The Company shall pay claims in a timely manner, and provide the necessary and appropriate provider outreach and education to avoid providers resubmitting claims multiple times to seek payment.	The Company shall provide the Department with data and information.
Sample MH/SUD Health Claims, Denied with Prior Authorization – high number of duplicate claims.	1 exception found (claim handling)	Company disagreed.	The Company shall pay claims in a timely manner, and provide the necessary and appropriate	The Company shall provide the Department with data and information.

			provider outreach and education to avoid providers resubmitting claims multiple times to seek payment.	
Sample MH/SUD Health Claims, Denied with Prior Authorization – high number of claims reprocessed under a new claim number due to incorrect provider affiliation/systems configuration error.	8 exceptions found (claim handling)	Company disagreed.	The Company shall ensure that its claim processing system is set-up correctly to avoid system configurations errors such as the system selecting the incorrect provider affiliation resulting in claim denial.	The Company shall provide the Department with a corrective action plan.
Sample MH/SUD Health Claims, Denied with Prior Authorization – the practice of settlement.	1 exception found (claim handling)	Company disagreed.	The Company shall pay claims in a timely manner, and provide the necessary and appropriate provider outreach and education to avoid providers resubmitting claims multiple times for payment and/or seeking volume claim settlement.	The Company shall provide the Department with data and information regarding claim settlement practices.
Sample Med/Surg Health Claims, Denied – provider appeal/reconsideration.	1 exception found (claim handling)	Company disagreed.	The Company shall pay the claim with the appropriate prompt pay interest.	The Company shall provide the Department with evidence of the claim adjustment.
Sample Med/Surg Health Claims, Denied with Prior Authorization – provider appeal/reconsideration.	2 exceptions found (claim handling)	Company disagreed.	The Company shall pay the claims with the appropriate prompt pay interest.	The Company shall provide the Department with evidence of the claim adjustments.
Sample Med/Surg Health Claims, Denied – internal payment	1 exception found (claim handling)	Company disagreed.	The Company shall pay the claim with	The Company shall provide the Department

<p>configuration error (provider affiliation).</p>			<p>the appropriate prompt pay interest.</p> <p>The Company shall ensure that its claim processing system is set-up correctly to avoid system configurations errors such as the system selecting the incorrect provider affiliation resulting in claim denial.</p>	<p>with evidence of the claim adjustment.</p> <p>The Company shall provide the Department with a corrective action plan.</p>
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EXAMINER'S SIGNATURE AND ACKNOWLEDGEMENT

The examiners would like to acknowledge the cooperation and assistance extended by Ambetter from New Hampshire Healthy Families during the course of the examination. Specifically, the examiners would like to acknowledge Ms. Karin Eckel, the Senior Manager of Compliance for NH Healthy Families. Ms. Eckel was cordial and collaborative throughout the examination, and always demonstrated a willingness to answer the examiners' questions in an expedient manner.

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

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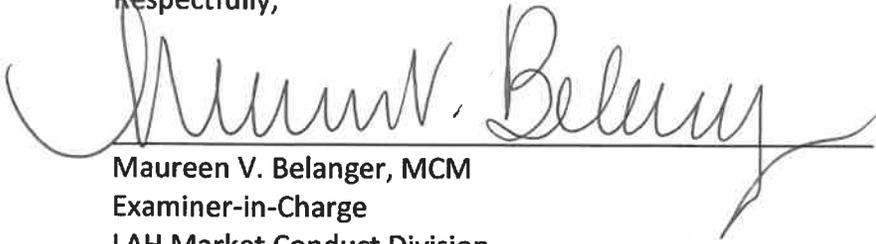
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Respectfully,

A handwritten signature in cursive script, reading "Maureen V. Belanger". The signature is written in black ink and is positioned above a horizontal line that underlines the text below.

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

APPENDIX A: 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	<i>Aggregate limitations:</i> a. Does the plan include lifetime limits for MH/SUD treatments? b. Does the plan include lifetime limits for Med/Surg treatments?
B.2	<i>Aggregate limitations:</i> a. What are the aggregate lifetime limits for MH/SUD treatments? b. What are the aggregate lifetime limits for Med/Surg treatments?
B.3	<i>Aggregate limitations:</i> 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	<i>Annual limitations:</i> 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	<i>Treatment limitations:</i> 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? <ul style="list-style-type: none"> • If yes, what is the benefit type and limitation in days or frequency?

	<p>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?</p> <ul style="list-style-type: none"> • If yes, what are the benefit type and limitations in days or frequency?
FINANCIAL LIMITATIONS	
Request No.	Request
C.1	<p>2/3 Substantially all requirements: How does the carrier ensure that the 2/3 substantially all requirements are met?</p>
C.2	<p>Deductibles: Please provide a listing of the deductibles for the ten most popular major medical plans.</p>
C.3	<p>Deductibles:</p> <p>a. Does the carrier have separate collective deductible(s) for MH/SUD benefits?</p> <p>b. Does the carrier have separate collective deductible(s) for Med/Surg benefits?</p>
C.4	<p>Deductibles:</p> <p>a. Does the carrier have separate individual deductible(s) for MH/SUD benefits?</p> <p>b. Does the carrier have separate individual deductible(s) for Med/Surg benefits?</p>
C.5	<p>Deductibles:</p> <p>a. Does the carrier have a separate aggregate deductible (s) for MH/SUD benefits?</p> <p>b. Does the carrier have a separate aggregate deductible (s) for Med/Surg benefits?</p>
C.6	<p>Copayments:</p> <p>a. What are the in-network copayment amount(s) for MH/SUD Office Visits?</p> <p>b. What are the in-network copayment amount(s) for Med/Surg Office Visits?</p> <p>c. What are the out-of-network copayment amount(s) for MH/SUD Office Visits?</p> <p>d. What are the out-of-network copayment amount(s) for Med/Surg Office Visits?</p>
C.7	<p>Copayments:</p> <p>a. What are the copayment amounts for treatments by a MH/SUD Specialist?</p> <p>b. What are the copayment amounts for treatments by a Med/Surg Specialist?</p>
C.8	<p>Copayments:</p> <p>a. What are the copayment amounts for laboratory services for MH/SUD treatments?</p> <p>b. What are the copayment amounts for laboratory services for Med/Surg treatments?</p>
C.9	<p>Copayments:</p> <p>a. What are the copayment amounts for X-ray services for MH/SUD treatments?</p> <p>b. What are the copayment amounts for X-ray services for Med/Surg treatments?</p>
C.10	<p>Copayments:</p> <p>a. What are the various copayment amounts for Emergency Room services or MH/SUD treatments?</p> <p>b. What are the various copayment amounts for Emergency Room services for Med/Surg treatments?</p>
C.11	<p>Copayments:</p> <p>a. What are the copayment amounts for therapy services such as Physical Therapy, Occupational Therapy, and Speech/Language Pathology for MH/SUD treatments?</p>

	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	<p>Benefit Classifications:</p> <p>a. Does the carrier provide coverage for all six categories for MH/SUD treatments?</p> <ul style="list-style-type: none"> • If no, which categories are excluded and why? <p>b. Does the carrier provide coverage for all six categories for Med/Surg treatments?</p> <ul style="list-style-type: none"> • If no, which categories are excluded and why?
D.2	<p>Benefit Classifications:</p> <p>a. Are there any limitations or exceptions imposed on any of the six categories for MH/SUD treatments?</p> <ul style="list-style-type: none"> • If yes, what are the limitations and exceptions? <p>b. Are there any limitations or exceptions imposed on any of the six categories for Med/Surg treatments?</p> <ul style="list-style-type: none"> • If yes, what are the limitations and exceptions?
D.3	<p>Medical Management Standards:</p> <p>a. Describe the policy development processes for Medical Management Standards for MH/SUD.</p> <p>b. Describe the policy development processes for Medical Management Standards for Med/Surg.</p>
D.4	<p>Medical Management Standards:</p> <p>a. Describe the processes utilized to update Medical Management Standards for MH/SUD.</p> <p>b. Describe the processes utilized to update Medical Management Standards for Med/Surg.</p>
D.5	<p>Medical Management Standards – Utilization Review and Case Management:</p> <p>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.).</p> <p>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.).</p>
D.6	<p>Medical Management Standards – Utilization Review:</p> <p>a. Please provide internal utilization review guidelines for determining allowable MH/SUD benefits.</p> <p>b. Please provide internal utilization review guidelines for determining allowable Med/Surg benefits.</p>
D.7	<p>Medical Management Standards – Utilization Review:</p> <p>a. How frequently, and with what stringency is utilization review required for MH/SUD benefit determinations?</p>

	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	<p>Written Treatment Plans:</p> <p>a. How frequently are the policies and procedures regarding written treatment plans updated for MH/SUD benefits?</p> <p>b. How frequently are the policies and procedures regarding written treatment plans updated for Med/Surg treatments?</p>
E.4	<p>Written Treatment Plans:</p> <p>a. What is the experience and expertise required for the individuals creating and updating the written treatment plans for MH/SUD benefits?</p> <p>b. What is the experience and expertise required for the individuals creating and updating the written treatment plans for Med/Surg benefits?</p>
E.5	<p>Formulary designs for prescription drugs:</p> <p>a. Please provide a list of formulary drugs for all plans for MH/SUD specific prescriptions.</p> <p>b. Please provide a list of formulary drugs for all plans for Med/Surg specific prescriptions.</p>
E.6	<p>Formulary designs for prescription drugs:</p> <p>Please provide the dates the carrier last submitted its formulary list to the NHID.</p>
E.7	<p>Formulary designs for prescription drugs:</p> <p>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.</p> <p>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.</p>
E.8	<p>Formulary designs for prescription drugs:</p> <p>Please provide a list of all plans with separate deductible amounts for Prescription Drug services, and include the amount(s) of the deductible.</p>
E.9	<p>Formulary designs for prescription drugs:</p> <p>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.</p>
E.10	<p>Formulary designs for prescription drugs:</p> <p>Please provide all documentation regarding requirements and frequency allowances for prescription drug refills.</p>
E.11	<p>Formulary designs for prescription drugs:</p> <p>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.</p>
E.12	<p>Fail-first policies or step therapy protocols:</p> <p>In detail, please provide all processes for “Fail First” or step therapy treatment requirements for MH/SUD Treatments, Med/Surg and Pharmacy benefit considerations.</p>
E.13	<p>Fail-first policies or step therapy protocols:</p>

	Are benefit exclusions imposed for failure to complete a course of treatment in the fail-first, or step therapy requirements?
E.14	<i>Fail-first policies or step therapy protocols:</i> 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	<i>Network Design – Network Adequacy:</i> 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. <i>Note:</i> the Company may also identify the provider specialties that are not included in this category if the list is shorter.
E.16	<i>Network Design – Network Adequacy:</i> 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	<i>Network Design – Network Adequacy:</i> Please identify what percentage of primary care providers are covered under an arrangement that delegates credentialing to the provider entity.
E.18	<i>Network Design – Network Adequacy:</i> Please identify what percentage of MH/SUD providers are covered under an arrangement that delegates credentialing to the provider entity.
E.19	<i>Network Design – Network Adequacy:</i> Please provide the website link to access the provider directory.
E.20	<i>Network Design – Network Adequacy:</i> How frequently is the provider directory updated?
E.21	<i>Network Design – Network Adequacy:</i> How frequently does the carrier perform disruption analysis to determine if additional providers could be added to the network(s)?
E.22	<i>Network Design – Network Adequacy and Provider Credentialing:</i> 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)?

	<p>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)?</p> <p>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)?</p>
E.23	<p>Network Design – Network Reimbursement rates:</p> <p>a. How does the carrier determine the appropriate reimbursement rates for MH/SUD providers in the network?</p> <p>b. How much does provider specific negotiating leverage influence MH/SUD provider payment rates?</p> <p>c. How does the carrier determine the appropriate reimbursement rates for Med/Surg providers in the network?</p> <p>d. How much does provider specific negotiating leverage influence Med/Surg provider payment rates?</p>
E.24	<p>Network Design – Network Reimbursement rates:</p> <p>a. How frequently are the fee schedules updated for MH/SUD providers in the network?</p> <p>b. How frequently are the fee schedules updated for Med/Surg providers in the network?</p> <p>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.</p> <p>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.</p> <p>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.</p>
E.25	<p>Network Design – Out-of-Network providers:</p> <p>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.</p>
E.26	<p>Network Design – Out-of-Network providers:</p>

	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	<i>Grievance, Appeals and Disclosures:</i> Please provide any additional disclosures that are available to the policyholders regarding filing a grievance and appeal.
E.37	<i>Grievance, Appeals and Disclosures:</i> a. How frequently are the grievance and appeals procedures updated for MH/SUD treatments? <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> 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	<i>Grievance, Appeals and Disclosures:</i> a. How frequently are the grievance and appeals procedures updated for Med/Surg treatments? <ul style="list-style-type: none"> 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;

	<ul style="list-style-type: none"> 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. <p>b. Also attach the following:</p> <ul style="list-style-type: none"> 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	<p>Claims: Please explain the claim 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.</p>
E.40	<p>Claims: Please provide the carrier’s claim training manuals.</p>
E.41	<p>Claims: How frequently does the carrier perform an internal audit on the claims process as a whole?</p>
E.42	<p>Claims: Please provide the most current internal claim audit report.</p>
E.43	<p>Claims: Please provide copies of the claims forms utilized for health claims.</p>
E.44	<p>Claims: Please provide the carrier’s claims form manual.</p>
E.45	<p>Claims: Claims files – A separate request will be submitted for presenting claims files under Section DR (Data Requests).</p>
OTHER CONSIDERATIONS	
Request No.	Request
F.1	<p>Availability of Plan Information:</p> <ul style="list-style-type: none"> 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	<p>Availability of Plan Information:</p> <ul style="list-style-type: none"> 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	<p>Availability of Plan Information:</p> <p>a. How frequently does the carrier review and update plan information for MH/SUD benefits?</p> <p>b. How frequently does the carrier review and update plan information for Med/Surg benefits?</p>
F.4	<p>Availability of Plan Information:</p> <p>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.</p> <p>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.</p>
F.5	<p>Clinical Trials:</p> <p>a. Are clinical trials and/or experimental/investigative treatments allowed for MH/SUD services?</p> <p>b. Are clinical trials and/or experimental/investigative treatments allowed for Med/Surg services?</p>
F.6	<p>Clinical Trials:</p> <p>a. Please provide the requirements and considerations for clinical trials for MH/SUD treatments. Please include any limitations or restrictions for these requirements.</p> <p>b. Please provide the requirements for consideration for clinical trials for Med/Surg treatments. Please include any limitations or restrictions for these requirements.</p>
F.7	<p>Autism Coverage:</p> <p>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.</p>
F.8	<p>Autism Coverage:</p> <p>Please provide processes and procedures for providing Autism Coverage.</p>
F.9	<p>Autism Coverage:</p> <p>Please provide the policy language outlining coverage for Autism services.</p>
F.10	<p>ASAM:</p> <p>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.</p>
F.11	<p>Delegated Service Contracts:</p> <p>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.</p>

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: <ul style="list-style-type: none"> 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)? <ul style="list-style-type: none"> • 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	<p><i>Medical Management Standards – Utilization Review and Case Management:</i></p> <ol style="list-style-type: none"> 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. <p>*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.</p>
E.45	<p><i>Claims:</i></p> <p>Provide a list of all paid, partially paid, denied, and denied with prior authorization claims for the examination period:</p> <ol style="list-style-type: none"> 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 B: 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

PARTIALLY 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
ClmDenDt	Date Claim Denied (MMDDYYYY)
DenRsnCo	Denial Reason Code, If Applicable
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

New Hampshire Insurance
Department

Market Conduct Exams
Provider Reimbursement Strategy Analysis
Behavioral Health Parity
Ambetter Health Plan in New Hampshire
Final Report

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1.0 Executive Summary

The New Hampshire Insurance Department (NHID) contracted with the BerryDunn Health Analytics Practice Area (BerryDunn) to analyze Ambetter of New Hampshire's (the Carrier's) commercial 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 standard 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 and 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 lower than Medicare rates. The MH/SUD ratio is similar to those found for M/S primary care and evaluation and management (E&M) services. While some M/S specialties were paid at rates higher than Medicare, and a few low-volume specialties significantly higher, other specialties were paid significantly less, relative to Medicare rates, than MH/SUD providers. The Carrier's weighted average MH/SUD commercial-to-Medicare reimbursement ratio, 0.86, is very similar to the overall weighted average for professional services in the analysis, 0.88. The overall weighted average result is not sensitive to the inclusion or exclusion of MH/SUD providers. Furthermore, the Carrier's inpatient psychiatric commercial-to-Medicare reimbursement ratio was higher than its acute physical health inpatient reimbursement ratio. These results do not provide a strong indication of a potential MHPAEA violation.

However, in order for 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 indicate the Carrier predominantly uses a Medicare reimbursement methodology to determine MH/SUD and M/S fee schedules. The Carrier noted a few deviations from its standard reimbursement methodology, for which details were not provided. In addition, the Carrier noted that MH/SUD non-physician providers are paid a reduced rate compared to physicians (advanced practice registered nurse (APRN) = 85%, midlevels = 75%) while the M/S non-physician providers do not have a reduced rate relative to Medicare. Although educational level was a factor used to determine the reimbursement rate for MH/SUD providers, it was not taken into account for M/S providers. No documented justification for this difference was provided, suggesting a potential MHPAEA violation. Out of approximately \$948,840 in physician services analyzed for this report (which does not include radiology, anesthesiology, or pathology services), \$1,634 was paid to psychiatrists.

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 the 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 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 specialty receives 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 of MH/SUD and M/S.

BerryDunn collected and reviewed from the Carrier 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.

As part of its review, BerryDunn reviewed Ambetter’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 one 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, for market conditions) 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 claimsⁱ 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).

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 for 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 medical and surgical services. Not included were radiology, laboratory/pathology, and anesthesiology services.ⁱⁱ 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,² to allow comparisons of commercial-to-Medicare ratios by provider specialty. Medicare reimburses these professional services using the Resource-Based Relative Value Scale (RBRVS).³ 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)⁴ and the Inpatient Psychiatric Facility Prospective Payment System (IPF PPS),⁵ respectively, which were developed with comparable methods and standards.

The MHPAEA service classification also includes Emergency and Pharmacy categories.⁶ Payers typically reimburse emergency department claims without regard to the behavioral

ⁱ Those claims with a line of business designation of "commercial" in the NH CHIS medical claims file.

ⁱⁱ 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.

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.⁷ 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.⁸ The RVUs assigned to the practice expense category are dependent on whether the procedure was performed in a facility or non-facility setting.⁹ 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.¹⁰ 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.¹¹

Two Current Procedural Terminology® (CPT®) code modifier-based payment adjustments were taken into account—bilateral procedureⁱⁱⁱ and assistant at surgery.^{iv} Bilateral procedures are reimbursed at 150% of the standard physician fee schedule rate for a unilateral procedure,^v while assistant at surgery procedures are reimbursed at 16% of the standard physician fee schedule rate.¹²

ⁱⁱⁱ CPT® Modifiers 50, LT, and RT

^{iv} 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.

^v 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.

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.^{vi} 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,^{vii} performed by all MH/SUD provider license types (physician, PhD psychologist, 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 us 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;¹³ 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.^{viii} As with procedures in the Physician Fee Schedule, inpatient events are first assigned weighted values (representing relative 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

^{vi} 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

^{vii} 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.

^{viii} 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/acutepaymtyssysfctsh.pdf>).

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.¹⁴ This weight is multiplied by the standard reimbursement rate, referred to as the Operating Standardized Amount¹⁵ to arrive at a Medicare episode reimbursement amount. The Operating Standardized Amount encompasses both the direct and indirect cost of treatment during an episode.¹⁶ Medicare also includes a capital amount, the Capital Standard Federal Payment Rate, which was excluded from this model¹⁷ 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 (EHR) 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.¹⁸ This was due to treatment costs being inadequately accounted for in the IPPS. The IPF PPS was developed as an 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.¹⁹ 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.²⁰ Such an episode is reimbursed at the Federal Per Diem Rate.

IPFs are identified by Medicare using their CMS certification number (CCN).²¹ 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	\$ 1,980,715	1.06	0.54
Inpatient Psychiatric	\$ 552,860	1.22	1.34

The Carrier's inpatient psychiatric commercial-to-Medicare reimbursement ratio was higher than its acute physical health inpatient reimbursement ratio. The professional services analysis found that the Carrier reimburses MH/SUD providers at rates lower than Medicare rates. The MH/SUD ratio is similar to those found for M/S primary care and E&M services. E&M services and primary care services together comprise 80% of the physician claim volume studied. MH/SUD services comprised an additional 8%. These three specialties were the top three specialties studied by allowed medical expense dollar volume. While some M/S specialties were paid at rates higher than Medicare, and a few low-volume specialties significantly higher, other specialties were paid significantly less, relative to Medicare rates, than MH/SUD providers. The Carrier's weighted average MH/SUD commercial-to-Medicare reimbursement ratio, 0.86, is very similar to the overall weighted average for professional services in the analysis, 0.88. The overall weighted average result is not sensitive to the inclusion or exclusion of MH/SUD providers. These results do not provide evidence of a potential MHPAEA violation.

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^{ix}

Professional Specialty	Commercial	Commercial-to-Medicare Payment Ratio	
	Allowed Medical Expense	Weighted Average	Median
Allergy & Immunology	\$ -	N/A	N/A
Colon & Rectal Surgery	\$ 3,221	1.06	1.31
Dermatology	\$ 2,313	0.61	0.22
Evaluation and Management	\$ 650,038	0.84	0.61
Gastroenterology	\$ 7,236	1.06	1.02
Neurological Surgery	\$ 9,419	1.59	0.73
Neurology	\$ 556	0.65	0.65
Obstetrics & Gynecology	\$ 49,438	1.06	0.79
Ophthalmology	\$ 2,115	0.97	1.00
Oral & Maxillofacial Surgery	\$ 810	0.93	0.68
Orthopaedic Surgery	\$ 53,232	1.04	1.00
Otolaryngology	\$ 14,482	0.66	0.59
Physical Medicine & Rehabilitation	\$ 326	0.96	1.01
Plastic Surgery	\$ 3,258	0.76	0.67
Primary Care	\$ 12,609	0.90	0.79
Psychiatry	\$ 110,154	0.86	0.87
<i>MD/DO</i>	\$ 1,634	1.01	1.15
<i>MSW</i>	\$ 29,684	0.87	0.83
<i>Other</i>	\$ 65,931	0.89	0.88
<i>Psychologist</i>	\$ 12,906	0.70	0.76
Surgery	\$ 18,013	0.94	0.77
Thoracic Surgery (Cardiothoracic Vascular Surgery)	\$ 3,371	0.87	1.00
Urology	\$ 9,249	0.74	0.61

4.1.2 Results of the Review of Ambetter’s Policies and Procedures, and Responses to Interrogatories

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.

^{ix} All specialties are included for E&M. Only non-E&M services are included for individual specialties

The Carrier provided its Ambetter Fee Schedule & Methodology Policy and Procedure (Fee Schedule Policy and Procedure). The Fee Schedule Policy and Procedure states that fee schedule are based on defined Medicare reimbursement methodologies and requirements for MH/SUD and M/S, and fee schedules are updated at the same intervals for MH/SUD and M/S (every three years). New codes are added quarterly.

In a response to interrogatories, the Carrier noted that a MH/SUD or M/S provider's negotiating leverage is influenced by market share and the amount of competition in the particular area. The interrogatory response notes, "All rates are subject to our corporate guidelines for reimbursement for a specific provider type. Rate proposals that do not align to our corporate guidelines require additional approvals at the Health Plan in some instances from Corporate." Details about this rate increase escalation process were not provided. In addition, the Carrier noted there are modifications to reimbursement rates to reflect services not reimbursed by Medicare and subject to corporate standards and guidelines developed for the New Hampshire Ambetter product that were not provided and could not be reviewed. The Fee Schedule Policy and Procedure was not specific to New Hampshire.

In a response to an interrogatory, the Carrier indicated that for MH/SUD, APRNs are reimbursed at 85% and midlevels at 75% of the MH/SUD physician provider fee schedule, while the rates for M/S and pediatric providers are the same (i.e., the Carrier reduces reimbursement rates for non-physician practitioners providing MH/SUD services, but not M/S). Although educational level was a factor used to determine the reimbursement rate for MH/SUD providers, it was not taken into account for M/S providers.²² Accordingly, the reduction of the MH/SUD non-physician provider reimbursement rate but not the M/S non-physician provider reimbursement rate would likely be a MHPAEA violation.

5.0 Conclusion

A claims analysis of commercial-to-Medicare provider reimbursement ratios shows that the Carrier reimburses MH/SUD providers at rates below the Medicare rates, and similarly, relative to Medicare, to primary care, and E&M services. Rates are updated every three years, so this may be a result of a time lag for rates to become current. Results varied for other specialties, with some small-volume specialties paid significantly higher than Medicare, and others paid significantly less relative to Medicare than MH/SUD, primary care, and E&M services. These results do not provide evidence of a potential MHPAEA violation.

BerryDunn also reviewed the Carrier's provider reimbursement policies and procedures. The foundation of setting provider reimbursement fee schedules is based on Medicare's methodologies with a process noted in the interrogatories to allow for increased reimbursement influenced by market share and competition. In addition, the Carrier noted there were modifications to reimbursement rates to reflect services not reimbursed by Medicare and subject to corporate standards and guidelines developed for the New Hampshire Ambetter product, which were not provided and could not be reviewed. While more information regarding the few factors outside the Medicare methodology basis would be helpful, the overall results of the claims analysis does not suggest that the consideration of these factors is performed in a disparate way for MH/SUD versus M/S. Nonetheless, for this process to be MHPAEA-compliant, documentation is required to allow for comparison of processes and standards for MH/SUD vs. M/S.

As noted in Section 4.1.2, MH/SUD non-physician providers, which represent about 98.5% of professional behavioral health service payments, are paid at a reduced amount, while the rates for M/S primary care providers and pediatric providers are paid the same as physicians. Because MH/SUD and M/S non-physician reimbursement is not treated in a comparable way, this would likely be a MHPAEA violation absent justifying documentation.

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>.

² “The Healthcare Provider Taxonomy Code Set is a hierarchical code set that consists of codes, descriptions, and definitions. Healthcare Provider Taxonomy Codes are designed to categorize the type, classification, and/or specialization of health care providers.” Accessed 8 October 2018: <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/MedicareProviderSupEnroll/Taxonomy.html>.

³ Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Final Rules. 42 CFR Parts 405, 410, 411, 414, 425, 495. Federal Register 80: 220. Published 16 December 2015. Accessed June 2018. <https://www.federalregister.gov/documents/2015/11/16/2015-28005/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>.

⁴ Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program; Extensions of the Medicare-Dependent, Small Rural Hospital Program and the Low Volume Payment Adjustment for Hospitals; 42 CFR Part 412. Federal Register 80:158. Published 17 August 2015. Accessed June 2018. <https://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf>.

⁵ Medicare Program; Inpatient Psychiatric Facilities Prospective Payment System – Update for Fiscal Year Beginning October 1, 2015 (FY 2016); 42 CFR Part 412. Federal Register 80:150. Published 5 August 2015. Accessed June 2018. <https://www.federalregister.gov/documents/2015/08/05/2015-18903/medicare-program-inpatient-psychiatric-facilities-prospective-payment-system-update-for-fiscal-year>.

⁶ 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>.

⁷ “RBRVS Overview.” Accessed June 2018. <https://www.ama-assn.org/rbrvs-overview>.

⁸ Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Final Rules. 42 CFR Parts 405, 410, 411, 414, 425, 495. Federal Register 80: 220. Published 16 December 2015. Accessed June 2018. <https://www.federalregister.gov/documents/2015/11/16/2015-28005/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>.

⁹ Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Final Rules. 42 CFR Parts 405, 410, 411, 414, 425, 495. Federal Register 80: 220. Published 16 December 2015. Accessed June 2018. <https://www.federalregister.gov/documents/2015/11/16/2015-28005/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>.

¹⁰ Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Final Rules. 42 CFR Parts 405, 410, 411, 414, 425, 495. Federal

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¹¹ Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2016; Final Rules. 42 CFR Parts 405, 410, 411, 414, 425, 495. Federal Register 80: 220. Published 16 December 2015. Accessed June 2018. <https://www.federalregister.gov/documents/2015/11/16/2015-28005/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>.

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¹⁶ Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program; Extensions of the Medicare-Dependent, Small Rural Hospital Program and the Low Volume Payment Adjustment for Hospitals; 42 CFR Part 412. Federal Register 80:158. Published 17 August 2015. Accessed June 2018. <https://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf>.

¹⁷ Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long Term Care Hospital Prospective Payment System Policy Changes and Fiscal Year 2016 Rates; Revisions of Quality Reporting Requirements for Specific Providers, Including Changes Related to the Electronic Health Record Incentive Program; Extensions of the Medicare-Dependent, Small Rural Hospital Program and the Low Volume Payment Adjustment for Hospitals; 42 CFR Part 412. Federal Register 80:158. Published 17 August 2015. Accessed June 2018. <https://www.gpo.gov/fdsys/pkg/FR-2015-08-17/pdf/2015-19049.pdf>.

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New Hampshire Insurance
Department

Market Conduct Examination

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

Ambetter Health Plan in 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 Ambetter Health Plan 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) law¹ that requires the use of the American Society of Addiction Medicine (ASAM) criteria^{2,3} when determining medical necessity for specific ASAM levels of care (LOC) and conducting utilization review, including during 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 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 ASAM criteria, BerryDunn analyzed the following:

- The Carrier’s responses to interrogatories, requests for information (e.g., policies and procedures), and data calls
- A random sample of 93 claims, representing 51 unique members, to determine whether ASAM criteria were used

Findings: Interrogatory, Request for Information, Data Call Review

1. 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 document ASAM inconsistently.
2. Risk assessment not considered in inter-rater reliability. The current inter-rater reliability (IRR) does not encourage utilization reviewers to consider the associated risk related to each of ASAM’s six dimensions. The Carrier reported it will conduct IRR utilizing ASAM for SUD cases in 2018.

Findings: Medical Claim Review

BerryDunn used the New Hampshire Comprehensive Health Information System (NHCHIS) as a data resource from which to select a random sample of individuals receiving substance use treatment services. The Carrier provided case records for these individuals from its systems.

BerryDunn reviewed all records for each individual to assess compliance with ASAM criteria. Findings from this review are summarized below.

1. Reviewers do not assess treatment alternatives. Utilization reviewers do not actively query 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). BerryDunn found no documentation that a utilization reviewer sought an internal consultation from a physician in terms of MAT.
2. Reviewers do not assess treatment alternatives. Utilization reviewers rarely posed questions or followed through with a provider related to family involvement, probation or parole involvement, or housing. Members appear to be finding their own sober living arrangements while in care. Utilizing elements of Dimension 6 are critical to member recovery.
3. Withdrawal Management (WM) documentation is unclear. Utilization reviewers do not clearly document WM levels.
4. Members are being assigned to the correct ASAM level of care. In one case in which a physician was involved in the denial process, the physician applied ASAM correctly. In all cases, members were in the appropriate LOC for the services that were authorized.
5. Risk scores are not documented consistently. Utilization reviews do not consistently capture risk scores related to each of the six dimensions.

This report proceeds as follows:

- Section 2.0 provides an introduction and background of the present targeted examination.
- Section 3.0 discusses the purpose and goal of the examination.
- 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

¹NH Rev Stat § 420-J:16 (2016). Accessed 15 October 2018:

<http://www.gencourt.state.nh.us/rsa/html/xxxvii/420-j/420-j-mrg.htm>.

² ASAM: American Society of Addiction Medicine. Accessed 12 October 2018:

<https://www.asam.org/resources/the-asam-criteria/about>.

³ NH State Law Definition of ASAM Criteria: NH Rev Stat § 420-J:15 (2016). Accessed 12 October 2018:

<http://www.gencourt.state.nh.us/rsa/html/xxxvii/420-j/420-j-15.htm>.

⁴ ASAM: American Society of Addiction Medicine. Resources. What is ASAM Criteria? Accessed 6 November 2018: <https://www.asam.org/resources/the-asam-criteria/about>.

⁵ ASAM: American Society of Addiction Medicine. Resources. What is ASAM Criteria?: Accessed 12 October 2018: <https://www.asam.org/resources/the-asam-criteria/about>.

⁶ ASAM: American Society of Addiction Medicine. Resources. What is ASAM Criteria?: Accessed 12 October 2018: <https://www.asam.org/resources/the-asam-criteria/about>.

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 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 provide a structured approach to create comprehensive and individualized treatment plans.² Treatment plans were developed through a multidimensional 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 recovery opportunities 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 of the examination is to ensure that the Carrier correctly uses ASAM as medical necessity criteria (MNC) to determine appropriate 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 its examination 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 staff who perform utilization review activities, including total full-time equivalents (FTEs), FTEs allocated to members with SUDs or co-occurring disorders, and staff 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 all 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 who offer all ASAM LOC

4.1.3 Quality

BerryDunn requested the following 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 physician advisors and utilization reviewers who make utilization determinations, with a focus on SUD clinical cases
- All clinical denials related to SUDs

4.2 Clinical Record Review

4.2.1 Sampling Process

Using the NHCHIS, BerryDunn pulled claims via a random sampling technique, with no member represented by more than one claim, for an LOC of intensive outpatient or higher. This sample of member claims was sent to the Carrier to identify the unique members and link to the entire episode of care for each member. The number of claims requested was chosen 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 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 that 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 SUDs and co-occurring disorders, including physical health concerns
- Social determinants
- Presenting problems
- 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 and continued stay review

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

BerryDunn used one clinical reviewer, so no IRR was needed or completed. As a result, trends, strengths, and opportunities for improvement could be tracked throughout the sample.

BerryDunn reviewed multiple claims for unique members and provided the ability to review elements of clinical care over time across clinical treatment settings. This process also captured coordination of care, attention to care integration opportunities, discharge practices, and evidence related to appropriate utilization of ASAM. Each submitted claim represented one LOC review, and in some instances, BerryDunn reviewed several LOC for the same member.

5.0 Results of Examination

5.1 Interrogatories, Data Calls, and Requests for Information

BerryDunn conducted a review of all submitted information. The findings are as follows.

5.1.1 Clinical Operations

ASAM is used for all LOC other than 4.0 (medically managed intensive inpatient service). InterQual criteria are used for 4.0 because 4.0 is a hospital-based service and requires medical management.

In EPC.UM.246 policy and procedure, precise ASAM language is not consistently used (e.g., “detox” is used rather than ASAM-referenced “withdrawal management”).

A description of ASAM LOC and ASAM clinical review protocols are not present in the policies and procedures.

The submitted policies and procedures reflect generic clinical information to be collected during the prior authorization process. There are elements identified in the Electronic Medical Record training manual, but the manual does not reflect the scope and depth of documentation, nor does it identify a template for narrative that is clinically helpful for ASAM documentation (EPC.UM.246 Development Review Evaluation and Use of Medical Necessity Criteria).

In CC.UM.02, utilization review decisions specifically refer to InterQual MNC and “other applicable MNC.” In CP.MP.68, ASAM is inferred but InterQual is identified.

The Carrier provided an Excel attachment of clinical denials for the relevant time period. Out of 25 denials, only 5 discuss or recommend alternative LOC.

The provider manual identifies ASAM as the identified criteria for SUDs.

5.1.2 Orientation and Training of Clinical Staff

The Carrier reported ASAM training is provided to new clinical staff and as needed. The Carrier did not provide the actual training materials or documentation of clinical staff training. The Carrier responded that staff may request ASAM training, or a supervisor may refer a clinical staff member for training. Provider networks are updated weekly, but there is no training on the topic provided.

5.1.3 Quality

The Carrier indicated that ASAM IRR will begin in 2018. BerryDunn reviewed the content and format of the IRR tool to be used. The tool is comprehensive, and provides updated education and repetition of ASAM principles and LOC. The case examples are described in case review format, but the ASAM dimensions and associated levels of risk are not clearly delineated, nor do they prompt the utilization reviewers to make informed clinical determinations based upon the ASAM MNC, as required.

5.2 Clinical Record Review/Claims Review

The Carrier submitted a total of 93 claims (reviews), representing 51 unique members.

5.2.1 Provider Distribution

Members received services from 10 providers: Joshua Park RTC; Phoenix; SE Services; Manchester Alcoholism and Rehab Center; Keystone Hall; Hampstead; Farnum; Friendship House; TruCare; and Fit NHH.

With regard to providers, BerryDunn found the following:

- In nine reviews, the provider was not identified on admission. If there were subsequent reviews, the provider was documented.
- Of the 93 claims, 68 reflected residential or WM LOC.
- Of the 51 unique members, 22 received services at Farnum that resulted in 41 claims reviewed at ASAM levels 3.5, 3.7, or 3.7 WM.
- The following ASAM LOC were represented in the sample: IOP (ASAM 2.1), Partial (ASAM 2.5), Residential 3.5 and 3.7, and 3.7 detox (ASAM 3.7 WM). These LOC require a prior authorization.
- It is unclear if providers are using ASAM principles, clinical models, and criteria in delivering treatment to members, or if LOC in the network are consistent with ASAM principles.

5.2.2 Care Management Documentation Summary

Table 1 provides an overview and summary of the prior authorizations and continued stay utilization reviews. There were 12 WM cases for which the documentation reflected that no review was required based upon the “state mandate.”

Table 1: Types of Reviews

Overview		
	Number of Reviews	Comments
Total Reviews	93	
Prior Auth	44	
Continued Stay	37	
State-Mandated Detox (WM) (No Prior Auth Required)	12	Cases documented as not reviewed (by the utilization reviewer) as per “state mandate.” If continued stay review completed, all met WM criteria.

5.2.3 Documentation

BerryDunn reviewed each of the claims to determine whether ASAM criteria were documented and applied appropriately.

- Of the 93 claims, utilization reviewers correctly documented ASAM MNC in 11 reviews.
- In three reviews, utilization reviewers transcribed the entire subsection of ASAM for specific LOC that did not differentiate among MNC for the identified LOC.
- In 52 reviews, utilization reviewers identified that members met ASAM criteria for Dimensions 1 – 6. However, the specific criteria within the dimensions were not adequately identified, nor were they clearly considered in documentation related to the differentiation in the actual ASAM MNC criteria for specific LOC.
- In one review, the utilization reviewer stated that MNC was met per ASAM, but provided no other definitive information.
- Six reviews contained no MNC documentation, yet the members were authorized to the correct LOC.
- InterQual was reflected in two reviews for Inpatient Psych with step-down to an appropriate SUD LOC. The step-down clinical information provided in the documentation appeared to meet the more acute WM LOC as determined by InterQual. InterQual is proprietary and therefore cannot be compared to ASAM in this report.

- Of all reviews, 12 were WM LOC that contained documentation stating that, under State mandate, detox requires no MNC review.
- It did not appear that there were any claims related to OP WM, 3.2 WM, or 3.1 residential/halfway house LOC. Sober living opportunities are mentioned in documentation, but no claims were reviewed for that LOC.
- In most instances, ASAM LOC were used except in the case of WM LOC. It was not clear, particularly in a 3.5 residential rehabilitation LOC, what level of WM is being delivered. 3.5 WM is not an ASAM LOC.

5.2.4 Utilization Review Process/Decision-Making

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 considered a critical treatment option, given the history of a member's OUD. There was also no documentation that a utilization reviewer sought an internal consultation from a physician in terms of MAT.⁵

BerryDunn found few times when a utilization reviewer posed questions related to family involvement, probation or parole involvement, or housing. Members appear to be finding their own sober living arrangements while in care. Using elements of Dimension 6 are critical to member recovery.

One specific utilization reviewer consistently collected appropriate clinical information and used ASAM correctly in making medical necessity determinations.

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.

BerryDunn found few cases that were taken to a physician for consultation related to LOC questions, medications, or quality of care issues. One case was referred to an Ambetter physician who denied the LOC requested. The physician appropriately used ASAM criteria in the denial documentation.

Table 2: Authorizations

Authorizations			
LOC	Number of Reviews	Percentage Meeting ASAM Criteria/Member in Correct LOC	Comments
Detox	4	100%	Level of detox not identified, but all appear to be 3.7 WM and members are in the correct LOC.
3.7 WM	19	100%	
3.7	10	100%	Two cases were step-down from hospital-based WM, and InterQual was used as MNC. The members met ASAM criteria for 3.7.
3.5	35	100%	
2.5	2	100%	
2.1	10	100%	
1.0	1	100%	Retrospective review.

5.2.5 Denials

Table 3: Denials

Denials					
LOC	Total	Physician Review	Appropriate Documentation of ASAM?	Full/Partial Denial	Correct Application of ASAM
3.5	1	1	Yes	Full	Yes

6.0 Conclusion

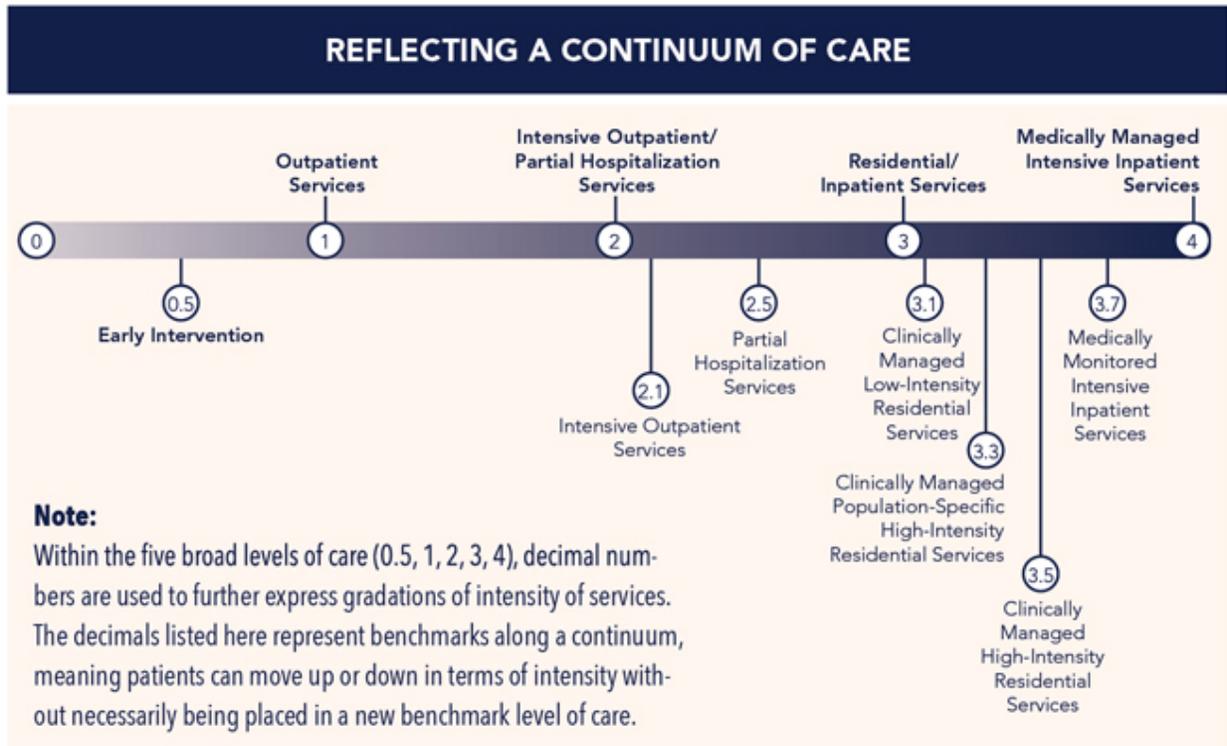
The Carrier uses ASAM during its utilization review processes; however, many utilization reviewers are not using the criteria correctly. The Carrier is currently in the process of conducting IRR for SUD cases, but the current tool does not encourage utilization reviewers to consider associated risk related to each of ASAM's six dimensions. A clinical template that drives ASAM discussion related to the six dimensions and risk associated with each dimension would be helpful to utilization reviewers for determining ASAM MNC related to LOC appropriate for the member. The adequacy of clinical staff training could not be identified from the materials and responses. Utilization reviewers should document ASAM LOC for WM more clearly.

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. The Carrier should ascertain that standard ASAM terminology is used throughout its documentation.

Appendix A: The Six Dimensions of Multidimensional Assessment⁶

AT A GLANCE: THE SIX DIMENSIONS OF MULTIDIMENSIONAL ASSESSMENT		
ASAM's criteria uses six dimensions to create a holistic, biopsychosocial assessment of an individual to be used for service planning and treatment across all services and levels of care. The six dimensions are:		
1	DIMENSION 1	Acute Intoxication and/or Withdrawal Potential Exploring an individual's past and current experiences of substance use and withdrawal
2	DIMENSION 2	Biomedical Conditions and Complications Exploring an individual's health history and current physical condition
3	DIMENSION 3	Emotional, Behavioral, or Cognitive Conditions and Complications Exploring an individual's thoughts, emotions, and mental health issues
4	DIMENSION 4	Readiness to Change Exploring an individual's readiness and interest in changing
5	DIMENSION 5	Relapse, Continued Use, or Continued Problem Potential Exploring an individual's unique relationship with relapse or continued use or problems
6	DIMENSION 6	Recovery/Living Environment Exploring an individual's recovery or living situation, and the surrounding people, places, and things

Appendix B: ASAM Continuum of Care⁷



Appendix C: Acronyms

ASAM – American Society of Addiction Medicine

IOP – Intensive Outpatient

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., 2013, pp. 290-298.

⁶ American Society of Addiction Medicine. Resources. What is the ASAM Criteria? Accessed 1 November 2018: <https://www.asam.org/resources/the-asam-criteria/about>.

⁷ American Society of Addiction Medicine. Resources. What is the ASAM Criteria? Accessed 1 November 2018: <https://www.asam.org/resources/the-asam-criteria/about>.