

NEW HAMPSHIRE INSURANCE DEPARTMENT
MARKET CONDUCT TARGETED EXAMINATION

OF

HARVARD PILGRIM HEALTH CARE OF NEW ENGLAND, INC., NAIC #96717

93 WORCESTER STREET

WELLESLEY, MASSACHUSETTS 02481

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

REGARDING MENTAL HEALTH PARITY AND SUBSTANCE USE DISORDER BENEFIT TREATMENTS

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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 Harvard Pilgrim Health Care of New England, Inc.'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.

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

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

- Evaluate the Medical Management Standards to ensure that the guidelines are clearly outlined and presented to consumers in a format compliant with all applicable statutes and regulations.
- Review and test the Company's website for ease of use and accuracy of on-line directory.
- Evaluate the Company's pre-certification/pre-authorization policies and procedural requirements to ensure that the Company is not imposing more restrictive requirements and determinations on MH/SUD treatments than on Med/Surg.
- Evaluate the Company's complaint volume for MH/SUD complaints versus Med/Surg complaints.
- Detect and identify discriminatory benefit designs.
- Evaluate the Company's formulary designs for prescription drugs to ensure access to appropriate drugs was not more restrictive for MH/SUD than for Med/Surg.
- Evaluate the Company's network adequacy and provider admission requirements for MH/SUD providers and Med/Surg providers.
- Evaluate benefits when treatment is received through an out-of-network provider for services related to MH/SUD and Med/Surg.
- Evaluate the Company's 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 followed as required by [RSA 420-J:16 \(Levels of Care Criteria\)](#).
- Determine the oversight of Delegated Service Contracts for both MH/SUD and Med/Surg Third-Party Administrators (hereinafter, "TPAs").
- Review Medication Assisted Treatment (MAT) criteria.

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.

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 was completed by the market conduct vendor, Examination Resources, LLC (hereinafter, "ER"), as well as Berry, Dunn, McNeil & Parker (hereinafter, "BerryDunn"). ER reviewed company policies and procedures for general compliance with MHPAEA, while BerryDunn reviewed company policies and procedures related to the use and application of ASAM criteria and provider reimbursement methodology and rates. Phase I summaries and findings are based upon ER's review, unless specifically indicated

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.

otherwise. Phase I included sending interrogatories and other data requests to obtain information from the Company.

Phase II, completed by Regulatory Insurance Advisors, LLC (hereinafter, “RIA”), included a series of data requests to perform MH/SUD and Med/Surg health and prescription drug claim file review in order to verify Medication Assisted Treatment (MAT) practices and overall compliance with both quantitative and non-quantitative requirements of the MHPAEA, as well as a review of limited company policies and procedures related to sample claim files. Phase II summaries and findings are based upon RIA’s review, unless specifically indicated otherwise. Phase II included sending data requests for claims universes, interrogatories, and follow-up Requests for Information (hereinafter, “RFIs”) to obtain information from the Company. RIA also reviewed provider reimbursement rates and methodologies through sample claim files and company policies and procedures; RIA’s provider reimbursement review summary is included under Phase I.

Phase I

ER examiners requested that the Company provide a detailed response to interrogatory questions as they related to plans the Company offered in New Hampshire during the examination period, including the premium assistance program (hereinafter, “PAP”) membership. For a point of reference, the Company’s top ten most common plans in New Hampshire during the examination period included:

Segment (IND, SG, LG)	Product/Plan – 2016	FFM Membership Dec 2016	PAP Membership Dec 2016	General Membership Dec 2016
SG	MD0000003691	41	0	7,711
LG	MD0000002709	0	0	6,016
IND	MD0000003801	0	5,218	0
LG	MD0000003921	0	0	4,847
IND	MD0000003727	3,296	0	830
SG	MD0000003719	0	0	3,551
LG	MD0000003925	0	0	3,390
SG	MD0000003702	0	0	2,819
LG	MD0000003920	0	0	2,520
IND	MD0000003799	0	2,520	0
Totals		3,337	7,738	31,684

Segment (IND, SG, LG)	Product/Plan – 2017	FFM Membership Dec 2017	PAP Membership Dec 2017	General Membership Dec 2017
SG	MD0000004159	114	0	7,675
IND	MD0000004198	0	5,483	0
IND	MD0000004177	3,070	0	990
LG	MD0000003921	0	0	3,841
SG	MD0000004158	0	0	3,622
LG	MD0000003923	0	0	3,312
LG	MD0000003925	0	0	3,135
IND	MD0000004199	0	3,043	0
SG	MD0000004164	0	0	3,032
LG	MD0000003924	0	0	2,789
Totals		3,184	8,526	28,396

In order to complete the MHPAEA compliance review, the Company submitted detailed information on how the financial requirements (hereinafter, “FR”), quantitative treatment limitations (hereinafter, “QTL”), and non-quantitative treatment limitations (hereinafter, “NQTL”) in the Company’s benefit plans in effect during the examination period complied with MHPAEA and state law. 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 examination included reviews in the following areas:

1. Quantitative Reviews
 - a. Aggregate lifetime dollar limitations
 - b. Annual dollar limitations
2. FR and QTL Reviews
 - a. Benefit classifications
 - b. Substantially all test requirements
 - c. Predominant test requirements
3. NQTL Reviews
 - a. Medical management standards
 - i. Prior-authorization and concurrent review requirements
 - ii. Written treatment plans
 - iii. Medical necessity criteria
 - iv. Criteria concerning experimental/investigational services
 - v. Failure to complete a course of treatment requirements
 - b. Formulary design
 - c. Step-therapy and fail-first protocols
 - d. Network development and design
 - i. Design
 - ii. Adequacy

- iii. Reimbursement rates
- iv. Out-of-network providers
- v. Emergency out-of-network services
- vi. Other restrictions on the scope and duration of benefits
- vii. Usual, customary and reasonable methodology
- 4. Provider reimbursement and usual, customary and reasonable (“UCR”)
- 5. Grievances and appeals
- 6. Claims handling
- 7. Other considerations
 - a. Availability of plan information
 - b. Denied applicants
 - c. Clinical trials
 - d. Autism coverage
 - e. Use of American Society of Addiction Medicine (“ASAM”) criteria (to include assessment of compliance with RSA 420-J:16-18)
 - f. Delegated service contracts
 - g. Medication assisted treatment

ER examiners sent an initial data request to the Company (a copy is included as Appendix A to this report), which included a request to complete the following items:

- MHPAEA FR/QTL Worksheet – this worksheet collects information regarding FR, QTL and plan payment data for each identified plan. A separate worksheet was to be completed for each plan offered by the Company in New Hampshire during the examination period. In lieu of completing this worksheet, the Company was allowed to submit Company generated worksheets setting forth the Company’s internal mental health parity testing for each plan.

ER examiners also sent the following data request to the Company (a copy is included as Appendix B to this report):

- MHPAEA NQTL Worksheet – this worksheet collects information regarding the Company’s classification of benefits and application of NQTLs for parity purposes. The worksheet requests information regarding:
 - Classification of benefits
 - Medical management standards - including utilization reviews and case management standards and guidelines
 - Medical necessity criteria
 - Experimental/investigational treatment standards
 - Referrals
 - Network design and development
 - Network Adequacy
 - Reimbursement rates

- Provider directory
- Out-of-network providers
- Out-of-network emergency services
- Formulary design
- Autism coverage

Along with the worksheets, the Company submitted supporting documentation, including copies of all internal processes, procedures, and guidelines applicable to the above-listed areas of review.

As a part of the initial data request, examiners also requested that the Company submit the following documents/information:

- Policy forms for each identified plan
- Complaint logs
- Listing of grievances/complaints and appeals received during the examination period
- Claims handling manuals, processes and procedures
- Listing of denied applicants
- Any delegated services contracts

Once received, examiners reviewed all of the documents/information submitted by the Company to test the Company's compliance with the provisions of MHPAEA and applicable state laws by completing the following steps:

- Mapped benefits and applicable FRs and QTLs of Med/Surg and MH/SUD benefits into the applicable classification to determine if the Company satisfied the substantially all and predominant tests with respect to financial requirements and QTLs.
- Compared the Company's policy forms for each plan to determine consistency between the FRs and QTLs provided in the forms and the FRs and QTLs listed in the MHPAEA FR/QTL Worksheets and other documents/information submitted and to ensure compliance with MHPAEA and applicable state law.
- Reviewed requested documents/information related to the processes, strategies, evidentiary standards, and other factors used to apply NQTLs to Med/Surg and MH/SUD benefits to ensure that the processes, strategies, evidentiary standards and other factors used in applying the NQTLs to MH/SUD benefits in the classification were comparable to, and applied no more stringently than those used in applying the NQTL to Med/Surg benefits in the classification.
- Reviewed copies of the Company's complaint log and a sample of grievances and appeals received during the examination period to determine if there was a

disproportionate number of grievances/complaints and appeals regarding MH/SUD benefits as compared to Med/Surg benefits.

- Reviewed requested information regarding claims handling, denied applicants and delegated services contracts to ensure that the limitations applied to the coverage of MH/SUD benefits was not less favorable than those applied to Med/Surg benefits.

Phase II

RIA examiners reviewed sample claim files and Company policies and procedures related to sample claim files for mental health parity compliance. 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 October 4, 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, "NQL") 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

Harvard Pilgrim Health Care of New England, Inc. (“HPHCNE”) was incorporated in 1978 as a Massachusetts not-for-profit corporation under the name MultiGroup Health Plan and commenced operations as a health plan on October 1, 1980. The Company is licensed as an HMO in New Hampshire and Massachusetts.

In 1986, MultiGroup Health Plan affiliated with Harvard Community Health Plan, and changed its name to Harvard Community Health Plan of New England. In 1996, it became Harvard Pilgrim Health Care of New England, following the affiliation of its parent corporation with Pilgrim Health.

Harvard Pilgrim Health Care, Inc. (“Harvard Pilgrim” or “HPHC”), formerly known as Harvard Community Health Plan, is the parent company of Harvard Pilgrim Health Care of New England. As the parent corporation, Harvard Pilgrim provides administrative services and staffing to HPHCNE. Harvard Pilgrim is a not-for-profit managed care organization. In 1995, Harvard Community Health Plan changed its name to Harvard Pilgrim Health Care. Its corporate headquarters are located at 93 Worcester Street, Wellesley, Massachusetts 02481.

The Company’s Financial Statements reflect the following information:

<i>Re: Harvard Pilgrim Health Care of New England, Inc.</i>	2016	2017
NH Covered Lives	93,617	93,374
Admitted Assets	\$151,280,958	\$141,956,951
Liabilities	\$91,194,980	\$85,917,222

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, Worksheets, Data Requests, Claim Universe File Layout, and other Vendor Reports sent to the Company.

Phase I

Based upon ER examiners' review of the information received from the Company, the following is a summary of ER examiners' findings:

Quantitative Reviews

As a part of the initial data request, examiners requested the submission of the MHPAEA FR/QTL Worksheet for all plans in effect during the examination period. Upon review, the Company identified 252 unique health plans in effect during the examination period. As the assembly of this information for such a large number of plans would take a substantial amount of time, the Company proposed to limit the review to 46 representative plans. The examiners and the Department agreed to limit the review to the proposed plans.

Once the 46 plans were identified, examiners reviewed the plan policy forms and plan documents to determine compliance with the following requirements under MHPAEA regarding aggregate lifetime dollar limits ("ALDL") and annual dollar limits ("ADL"):

- If the plan does not include an ALDL or ADL on any Med/Surg benefits or includes an ALDL or ADL that applies to less than one-third of all Med/Surg benefits, it may not impose an ALDL or ADL, respectively, on MH/SUD benefits.
- If an ALDL/ADL applies to more than one-third but less than two-thirds of Med/Surg benefits, then a plan may only apply an ALDL/ADL to MH/SUD benefits that is no more restrictive than the limit applied to Med/Surg benefits.
- If an ALDL/ADL applies to at least two-thirds of M/S benefits the plan can either:
 - Apply the ALDL/ADL to both Med/Surg and MH/SUD benefits subject to the limit without distinguishing between the Med/Surg benefits and MH/SUD benefits, or
 - Apply an ALDL/ADL on MH/SUD benefits that is no more restrictive than the ALDL/ADL on Med/Surg benefits.

ER examiners noted no exceptions for this review.

FR and QTL Reviews

MHPAEA provides that a plan may not apply any FR or QTL to MH/SUD benefits in any classification that is more restrictive than the predominant FR or QTL of that type applied to substantially all Med/Surg benefits in the same classification.

In order to test compliance with this requirement, examiners requested that the Company complete and submit the MHPAEA FR/QTL Worksheet included as Appendix A to this report for each of the 46 identified plans. The Company informed examiners that it completes an internal MHPAEA compliance evaluation of all plans subject to the requirements of MHPAEA and that it would make available copies of the Harvard Pilgrim Health Care Federal Mental Health Parity Quantitative Compliance Evaluation (“Evaluation”) for each identified plan. The Evaluation provided a comparative analysis of the financial requirements and QTLs imposed for both Med/Surg and MH/SUD benefits and evaluates compliance with MHPAEA requirements.

The first step in completing the review of this requirement was to identify which benefits covered under each plan were MH/SUD benefits and which were Med/Surg benefits and to map every benefit in to one of six classifications identified under 45 CFR § 146.136(c)(2)(ii)(A):

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency services
- Prescription drugs

Once the benefits and the applicable FR and QTLs have been mapped to the proper classification, the determination of compliance requires the application of two tests:

- Substantially all test – If a type (e.g., coinsurance, copayment, deductible or out-of-pocket maximum) of FR or QTL does not apply to at least two-thirds of all (i.e., substantially all) Med/Surg benefits in a classification, then that type cannot be applied MH/SUD benefits in that classification. If the substantially all test is not satisfied, then the plan does not comply with MHPAEA.
- Predominant test – if the substantially all test is satisfied, the plan must also meet the predominant test which provides that if a type of FR or QTL applies to substantially all Med/Surg benefits, the level of the FR or QTL that is considered the predominant level of that type in a classification of the level that applies to more than one-half of Med/Surg benefits in that classification subject to the FR or QTL. The plan may not apply a FR or QTL greater than the predominant level applied to Med/Surg benefits.

ER examiners compared the information included in the Evaluations to the financial requirements and QTLs listed in the applicable plan policy forms and plan documents to ensure consistency. In addition, the information included in the Evaluations was reviewed to determine whether:

- The Company defined and properly categorized benefits as MH/SUD benefits consistent with generally recognized independent standards of current medical practice;
- The placement of benefits into a classification was reasonable and that the same standards of determination was applied to Med/Surg benefits and to MH/SUD benefits; and
- The Company applied the proper methodology when determining whether the plan satisfied the substantially all and predominant tests.

ER examiners noted no exceptions for this review.

NQTL Reviews

The review of NQTLs included a review of the following limitations:

- Medical management standards – included the review of:
 - medical necessity or medical appropriateness criteria;
 - criteria for determining whether a treatment is experimental or investigative;
 - utilization review criteria, including preauthorization and concurrent review requirements;
 - exclusions based on failure to complete a course of treatment; and,
 - requirements regarding the submission of written treatment plans.
- Formulary design
- Network development and design – including the review of the adequacy and availability of MH/SUD providers, requirements for referrals and access to out-of-network providers and out-of-network emergency services
- Provider reimbursement rates and methods for determining usual, customary, and reasonable charges
- Step therapy and fail-first protocols (i.e., refusal to pay for higher-cost therapies until it can be shown that a lower-cost therapy is not effective)
- 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

To assist in the analysis of the application of NQTLs by the Company, ER examiners requested that the Company complete the MHPAEA NQTL Worksheet included in this report as Appendix B. The examiners reviewed the responses and supporting documents/information submitted by the Company to ensure that the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to MH/SUD benefits in a classification were comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the NQTL to Med/Surg benefits in the classification.

Medical Management Standards

Examiners reviewed the Company's written policies and procedures regarding medical management standards and guidelines applicable to both Med/Surg and MH/SUD benefits. This included a review of the policies and procedures of United Behavioral Health/Optum (hereinafter, "UBH/Optum" or "UBH") with whom the Company has a delegated services agreement in place to manage all MH/SUD benefits.

As a part of the review, examiners reviewed the following medical management policies and procedures:

- Harvard Pilgrim Health Care Utilization Management Care Management Program Description 2016-17
- HPHC UM and Care Management Policy - Utilization Review
- HPHC Prior Authorization Policy
- HPHC Prior Authorization Policies (specific services)
- Repetitive Transcranial Magnetic Stimulation Request Form
- Psychological And Neuropsychological Testing Request Form
- 2017 Magellan1 Clinical Guidelines For Medical Necessity Review Harvard Pilgrim Health Plan
- HPHC Medical Review Criteria (specific services)
- HPHC UMCM Policy Experimental, Investigational, and Unproven Services
- HPHC Clinical Trials policy
- UBH Clinical Criteria Policy
- UBH Management of Behavioral Health Benefits
- UBH NH Management of Behavioral Health Benefits Addendum
- UBH 2016 Level of Care Guidelines

Except as specifically noted below, the medical management guidelines, and the processes, strategies, evidentiary standards and other factors used in developing and applying the limitations set forth in the guidelines, established for Med/Surg by the Company and by UBH/Optum for MH/SUD were determined to be comparable.

ER examiners noted no exceptions for this review; other examiners did have findings as noted below.

The NHID found that the UBH/Optum definition of medical necessity is different from, the Company's definition of medical necessity. Specifically, the Company's definition is identical to New Hampshire's statutory definition of medical necessity (RSA 420-J:3, XXV-b), which includes the concept of treatment "demonstrated through scientific evidence to be effective in improving health outcomes" and "representative of best practices in the medical profession." The UBH/Optum definition does not include these statutory concepts, and instead adds a component related to cost-effectiveness, referencing treatment "not more costly than an alternative drug, service or supply that is at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the member's mental illness, substance use disorder, or its symptoms." This approach could result in a more stringent standard for medical necessity in the MH/SUD context than for Med/Surg.

Formulary Design

This portion of the review was completed by a licensed pharmacist with over 20 years of clinical experience. The 2016 and 2017 HPHC Premium and Value formularies were reviewed to determine whether the processes, strategies, evidentiary standards, or other factors used in developing the formulary design with respect to the coverage of MH/SUD drugs was comparable and limitations applied were no more stringent than those applied to Med/Surg drugs.

Specifically, the examiners/pharmacist reviewed and compared:

- Prior authorization requirements to determine if the requirements imposed were comparable and no more stringently applied to MH/SUD drugs;
- Step therapy/fail-first protocols to determine if the requirements are comparable and no more stringently applied to MH/SUD drugs;
- Tiering placement of MH/SUD and Med/Surg drugs to determine if comparable standards were used in determining tier placement for MH/SUD drugs and that these drugs were not being consistently pushed to the higher cost sharing tiers; and,
- Formularies were reviewed to assess accessibility of MH/SUD drugs - particularly coverage for SUD drugs.

Based upon this review, examiners/pharmacist found no exceptions regarding prior authorization requirements, tiering placement, or accessibility of MH/SUD drugs. Examiners/pharmacist observed however, differences in the results of step therapy protocols as applied to MH/SUD drugs when compared to those applied to Med/Surg drugs on the formularies. The disparity in the application of step therapy protocols was found to be greater with respect to the Premium formularies.

Network Development and Design

Examiners reviewed the Company's and UBH/Optum's network admission, credentialing, and network closure standards for Med/Surg providers and MH/SUD providers to determine whether comparable standards were being applied to MH/SUD providers as applied to Med/Surg providers and to ensure that more stringent standards were not being applied to MH/SUD providers.

Examiners reviewed the credentialing standards for physicians, facilities, licensed non-physician providers and for unlicensed professionals and paraprofessionals to ensure that more restrictive requirements were not applied to MH/SUD providers than to Med/Surg providers and that comparable standards were applied. The Company follows National Committee for Quality Assurance ("NCQA") standards with respect to the credentialing standards for non-licensed professionals. In addition, the Company does not employ provisional credentialing and only .33% of the Company's primary care providers are subject to contracts where the credentialing process was delegated to another entity.

Both the Company and UBH/Optum have network adequacy policies and procedures and each perform annual adequacy assessments. The policy and procedures were found to be compliant with all requirements required under federal and state law.

The Company has internal policies and procedures regarding referrals and access to out-of-network providers for MH/SUD services, and applies the same standards to both MH/SUD and Med/Surg providers.

ER examiners noted no exceptions for this review.

Provider Reimbursement – BerryDunn and RIA Reviews

Contract examiners from BerryDunn and RIA completed distinct reviews from one another relative to Provider Reimbursement.

BerryDunn and RIA examiners found exceptions in terms of Provider Reimbursement. Specifically, MH/SUD providers are reimbursed at lower rates than Med/Surg providers, and the Company did not provide a clear explanation to explain provider reimbursement disparities. Please refer to the *Examination Details and Findings* section for additional information.

Step Therapy/Fail First Protocols

In addition to the review of step therapy/fail first requirements with respect to prescription drug coverage, examiners also reviewed the Company's and UBH/Optum's utilization review

policies and procedures to determine whether comparable processes and procedures were being applied to MH/SUD benefits as applied to Med/Surg benefits.

ER examiners noted no exceptions for the additional step therapy/fail-first protocols review.

Other Restrictions on Scope or Duration of Benefits

In addition to the review of the above NQTLs, examiners also reviewed restrictions based upon geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided. Examiners reviewed provider listings, credentialing standards and utilization review policies and procedures with respect to restrictions placed on access to MH/SUD benefits based upon geographic location, facility type (e.g., limiting coverage of certain services to specific type of facility) and provider specialty (e.g., providing that coverage for a particular service will only be covered when provided by a specific type of provider) to ensure accessibility to MH/SUD services and to ensure the standards for applying these limitations were comparable and applied no more stringently to MH/SUD services than to Med/Surg services.

ER examiners noted no exceptions for this review.

Grievances and Appeals

During the examination period, the Company received 28 grievances/complaints regarding MH/SUD benefits. Examiners tested 100% of the grievances/complaints. In addition, examiners randomly selected samples of 113 appeals from a total population of 766 member appeals (including appeals regarding failure to pay and denial due to lack of medical necessity) received by the Company during the examination period. Appeals were reviewed to determine whether there was any pattern of denying certain MH/SUD benefits, if there was a higher number of MH/SUD appeals and/or a greater percentage of denied MH/SUD appeals.

In addition to the grievance/complaint and appeal files, examiners reviewed the following internal appeals and external review policies and procedures to determine compliance with state laws and MHPAEA requirements:

- HPHC Appeals Procedures – Executive Summary
- HPHC Appeals Procedures – Expedited Appeals
- HPHC Appeals Procedures – External Review
- HPHC Appeals Procedures – Post Service Appeals
- HPHC Appeals Procedures – Pre-Service Appeals
- UBH Independent External Reviews of Non-Coverage Determinations
- UBH Management of Behavioral Health Benefits
- UBH Member Internal Appeals of Non-Coverage Determinations

- UBH New Hampshire Addendum to Independent External Reviews of Non-Coverage Determinations
- UBH New Hampshire Independent External Reviews of Non-Coverage Determinations Addendum
- UBH NH Management of Behavioral Health Benefits Addendum

ER examiners noted no exceptions for this review.

Claims Handling Policies and Procedures

The examiners reviewed the Company's claims handling manuals, internal processes, procedures, and guidelines regarding the processing and payment of claims as well as the most current internal claim audit report to ensure that the coverage provided for MH/SUD benefits was consistent with the coverage set forth in policy forms and documents for the 46 identified plans and complied with the requirements under federal and state law.

Claims handling processes and procedures were tested to determine whether more stringent requirements were imposed on the processing of MH/SUD claims than placed on Med/Surg claims.

ER examiners noted no exceptions for this review.

Other Considerations

Availability of Plan Information

Examiners reviewed the plan documents and the Company's website to test how readily accessible plan information is for MH/SUD benefits and Med/Surg benefits. The information for both, including policies/certificates, Summary of Benefits and Coverage and utilization review guidelines, were readily accessible on the Company's website. The website also provides information on how a customer may request hard copies of the documents.

ER examiners noted no exceptions for this review.

Denied Applicants

The Company submitted a listing of individual and group applicants denied coverage during the examination period. The list and the denial reasons presented were reviewed to ensure that the basis for denial complied with the requirements under federal and state law and that the Company did not place any impermissible limitations on accessibility to coverage.

ER examiners noted no exceptions for this review.

Clinical Trials

Examiners reviewed the Company's and UBH/Optum's utilization review and claims handling policies and procedures with respect to clinical trials, to ensure that access to clinical trials for MH/SUD conditions was provided, that the strategies, processes, evidentiary standards and other factors applied to benefits for clinical trials for the treatment of MH/SUD conditions were comparable and applied no more stringently than those applied to clinical trials for the treatment of Med/Surg conditions.

ER examiners noted no exceptions for this review.

Autism Coverage

Examiners reviewed the Company's and UBH/Optum's utilization review and claims handling policies and procedures, as well as policy language for plans in effect during the examination period regarding Autism benefits to ensure that the coverage provided for Autism complied with the requirements under state law and that any strategies, processes, evidentiary standards and other factors used to apply non-quantitative limitations to Autism benefits are comparable and applied no more stringently than those applied to Med/Surg benefits.

ER examiners noted no exceptions for this review.

ASAM Criteria Compliance – ER, RIA and BerryDunn Reviews

RSA 420-J:16-18 sets forth standards for the coverage of SUD benefits for carriers providing health insurance through a managed care system of health care delivery and reimbursement. The statutes set forth standards for:

- The use of ASAM criteria when determining medical necessity and utilization review standards for levels of care for SUD services
- Prior authorization requirements
- Authorization for medication-assisted treatment (hereinafter, "MAT")

The ASAM criteria is a comprehensive set of guidelines for placement, continued stay and transfer/discharge of patients with addiction and co-occurring conditions.

ER Review

ER examiners reviewed UBH/Optum's utilization review and medical necessity criteria and authorization requirements to test whether ASAM criteria for levels of care and ASAM screening and assessment tools for prevention of, or early intervention in

addiction were used in the development of the Company's policies and procedures with respect to coverage of SUD benefits.

ER examiners noted no exceptions for this review.

RIA Review

RIA examiners reviewed prior authorization and concurrent review notes in sample claim files where UBH/Optum's Level of Care Guidelines were applied, as well as UBH/Optum's medical management policies and procedures.

RIA examiners found one general (1) exception in terms of the inclusion of ASAM criteria during the medical necessity/utilization review process. Please refer to the *Examination Details and Findings* section for additional information.

BerryDunn Review

BerryDunn reviewed medical management policies, clinical rosters, staffing data, clinical review data, and UBH/Optum narratives in response to BerryDunn interrogatories 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 1 exception in the Company's application of ASAM criteria during the medical necessity/utilization review process. Please refer to the *Examination Details and Findings* section for additional information.

Delegated Service Contracts

As indicated previously, the Company delegates the administration of MH/SUD benefits to UBH/Optum pursuant to a delegated services agreement. The agreement was reviewed to determine if:

- UBH/Optum applied clinically appropriate criteria and guidelines; and
- The criteria and guidelines utilized did not impose any limitations on MH/SUD benefits that are more stringent than those applied to Med/Surg services.

ER examiners noted no exceptions for this review.

Medication-Assisted Treatment

As a part of the examiners’ medical management standards and formulary design reviews, the coverage of medication-assisted treatment for opioid addiction was reviewed:

- To determine if medical necessity/appropriateness and prior authorization requirements imposed were comparable and no more stringently applied.
- Any step therapy/fail-first protocols to determine if the requirements are comparable and no more stringently applied.
- Formularies were reviewed to assess accessibility of MH/SUD drugs - particularly coverage for substance use disorder drugs.

ER examiners noted no exceptions for this review.

Phase II

RIA examiners reviewed sample claim files for mental health parity compliance, as well as limited policies and procedures related to sample claim files for mental health parity compliance.

Claims

Sample Claim Files Reviewed

Samples: HEALTH CLAIMS PAID

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

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

MH/SUD Total Universe Population	229,186
Med/Surg Total Universe Population	1,928,758

MH/SUD Health Sample Size	119
Med/Surg Health Sample Size	25

Claim type	MH/SUD Sample Size	Med/Surg Sample Size
In-patient/In-Network	4	0
In-patient/Out-of-Network	0	0

Out-patient/In-Network	108	19
Out-patient/Out-of-network	5	0
Emergency Services	2	5
Prescription Drug Services	0	1

Samples: HEALTH CLAIMS PARTIALLY PAID

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

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

MH/SUD Total Universe Population	18,339
Med/Surg Total Universe Population	1,544,351

MH/SUD Health Sample Size	119
Med/Surg Health Sample Size	25

Claim type	MH/SUD Sample Size	Med/Surg Sample Size
In-patient/In-Network	19	1
In-patient/Out-of-Network	1	0
Out-patient/In-Network	73	20
Out-patient/Out-of-network	6	0
Emergency Services	0	4
Prescription Drug Services	20	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 two (2) exceptions in terms of insufficient denial code information included on member Explanation of Benefits (hereinafter, “EOB” or “EOBs”) under operational procedures.

The examiners found no exceptions in terms of Med/Surg claims denied under claim handling procedures. However, the examiners found one (1) exception in terms of insufficient benefit information included on member EOBs under operational procedures.

Please refer to the *Examination Details and Findings* section for additional information.

MH/SUD Total Universe Population	25,704
Med/Surg Total Universe Population	408,838

MH/SUD Health Sample Size	119
Med/Surg Health Sample Size	25

Claim type	MH/SUD Sample Size	Med/Surg Sample Size
In-patient/In-Network	13	4
In-patient/Out-of-Network	3	1
Out-patient/In-Network	64	18
Out-patient/Out-of-network	39	2
Emergency Services	0	0
Prescription Drug Services	0	0

Samples: HEALTH CLAIMS DENIED WITH PRIOR AUTHORIZATION

The examiners found one (1) exception in terms of MH/SUD health claims denied with prior authorization as related to MH/SUD utilization management (hereinafter, “UM”) policies. While reviewing sample claim files requiring prior authorization (hereinafter, “PA”) and/or concurrent review, examiners observed differences in medical management standards utilized by UBH/Optum and the Company for MH/SUD and Med/Surg. Additionally, the examiners found one (1) exception in terms of MH/SUD health claims denied with prior authorization under claim handling procedures, and one (1) exception under data issues. Specifically, one exception for unfair claim settlement practices, and one exception for an incomplete claim file.

The examiners found three (3) exceptions in terms of Med/Surg claims denied with prior authorization under operational procedures. Specifically, two EOBs did not include the NHID’s contact information, and one EOB did not include sufficient information describing benefits.

Please refer to the *Examination Details and Findings* section for additional information.

MH/SUD Total Universe Population	920
Med/Surg Total Universe Population	21,988

MH/SUD Health Sample Size	115
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Med/Surg Health Sample Size	25
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Claim type	MH/SUD Sample Size	Med/Surg Sample Size
In-patient/In-Network	41	1
In-patient/Out-of-Network	3	0
Out-patient/In-Network	41	24
Out-patient/Out-of-network	30	0
Emergency Services	0	0
Prescription Drug Services	0	0

Samples: PRESCRIPTION DRUG CLAIMS PAID

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

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

MH/SUD Rx Universe Population	1,432,796
Med/Surg Rx Universe Population	158,590

MH/SUD Rx Sample Size	117
Med/Surg Rx Sample Size	25

Claim type	MH/SUD Sample Size	Med/Surg Sample Size
Retail In-Network	114	24
Retail Out-of-Network	0	0
Mail Order In-Network	3	1
Other	0	0

Samples: PRESCRIPTION DRUG CLAIMS DENIED

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

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

MH/SUD Rx Universe Population	252,598
Med/Surg Rx Universe Population	26,849

MH/SUD Rx Sample Size	117
Med/Surg Rx Sample Size	25

Claim type	MH/SUD Sample Size	Med/Surg Sample Size
Retail In-Network	109	22
Retail Out-of-Network	0	0
Mail Order In-Network	8	3
Other	0	0

Samples: Adverse Benefit Determination Notifications

Examiners found 1 (one) exception in terms of MH/SUD partially paid, denied, and denied with prior authorization claims under operational procedures for failure to consistently include NHID contact information on member EOBs. Please refer to the *Examination Details and Findings* section for additional information.

General Examination Findings

Failure to Facilitate Examination

RIA examiners found 1 (one) exception for failure to facilitate the examination. Please refer to the *Examination Details and Findings* section for additional information.

Compliance with Previous Examination Recommendations:

The findings and recommendations identified in the previous examination, Ins. No. 15-073-MC, included:

- A follow-up examination of delegated services and National Committee on Quality Assurance (NCQA) oversight to be completed.
- Provide additional information on how carrier demonstrates it handles requests from members in service area that do not have adequate contracted MH/SUD providers available.
- Ensure consumer ease of access to website and accurate MH/SUD provider listings.
- Review and consider the potential adoption of the 2016 NCQA provider audit process rules effective July 2016 and consider DirectAssure program from Council for Affordable Quality Healthcare (CAQH).

- Address claims data through expanded interrogatories in the delegated service and NCQA oversight examination.
- Provide information regarding clinical basis for limitations as contrary to the dosing guidelines for Evzio and Narcan.
- Ensure medical necessity and utilization review policies and guidelines are easily accessible to consumers on the carrier’s website and the delegate’s website.
- Include medical management policy and procedures review into the delegated services and NCQA oversight examination.
- Provide additional information demonstrating that prior authorization requirement on MH and drug/alcohol rehabilitation services is not a parity violation.
- Include review of provider reimbursement in delegated services and NCQA oversight examination to review possible parity violation.

During the course of examination Ins. No. 17-047-MC, it was determined that the Company has taken some of the above-mentioned corrective action measures to come into compliance with previous examination findings and recommendations. However, other items were being reviewed as part of the follow-up examination recommended above.

EXAMINATION DETAILS AND FINDINGS

Phase I

Based upon the each examination team’s scope of review, examiners reviewed information from the Company and followed up with any outstanding questions. Respective review findings related to policies and procedures are included below.

Formulary Design Review – ER Review:

Regulatory Authority

45 CFR §146.136 - Parity in mental health and substance use disorder benefits

(c)(4) *Nonquantitative treatment limitations—(i) General rule.* A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

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

- (A) Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- (B) Formulary design for prescription drugs;
- (C) For plans with multiple network tiers (such as preferred providers and participating providers), network tier design;
- (D) Standards for provider admission to participate in a network, including reimbursement rates;
- (E) Plan methods for determining usual, customary, and reasonable charges;
- (F) 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);
- (G) Exclusions based on failure to complete a course of treatment; and
- (H) 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.

Testing Methodology – ER Review:

The formulary design review was completed by a licensed pharmacist with over 20 years of clinical experience. The pharmacist reviewed the 2016 and 2017 HPHC Premium and Value formularies to determine whether any processes, strategies, evidentiary standards, or other factors used in developing the formulary design with respect to the coverage of MH/SUD drugs was comparable and limitations such as prior authorization and step therapy/fail first requirements were applied no more stringently than those applied to Med/Surg drugs.

Specifically, the examiners/pharmacist reviewed and compared:

- Prior authorization requirements to determine if the requirements imposed were comparable and no more stringently applied to MH/SUD drugs.
- Step therapy/fail-first protocols to determine if the requirements were comparable and no more stringently applied to MH/SUD drugs.
- Tiering placement of MH/SUD and Med/Surg drugs to determine if comparable standards were used in determining tier placement for MH/SUD drugs and that these drugs were not being consistently pushed to the higher cost sharing tiers.
- The accessibility of MH/SUD drugs - particularly coverage of SUD drugs.

In response to the initial data request, the Company submitted copies of the following formularies:

- HPHC Premium Formulary Three-Tier Drug List (2016)
- HPHC Premium Formulary Four-Tier Drug List (2016)
- HPHC Value Formulary Four-Tier Drug List (2016)
- HPHC Value Formulary Five-Tier Drug List (2016)
- HPHC Premium Formulary Three-Tier Drug List (2017)
- HPHC Premium Formulary Four-Tier Drug List (2017)
- HPHC Value Formulary Four-Tier Drug List (2017)
- HPHC Value Formulary Five-Tier Drug List (2017)

In addition to reviewing the formularies and the medical management policies and procedures listed in the Executive Summary provision of this Report, examiners/pharmacist reviewed the following internal policies and procedures regarding prescription drugs:

- HPHC Pharmacy Services Policy and Criteria - Pharmacy Exceptions
- Formulary Change Request (“FCR”) Policy
- PHA_Commercial Weekly Drug Update Process
- HPHC Pharmacy Services Policy and Criteria - Formulary Change Requests
- 2016 Premium Formulary Step Therapy Requirements
- 2017 Premium Formulary Step Therapy Requirements
- 2016 Value Formulary Step Therapy Requirements
- 2017 Value Formulary Step Therapy Requirements
- HPHC Medication Prior Authorization Program (including Step Therapy)

For each formulary provided, the pharmacist utilized the following categories to identify MH/SUD drugs:

- Anti-Addiction Substance Abuse Treatment Agents
- Antianxiety Agents
- Antidepressants
- Antipsychotic Agents
- Central Nervous System Agents
- Sleep Disorder Agents

Examiner Findings – ER Review:

Based on the examiners/pharmacist formulary design review, the following exceptions were determined with respect to the application of step therapy requirements:

1. A review of all formulary drugs reported to be subject to step therapy requirements on each formulary revealed there to be a disproportionate share of MH/SUD drugs subject

to step therapy requirements. Although MH/SUD prescription drugs encompassed less than 10% of all drugs on the formularies, over 50% of MH/SUD prescription drugs on the formularies was subject to step therapy requirements. Although this NQTL was applied to both Med/Surg prescription drugs and MH/SUD prescription drugs, it was applied more stringently to MH/SUD prescription drugs.

2. For many antidepressant and sedative/hypnotic drug classes, a step therapy age (hereinafter, "STA") edit was applied more frequently, and therefore more stringently, to these MH prescription drugs than to Med/Surg prescription drugs.
3. MH drugs in the sedative/hypnotics drug category required a 7-day trial of the prerequisite drug, while all other Med/Surg drugs reviewed only required a 1-day trial of the prerequisite drug. While the 7-day trial may be clinically appropriate for sedative/hypnotics, it would also be clinically appropriate for several other drug categories for Med/Surg prescription drugs to establish an adequate trial. Accordingly, a more stringent requirement is being applied to this MH category of prescription drugs.

Company Position – ER Review:

The Company provided the following responses to the exceptions found:

1. The Company disagreed with the examiner/pharmacist's finding regarding the application of step therapy requirements for MH/SUD drugs as compared to Med/Surg drugs. The Company acknowledges it applies the step therapy requirement to a larger share of MH/SUD drugs within its formularies, but disagrees with the examiner/pharmacist's determination of that share. While the examiner/pharmacist utilized the HPHC Premium and Value Step Therapy lists to count the number of drugs on the formularies subject to step therapy requirements, HPHC counted the drugs on its formulary by RxNorm concept unique identifiers (hereinafter, "RxCUIs") and found that approximately 10% of its formulary comprise MH/SUD drugs, as defined by the examiner, and only approximately 14% of said MH/SUD drugs were subject to step therapy requirements during the Examination period.

Additionally, the Company stated it elected to conduct its analysis using the RxNorm system because the Centers for Medicare and Medicaid Services requires use of RxCUIs to compare drug offerings between carriers, and the Company also believed it offered the most standardized and accurate portrayal of drug offerings between carriers.

The Company also stated it applies step therapy requirements to the antidepressant category of drugs because it has a large number of generic medications and branded agents, many of which have interchangeable generic alternatives within the same therapeutic class (i.e., SSRI and SNRI). The Company further stated that step therapy provides an automated process to ensure a generic option is tried prior to using a

branded agent and that this approach supports cost effective prescribing with minimal clinical and operational impact.

2. The Company disagreed with the examiner's conclusion that applying the STA edit more frequently to MH sedative/hypnotic drugs creates a more stringent restriction on MH drugs than Med/Surg drugs. The Company stated the STA edit is designed to prevent a step therapy requirement from applying to members under a certain age, specifically the age of 18, and therefore application of a STA edit would have the effect of decreasing any barriers to access for the pediatric population. The Company further stated that employing a STA edit allows management of a category of drugs for adults while also allowing for unrestricted access for the pediatric population where prescribing, dosing and individual response to medication is often more variable.
3. The Company disagreed with the examiner/pharmacist's conclusion that the Company was applying a more stringent day trial requirement to MH sedative/hypnotic drugs than to Med/Surg drugs. The Company further stated the step therapy requirement was applied through an automated coding process adjudicated at the point of service and that while many drugs with a day trial requirement had a 1-day trial requirement, the majority of the claims for those drugs equate to a prescription for a 30-day supply of the drug. Sedative/hypnotics is a class of drugs that is prescribed for use on an as-needed basis and that necessitates more than one use to assess effectiveness. The requirement for a 7-day trial was designed to ensure an adequate trial of a generic sedative/hypnotic drug without being overly burdensome to the member.

To address the Company's response, examiners/pharmacist requested a listing of RxCUIs for each formulary and identification of any other drugs on the formularies that were categorized as medications prescribed on an "as-needed" basis along with any day trial requirement applied to these drugs.

Upon review of the additional information received from the Company, examiners/pharmacists came to the following conclusions:

1. Examiners/pharmacist agree with the Company's assessment that when utilizing RxCUIs, approximately 10% of the formularies are comprised of MH/SUD drugs (examiners identified a range of 10-13% for the Premium and Value formularies provided), and that approximately 14% (examiners identified slightly less, 6-13%, depending on the formulary) of the MH/SUD drugs are subject to step therapy requirements.

Of the MH/SUD drugs on the 2016 and 2017 Premium formularies, approximately 12-13% had step therapy limitations applied as compared to 1% of the Med/Surg drugs. Of those MH/SUD drugs on the 2016 and 2017 Value formularies, approximately 6% had step therapy applied as compared to 0.5% to 0.8% of the Med/Surg drugs.

In addition, the Company indicates that step therapy is an automated process intended to streamline what might otherwise be implemented as a manual prior authorization process, for branded drugs with generics available. The intent of the edit is to encourage generic utilization. This results in applying step therapy limitations to MH/SUD drugs in addition to brand/generic copay differentials, whereas for Med/Surg drugs, the Company appears to rely on the copay differential to drive the generic utilization.

Examiners concluded that the additional analysis further supports that step therapy is more stringently applied to MH/SUD drugs than it is to Med/Surg drugs on the formularies.

2. Examiners/pharmacist re-assessed the exception noted with respect to the application of STA edits based upon the Company's response. Based upon the Company's explanation of how the STA edit was applied, examiners/pharmacist agree that the application of the STA edit removes barriers to access for the pediatric population, making the application less stringent although examiners/pharmacist do note that this policy appears out of step with guidelines as these drugs are rarely studied in the pediatric population. Examiners found no exceptions with the application of the step STA edit and no further action is recommended.
3. Examiners/pharmacist re-assessed the exception noted with respect to the application of a 7-day trial requirement for sedative/hypnotic drugs. The Company provided additional information regarding its automated step therapy review process. Once a member has already tried a first level drug, the system will look back at the member's claim history and automatically approve a claim for a second level drug if the member's claim record shows that s/he has already tried the first level drug within a certain period of time. A step therapy trial value is assigned by counting the doses in a prescription as well as the length of time the member has used the medication to approximate a sufficient trial period. Sedative/hypnotic drugs were assigned a value of "7" because response to medications for insomnia can be impacted by several external factors and, clinically, seven days ensured a sufficient trial to determine if the drug was effective. A value of "7" means that the system will go back and look for a minimum of a 7-day supply of the drug, approximated by the number of doses and days since the prescription was filled, over the lookback period.

In addition, the Company identified a Med/Surg drug on the Company's step therapy list, Liptruzet, a cholesterol drug that required a 30-day trial period of a first level drug to assess efficacy before coverage of Liptruzet would be granted.

Based upon this additional information, it appears the Company applied a comparable process to determine day trial requirements and while the application of the requirements of the automated system may result in differing day trial requirements, the process is not being applied more stringently to MH/SUD drugs. Accordingly, examiners/pharmacist find no exceptions with respect to day trial requirements applied to MH/SUD drugs and no further action is recommended.

Examiner Recommendations – ER Review:

Examiners recommend that the Company evaluate its step therapy requirements as applied to MH/SUD medications to ensure compliance with the requirements under MHPAEA. Examiners will require the Company to provide an action plan, subject to NHID approval, to address step therapy compliance.

Provider Reimbursement – RIA and BerryDunn Reviews:

The NHID engaged a second contract examiner, BerryDunn, to perform an in-depth review of the Company’s provider reimbursement policies, practices, and payment levels. BerryDunn and RIA examiners performed separate and distinct reviews of the Company’s provider reimbursement practices and methodologies. The Company received BerryDunn and RIA review analyses separately, and responded to each review analysis separately. This section encompasses both reviews. However, the Department’s findings rely only on the BerryDunn analysis, not the RIA analysis.

Legal standard

45 CFR 146.136 (c)(4): Nonquantitative treatment limitations—(i) General rule. A group health plan (or health insurance coverage) may not impose a nonquantitative treatment limitation with respect to mental health or substance use disorder benefits in any classification unless, under the terms of the plan (or health insurance coverage) as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the nonquantitative treatment limitation to mental health or substance use disorder benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation with respect to medical/surgical benefits in the classification.

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

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

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

RIA Review:

In determining parity in provider reimbursement, examiners reviewed and compared reimbursement rates for the seven CPT codes in MH/SUD and Med/Surg sample claim files.

Examiners also reviewed the Company's fee schedules, as well as policies and procedures for setting reimbursement rates. Per the Company's request in its response to RIA examiners, RIA examiners also reviewed the Company's response to the NHID regarding the BerryDunn provider reimbursement review. RIA examiners found one (1) exception in terms of provider reimbursement. However, the NHID examiner findings (discussed below) do not rely on the RIA findings; this review is mentioned only in order to provide a complete description of the examination process.

Testing Methodology – BerryDunn Review:

BerryDunn conducted a quantitative analysis of the Company's provider reimbursement levels using 2016 data from the New Hampshire Comprehensive Health Information System (hereinafter, "NHCHIS"). Specifically, BerryDunn compared the ratios of the Company's commercial MH/SUD provider reimbursement rates and Med/Surg provider reimbursement rates, as reported by the Company to the NHCHIS, to Medicare reimbursement rates for the same services.²

BerryDunn selected this methodology because Medicare's method of developing payment methods is resource-based and applies a consistent standard to both MH/SUD and Med/Surg reimbursement calculations.³ Medicare uses the Resource Based Relative Value Scale (hereinafter, "RBRVS") to apply relative weights to payment levels, and the weights are based on the resources associated with the providers' work, practice expense, and professional liability insurance. In order to conduct the analysis, BerryDunn identified specific services in the Inpatient, Outpatient, Emergency, and Pharmacy service categories for comparison.

In addition to the quantitative review, BerryDunn examiners propounded interrogatories regarding the Company's provider reimbursement policies and procedures, and reviewed the responses in tandem with 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

² 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.

³ 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.

in operation, were nevertheless being applied in a manner that was comparable between MH/SUD and Med/Surg services.

Examiner Observations – BerryDunn Review:

Both the inpatient and professional claims analyses showed a large discrepancy in commercial-to-Medicare payment ratios between Med/Surg services and MH/SUD services, with MH/SUD inpatient episodes showing a much lower commercial-to-Medicare reimbursement ratio (1.30 for MH/SUD episodes vs. 2.83 for Med/Surg episodes) and MH/SUD professional services showing the lowest commercial-to-Medicare reimbursement ratio, 1.01, among all professional specialties. By comparison, the BerryDunn analysis found a Med/Surg primary care ratio of 1.40, a Med/Surg evaluation and management services ratio of 1.65, and a gastroenterology ratio of 1.89.

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

In an attempt to measure the comparability of the processes used to determine provider fee schedules for MH/SUD versus Med/Surg, as well as the stringency with which the factors are applied, BerryDunn asked the Company for any analytical framework or formula it used to set reimbursement rates, such as the relative value units (hereinafter, "RVUs"), education level, established base plan rate, geographic scarcity, and market domination. The Company responded that the factors are applied on a procedure code basis and that the process involves a comparison to available market data.

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

During the exam time period the Company updated its Med/Surg fee schedules twice, but did not make changes to its MH/SUD fee schedule. The Company indicated that a higher percentage (90%) of primary care providers (hereinafter, "PCPs") than MH/SUD providers (65%) are paid at rates above the statewide fee schedule. Paying PCPs more frequently at levels above the statewide fee schedule suggests that, from a network contracting perspective, there is greater demand for in-network PCPs than for MH/SUD providers. In addition, the Company estimated that provider negotiating leverage impacted Med/Surg reimbursement rates by 30%-55%, and MH/SUD rates by 10%-35%.

BerryDunn provided evidence in its report that New Hampshire ranks near the top of the country in its supply of surgeons, OB/GYNs and Pediatricians, while the per capita supply of MH/SUD providers is notably below national averages. This appears inconsistent with the Company's payment of higher rates for Med/Surg providers, based on supply and demand for their services, than for MH/SUD providers. With such comparatively high availability of providers in Med/Surg specialties, and therefore more flexibility for the carrier in choosing in-

network providers, we would expect to see more frequent and greater reimbursement increases for the MH/SUD providers.

Company Position – BerryDunn Review:

The Company disagreed with both contract examiners' observations and findings, and provided both an initial response, which was discussed during the exit conference, and a supplemental response, which was reviewed by the NHID following the exit conference.

The Company asserted that both the Company and its behavioral health administrator, UBH/Optum, consider the same factors in setting base statewide provider reimbursement rates, and that the process followed by the Company and UBH/Optum in applying these factors to set final and provider specific reimbursement rates is comparable.

The Company noted that in developing a base fee schedule it relies on Medicare RVUs as one factor, among many it considers, but confirmed that its final reimbursement levels are largely driven by adjustments for market conditions. "Market conditions" were essentially defined by the Company as provider negotiation leverage. The Company noted that it uses a review of actual paid commercial claims data to support its determination of market competitive rates, as well as considering anticipated demand for services and market power of the contracting party. However, the Company disagreed with BerryDunn's analytical reliance on Medicare payment rates because the federal agencies have not specified their use for parity analysis, and because "there may be many codes that HPHC and UBH/Optum cover that are not covered by Medicare."

The Company indicated that "resource use is a much more important factor on the Medicare side because Medicare rates cannot be negotiated." This statement suggests that the RBRVS/Medicare system is reflective of the associated resources needed to deliver a specific professional service, but that the reality of commercial market forces may lead to differences in the contracted rate for payment. Considering the supply and demand for MH/SUD services, we would expect market forces to provide upward pressure on MH/SUD rates, not down, from the relative differences implanted by Medicare.

The Company made reference to market forces from two different perspectives. The first is from the supply and demand side for the MH/SUD providers, and the second suggests the "market" relates to the ability of the Company to compete with other insurance carriers from a premium perspective. The Company's comment "market conditions (i.e., what the payer has to pay in order to remain competitive in the market) are equally if not more important to a commercial payer's provider reimbursement methodology" suggest a focus on the carrier's competitive position in the commercial insurance market. However, the Company did not explain why this is of particular importance given that its competitors are also subject to the parity laws.

In its supplemental response, the Company stated that MHPAEA is “about parity with respect to the process applied, not the outcome of that process,” and asserted that carriers have “broad discretion to consider ‘a wide array of factors’ in setting provider reimbursement rates.” The Company also asserted that market conditions for MH/SUD providers are different from market conditions for Med/Surg providers – for example, that PCPs are much more likely to be part of an alternative payment arrangement than MH/SUD providers. However, the Company did not provide information showing that alternative payment arrangements are less favorable for the provider than a fee-for-service arrangement, resulting in parity overall.

The Company also noted that provider licensure levels will impact provider reimbursement, as there are a variety of non-physician MH/SUD providers with wide variations in training.

Examiner Findings:

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

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

Second, in view of this strong indicator of potential non-compliance, the Department examined whether the Company was in compliance with MHPAEA’s requirement that the Company be able to demonstrate that its provider reimbursement practices for MH/SUD services and Med/Surg services are comparable. The examiners find that the Company did not produce sufficient documentation during the examination regarding the processes, strategies, evidentiary standards or other factors it uses to set reimbursement rates or otherwise provide sufficient information to demonstrate that the Company applies these standards comparably to MH/SUD reimbursement and not more stringently to MH/SUD providers than to Med/Surg providers. The Company provided insufficient detail about the process used to determine provider reimbursement using the factors provided. Based upon the lack of documentation provided during the examination, the NHID examiners find that the company failed to meet MHPAEA’s comparability demonstration requirement.

To the extent that the Company attributed the vast differences in commercial-to-Medicare payment ratios between Med/Surg services and MH/SUD services to differences in bargaining power between MH/SUD providers on the whole and Med/Surg providers on the whole, this

explanation of its practices does not support a finding that it applied a consistent, non-arbitrary, and non-discriminatory methodology.

Third, the examiners also find that there is no evidence in the examination record to support a finding that the Company intentionally applied its processes, strategies, evidentiary standards, or factors more stringently when setting rates for MH/SUD services. Therefore, examiners do not believe any fines or penalties are warranted.

Examiners recommend that the Company undertake an action plan which includes the requirement that the Company develop a precise analytical framework for establishing reimbursement rates and comply with reporting requirements that will allow the Company to demonstrate, and the NHID to confirm, that the Company does not apply its processes, strategies, evidentiary standards and other factors more stringently when setting reimbursement rates for MH/SUD providers.

ASAM Criteria 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 472 MH/SUD health (ACL sampling methodology) sample claim files to ensure compliance with RSA 420-J:16, where applicable, as well as MHPAEA. Examiners reviewed prior authorization and concurrent review notes in sample claim files. Not all sample claims included services requiring the application of ASAM criteria. The review of PA and concurrent review notes in sample claim files prompted examiners to review the following medical management policies and procedures:

- UBH Clinical Criteria Policy
- UBH Management of Behavioral Health Benefits
- UBH NH Management of Behavioral Health Benefits Addendum
- UBH 2016 Level of Care Guidelines
- Harvard Pilgrim Health Care Utilization Management Care Management Program Description 2016-17
- HPHC UM and Care Management Policy - Utilization Review
- HPHC Prior Authorization Policy
- HPHC Prior Authorization Policies (specific services)
- Psychological And Neuropsychological Testing Request Form
- 2017 Magellan1 Clinical Guidelines For Medical Necessity Review Harvard Pilgrim Health Plan

- HPHC Medical Review Criteria (specific services)
- HPHC UMCM Policy Experimental, Investigational, and Unproven Services

Examiner Observations:

UBH/Optum utilizes its proprietary Levels of Care Guidelines instead of the ASAM Criteria. Examiner observed that UBH/Optum’s Levels of Care Guidelines do not clearly reflect ASAM Criteria principles.

Examiner Findings:

Examiners found one (1) exception in terms of the inclusion of ASAM criteria during the medical necessity/utilization review process.

Examiner Recommendations:

The Company shall take corrective action measures to comply with RSA 420-J:16, subject to prior approval of the NHID.

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, BerryDunn 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 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, rather than using the ASAM criteria, the Company used UBH/Optum’s Level of Care Guidelines (hereinafter, “LOCG”), a proprietary document that does not specifically reflect the ASAM criteria, and that in BerryDunn’s view is more restrictive than the ASAM criteria. BerryDunn also expressed concern that the LOCG allowed exceptions to be made from its standards. In its file review, BerryDunn observed that there was no reference to ASAM in the utilization review files, nor was there a clinical template that drove discussion related to the six ASAM dimensions. While clinical information related to the six dimensions was found in the narratives, the associated risk was not necessarily identified as influential, and the utilization reviewers did not analyze and synthesize the member clinical data into a cohesive clinical picture to demonstrate the need for a specific level of care.

With respect to specific cases, BerryDunn cited several examples of high-risk cases where there was no documented evidence of physician consultation, and the examiners had concerns about consistency with ASAM, particularly with respect to ASAM Dimensions 4, 5 and 6. The examiners also noted that in many cases there was no evidence that utilization reviewers actively queried providers about member treatment options, particularly MAT. Overall, however, the BerryDunn examiners concluded that the outcomes of the reviewed claims appeared generally consistent with ASAM, and that the level of care determinations of the reviewed claims resulted in a 95.7% level of accuracy.

Company Position:

The Company disagreed with the contract examiners’ observations. With respect to the LOCG, the Company asserted that the guidelines are not more restrictive than ASAM, and are based on ASAM principles. With respect to the allegation that utilization reviewers did not synthesize member data into a cohesive clinical picture, the Company noted that the reviewers may not have all clinical information available to them.

The Company also noted that as of January 31, 2019, UBH/Optum stopped using its proprietary LOCGs for SUD treatment and is now using the ASAM criteria. All clinical staff have been trained in the use of the criteria, and UBH/Optum is actively promoting the evidence-based use of MAT. The Company also uses a new template keyed to the six ASAM dimensions to document clinical data.

Examiner Findings:

Having reviewed the reports of the contract examiners as well as the Company’s responses, the NHID examiners determined that the Company’s use of UBH/Optum’s LOCG may have created inconsistencies with New Hampshire’s ASAM law. The NHID examiners appreciate that the

Company has discontinued use of the LOCGs, and taken steps to better align its clinical template and practices with the ASAM criteria.

Phase II

Based upon RIA’s scope of review for the examination, RIA examiners reviewed sample claim files to determine mental health parity compliance, as well as company policies, procedures and processes, plan documents, and marketing and member materials. RIA examiners sent out fourteen (14) RFIs to follow up with the Company regarding outstanding questions and/or for purposes of clarification.

Claims:

Testing Methodology:

Examiners reviewed sample claim files to determine mental health parity compliance, consistencies in the policies and procedures presented, and the application of these policies and procedures. The examiners also reviewed issues with timely payments and appropriate notifications. 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	229,186
Med/Surg Total Universe Population	1,928,758

MH/SUD Health Sample Size	119
Med/Surg Health Sample Size	25

Claim type	MH/SUD Sample Size	Med/Surg Sample Size
In-patient/In-Network	4	0
In-patient/Out-of-Network	0	0
Out-patient/In-Network	108	19
Out-patient/Out-of-network	5	0
Emergency Services	2	5
Prescription Drug Services	0	1

Examiner Findings:

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

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

Samples: HEALTH CLAIMS PARTIALLY PAID

MH/SUD Total Universe Population	18,339
Med/Surg Total Universe Population	1,544,351

MH/SUD Health Sample Size	119
Med/Surg Health Sample Size	25

Claim type	MH/SUD Sample Size	Med/Surg Sample Size
In-patient/In-Network	19	1
In-patient/Out-of-Network	1	0
Out-patient/In-Network	73	20
Out-patient/Out-of-network	6	0
Emergency Services	0	4
Prescription Drug Services	20	0

Examiner Findings:

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

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

Samples: HEALTH CLAIMS DENIED

MH/SUD Total Universe Population	25,704
Med/Surg Total Universe Population	408,838

MH/SUD Health Sample Size	119
Med/Surg Health Sample Size	25

Claim type	MH/SUD Sample Size	Med/Surg Sample Size
In-patient/In-Network	13	4
In-patient/Out-of-Network	3	1
Out-patient/In-Network	64	18
Out-patient/Out-of-network	39	2
Emergency Services	0	0
Prescription Drug Services	0	0

Examiner Findings:

The examiners found no exceptions in terms of MH/SUD health claims denied under parity procedures and claim handling procedures. However, the examiners found two (2) exceptions in terms of insufficient denial code information included on member EOBs under operational procedures.

The examiners found no exceptions in terms of Med/Surg claims denied under claim handling procedures. However, the examiners found one (1) exception in terms of insufficient benefit information included on member EOBs under operational procedures.

Company Position:

The Company agreed with the two exceptions found for the MH/SUD health claims denied under operational procedures.

The Company disagreed with the one exception found for the Med/Surg health claim denied under operational procedures.

Examiner Recommendations:

The Company shall take corrective action measures to ensure that EOB and explanation of payment (hereinafter "EOP") documents contain clear information in order for members and providers to understand claim payment or denial. Denial codes shall not conflict with one another, and shall be easily identifiable and linked to the correct service item within a claim. Benefit and payment descriptions shall be clear.

Samples: HEALTH CLAIMS DENIED WITH PRIOR AUTHORIZATION

MH/SUD Total Universe Population	920
Med/Surg Total Universe Population	21,988

MH/SUD Health Sample Size	115
Med/Surg Health Sample Size	25

Claim type	MH/SUD Sample Size	Med/Surg Sample Size
In-patient/In-Network	41	1
In-patient/Out-of-Network	3	0
Out-patient/In-Network	41	24
Out-patient/Out-of-network	30	0
Emergency Services	0	0
Prescription Drug Services	0	0

Examiner Observations:

Examiners observed a high rate of MH/SUD claim denials due to the “UM1: exceeds UM authorization” denial code, which prompted examiners to closely review all PA and concurrent review notes for MH/SUD claims with the above-mentioned denial code. Examiners requested the credentials of the UBH/Optum personnel making UM determinations, a description of the UM determination process for each claim, verification of units utilized prior to the target claim processing, and a clear description of the UBH/Optum UM determination process in terms of medical management standards applied and used for determination. Examiners observed that the Company and UBH/Optum have different definitions of “medical necessity” and the UBH/Optum UM determination process appears to differ from the Company’s UM determination process in that different steps are followed in making determinations (e.g., a greater degree of discretion may be applied for MH/SUD benefit determinations).

Examiner Findings:

The examiners found one (1) exception in terms of MH/SUD health claims denied with prior authorization as related to MH/SUD UM policies. Examiners observed differences in medical management standards utilized by UBH/Optum and the Company for MH/SUD and Med/Surg UM determinations. Additionally, the examiners found one (1) exception in terms of MH/SUD health claims denied with prior authorization under claim handling procedures, and one (1) exception under data issues. Specifically, one exception for unfair claim settlement practices, and one exception for an incomplete claim file.

The examiners found three (3) exceptions in terms of Med/Surg claims denied with prior authorization under operational procedures. Specifically, two EOBs did not include the NHID’s contact information, and one EOB did not include sufficient information describing benefits.

Company Position:

The Company disagreed with the one exception found for the MH/SUD health claim denied with prior authorization as related to MH/SUD UM policies.

The Company agreed with the one exception found for the MH/SUD health claim denied with prior authorization under claim handling procedures.

The Company disagreed with the one exception found for the MH/SUD health claim denied with prior authorization under data issues.

The Company agreed with the two exceptions found for Med/Surg health claims denied with prior authorization under operational procedures regarding failure to include NHID contact information on EOBs.

The Company disagreed with the one exception found for the Med/Surg claim denied with prior authorization under operational procedures regarding not including sufficient benefit and payment information on the member’s EOB.

Examiner Recommendations:

The Company shall take steps, subject to prior approval of the NHID, to ensure that the processes for UM determinations are comparable for both MH/SUD and Med/Surg.

The Company shall re-process and pay the claim with interest that the Company denied incorrectly. The Company shall provide proof of payment to examiners. The Company took corrective action on 5/3/2019 by re-processing the claim to pay.

The Company shall provide complete claim files to examiners upon first request during future exams.

The Company shall immediately begin including the NHID’s address and telephone number on all EOBs containing an adverse benefit determination per N.H. Code Admin. R. Ins. 1001.05.

The Company shall take corrective action measures to ensure that EOB and EOP documents contain clear information in order for members and providers to understand claim payment or denial. Denial codes shall not conflict with one another, and shall be easily identifiable and linked to the correct service item within a claim. Benefit and payment descriptions shall be clear.

Samples: PRESCRIPTION DRUG CLAIMS PAID

MH/SUD Rx Universe Population	1,432,796
Med/Surg Rx Universe Population	158,590

MH/SUD Rx Sample Size	117
Med/Surg Rx Sample Size	25

Claim type	MH/SUD Sample Size	Med/Surg Sample Size
Retail In-Network	114	24
Retail Out-of-Network	0	0
Mail Order In-Network	3	1
Other	0	0

Examiner Findings:

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

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

Samples: PRESCRIPTION DRUG CLAIMS DENIED

MH/SUD Rx Universe Population	252,598
Med/Surg Rx Universe Population	26,849

MH/SUD Rx Sample Size	117
Med/Surg Rx Sample Size	25

Claim type	MH/SUD Sample Size	Med/Surg Sample Size
Retail In-Network	109	22
Retail Out-of-Network	0	0
Mail Order In-Network	8	3
Other	0	0

Examiner Findings:

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

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

Samples: Adverse Benefit Determination Notifications

Examiner Observations:

RIA examiners reviewed all EOB notifications and disclosures included in sample claim files. In particular, examiners observed that MH/SUD partially paid, denied, and denied with prior authorization sample claim file EOBs did not consistently include NHID contact information.

Examiner Findings:

Examiners found one (1) exception in terms of MH/SUD partially paid, denied, and denied with prior authorization claims under operational procedures for failure to consistently include NHID contact information on member EOBs.

Company Position:

The Company agreed with the exception.

Examiner Recommendations:

The Company shall immediately begin including the NHID's address and telephone number on all EOBs containing an adverse benefit determination per N.H. Code Admin. R. Ins. 1001.05.

General Examination Findings:

Failure to Facilitate Examination

Regulatory Authority

RSA 400-A:37 Examinations.

III. Conduct of Examinations.

(b)(1) Every company or person from whom information is sought, its officers, directors and agents must provide to the examiners timely, convenient and free access at all reasonable hours at its offices to all books, records, accounts, papers, documents and any or all computer or other recordings relating to the property, assets, business and affairs of the company being examined. The officers, directors, employees and agents of the company or person must facilitate the examination and aid in the examination so far as it is in their power to do so. The refusal of any company, by its officers, directors, employees or agents, to submit to examination or to comply with any reasonable written request of the examiners shall be grounds for suspension or refusal of, or

nonrenewal of any license or authority held by the company to engage in an insurance or other business subject to the commissioner's jurisdiction. Any such proceedings for suspension, revocation, or refusal of a license or authority shall be conducted pursuant to RSA 400-A:15, III.

Examiner Observations:

After other delays, the Company failed to respond to four (4) RFIs in a timely manner, which impacted the timeline of the exam.

Examiner Findings:

RIA examiners found one (1) exception for failure to facilitate the examination.

Company Position:

The Company disagreed with the exception.

Examiner Recommendations:

The Company shall allocate appropriate resources for an examination team for future examinations with primary and secondary points of contact, and utilize software or another system to effectively track deadlines.

SUMMARY OF RECOMMENDATIONS

Vendor Review	Area of Examination	Examiner Findings	Company Position	Examiner Recommendations	NHID Response
RIA	Failure to Facilitate Examination	1 exception found.	Company Disagreed.	The Company shall allocate appropriate resources for an examination team for future examinations with primary and secondary points of contact, and utilize software or another system to effectively track deadlines.	No further Company action is required.
RIA	Sample MH/SUD DWPA Health Claims – Incomplete Claim File	1 exception found.	Company Disagreed.	The Company shall provide complete claim files to examiners upon first request during future exams.	No further Company action is required.
RIA	Sample MH/SUD DWPA Health Claims – Unfair Claim Settlement Practices	1 exception found.	Company Agreed.	The Company took action to address this issue on 5/3/2019 by re-processing and paying the claim.	No further Company action is required.
RIA	Sample MH/SUD DWPA Health Claims – MH/SUD Medical Management standards differ between the MH/SUD and Med/Surg UM determination process.	1 exception found. (NQTL)	Company Disagreed.	The Company shall take action to comply with MHPAEA, subject to prior approval of the NHID.	The Company shall provide the Department with a compliance assurance plan or evidence that this has been addressed.
RIA	Sample MH/SUD Denied Health Claims – EOB Requirements re: RFI 011 (misinformation and error/N130)	1 exception found.	Company Agreed.	The Company shall take measures to ensure that EOB and EOP documents contain clear information in order for members and providers to understand claim payment or denial. Denial codes shall not conflict with one	The Company shall provide the Department with a compliance assurance plan.

				another, and shall be easily identifiable and linked to the correct service item within a claim. Benefit and payment descriptions shall be clear.	
RIA	Sample MH/SUD Denied Health Claims – EOB Requirements re: RFI 010 (misinformation/failure to forward claim to HPHC)	1 exception found.	Company Agreed.	The Company shall take measures to ensure that EOB and EOP documents contain clear information in order for members and providers to understand claim payment or denial. Denial codes shall not conflict with one another, and shall be easily identifiable and linked to the correct service item within a claim. Benefit and payment descriptions shall be clear.	The Company shall provide the Department with a compliance assurance plan.
RIA	Sample Med/Surg Denied Health Claims – Required EOB Information	1 exception found.	Company Disagreed.	The Company shall take measures to ensure that EOB and EOP documents contain clear information in order for members and providers to understand claim payment or denial. Denial codes shall not conflict with one another, and shall be easily identifiable and linked to the correct service item within a claim. Benefit and payment descriptions shall be clear.	The Company shall provide the Department with a compliance assurance plan.

RIA	Sample Med/Surg DWPA Health Claims – Required EOB Information	1 exception found.	Company Disagreed.	The Company shall take measures to ensure that EOB and EOP documents contain clear information in order for members and providers to understand claim payment or denial. Denial codes shall not conflict with one another, and shall be easily identifiable and linked to the correct service item within a claim. Benefit and payment descriptions shall be clear.	The Company shall provide the Department with a compliance assurance plan.
RIA	Sample Med/Surg DWPA – Required EOB Information (NHID Info)	2 exceptions found.	Company Agreed.	The Company shall immediately begin including the NHID’s address and telephone number on all EOBs containing an adverse benefit determination per N.H. Code Admin. R. Ins. 1001.05.	The Company shall provide the Department with a compliance assurance plan or evidence that this had been corrected.
RIA	Sample MH/SUD Partially Paid, Denied and DWPA Health Claims – Missing NHID Contact Information	1 exception found.	Company Agreed.	The Company shall immediately begin including the NHID’s address and telephone number on all EOBs containing an adverse benefit determination per N.H. Code Admin. R. Ins. 1001.05.	The Company shall provide the Department with a compliance assurance plan or evidence that this has been corrected.
RIA and BerryDunn	Provider Reimbursement Practices – Company did not provide sufficient documentation to	RIA Review Findings - 1 exception found. (NQTL)	Company Disagreed.	The Company shall take agreed upon action to address this issue, subject to ongoing NHID	The Company shall provide the Department with a compliance assurance plan.

	meet MHPAEA’s comparability demonstration requirement.	NHID Findings based upon BerryDunn Review - 1 exception found. (NQTL)		oversight and reporting.	
RIA and BerryDunn	ASAM Criteria Compliance – potential inconsistency between UBH/Optum LOCGs and ASAM criteria	RIA Review Findings (from MH/SUD DWPA health sample claim review) - 1 exception found. NHID Findings based upon BerryDunn Review - 1 exception found.	Company Disagreed.	The Company has discontinued use of the UBH/Optum Level of Care Guidelines.	No further Company action is required.
ER	Prescription Drug/Formulary Step Therapy (“ST”) – ST protocols were more stringently applied to MH/SUD drugs than Med/Surg drugs on formularies.	ER Review Findings - 1 exception found. (NQTL)	Company Disagreed.	The Company shall take action to comply with MHPAEA, subject to prior approval of the NHID.	The Company shall provide the Department with a compliance assurance plan.
NHID	Medical Management Standards – definition of medical necessity potentially inconsistent with NH standards.	ER Review Findings - 1 exception found (NQTL)	Company Disagreed.	The Company has discontinued use of the UBH/Optum medical necessity definition.	No further Company action is required.

EXAMINER'S SIGNATURE AND ACKNOWLEDGEMENT

The examiners would like to acknowledge the cooperation and assistance extended by personnel at Harvard Pilgrim Health Care of New England, Inc. during the course of the examination.

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

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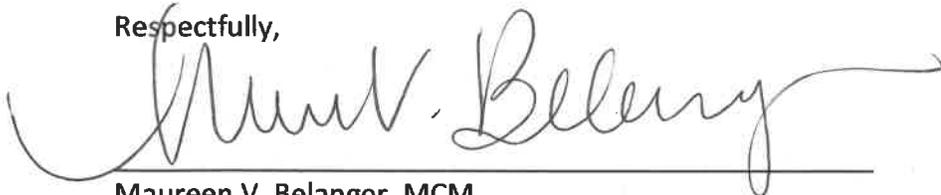
Jennifer Dodge, MPPM
Senior Economist, Berry Dunn McNeil & Parker, LLC

Yoko McCarthy, MBA, CISA, CFE
Assurance Specialist, Berry Dunn McNeil & Parker, LLC

Valerie Hamilton, JD, RN, MHA
Clinical/Legal Specialist, Berry Dunn McNeil & Parker, LLC

Carole Taylor, MSN, RN
Clinical Specialist, Carole Taylor Consulting Options, LLC

Respectfully,

A handwritten signature in cursive script that reads "Maureen V. Belanger". The signature is written in black ink and is positioned above a horizontal line.

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



THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

21 SOUTH FRUIT STREET SUITE 14
CONCORD, NEW HAMPSHIRE 03301

APPENDIX A: Letter to Commissioner Regarding Examination and HPHCNE Rebuttal

John Elias
Commissioner

Alexander K. Feldvebel
Deputy Commissioner

July 12, 2019

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

Dear Commissioner Elias,

In accordance with RSA 400-A:37, IV (a), on June 27, 2019, Harvard Pilgrim Health Care of New England, Inc. (NAIC # 96717) submitted a rebuttal (Rebuttal) to the Mental Health Parity examination Verified Report that was issued on May 28, 2019.

I recommend that the full text of the Rebuttal be appended to the Report, along with this memorandum. Department examiners have reviewed the Rebuttal and offer the following responses (*in italics*) to specific issues raised; these responses are in addition to the findings already made in the Verified Report. Department examiners do not recommend that any changes be made to the Verified Report, other than to update the Summary of Recommendations table to reflect the rebuttal. A copy of the updated table is attached for your reference.

1. **Medical Necessity Definition.** Company assertion: The Company disagrees with examiners' finding that the UBH/Optum definition of medical necessity is different from, and more stringent than, the Company's definition of medical necessity. The Company characterizes the differences as "minor wording differences" and asserts that in the BerryDunn review of compliance with New Hampshire's law requiring reliance on American Society of Addiction and Medicine (ASAM) criteria in determining medical necessity and developing utilization review standards, the examiners found that members were placed in the appropriate level of care nearly 96 percent of the time, which, the Company asserts, demonstrates that the Optum definition is not materially different from the Company's definition.

Department examiners disagree. The Company's rebuttal does not address the central concern expressed in the report, which is that Optum's definition of medical necessity incorporates a cost-effectiveness component which is not present in the Company's own policy. Because Optum is the administrator for behavioral health services only, this means the more stringent cost-effectiveness component is applicable to behavioral

health services only, resulting in a parity violation. The BerryDunn ASAM clinical review findings are not relevant to this finding, as they relate to the policy as applied.

The Company has agreed to discontinue use of the Optum definition, so no further corrective action is needed, other than submission of evidence that this change has been made.

2. **Step Therapy.** Company assertion: The Company asserts that its step therapy requirements comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) because the same review process and standards apply to the review of prescription drugs for both medical/surgical (Med/Surg) and mental health/substance use disorder (MH/SUD) treatment.

Department examiners disagree. The Company's assertion is that disparate results – i.e., a higher prevalence of step therapy being required for MH/SUD prescriptions than for Med/Surg prescriptions – are irrelevant so long as the policies the Company uses are the same for both. This assertion is inconsistent with 45 CFR section 146.136(c)(4)(i), which requires parity “in operation” as well as in the standard or process being applied. In response to the federal guidance referenced by the Company, it is true that “disparate results alone” are not conclusive as to whether there is a parity violation – but disparate results are highly indicative of a violation, and require further explanation beyond simply an assertion that the same policies apply to both MH/SUD and Med/Surg.

Within 90 days of the effective date of the Final Order and Final Adopted Report, the Company shall submit a corrective action plan to make its step therapy requirements consistent with MHPAEA.

3. **Provider reimbursement.** Company assertion: Similar to its arguments with respect to step therapy, the Company asserts that examiners' numeric findings of consistently lower levels of provider reimbursement for MH/SUD providers as compared to Med/Surg providers are irrelevant, so long as the processes used to establish the rates are comparable. The Company cites federal guidance indicating that reimbursement rates are not required to be identical in order to satisfy parity requirements, and notes that the federal agencies expect to issue further guidance soon on parity standards relative to provider reimbursement. The Company also asserts that differences in provider education and training may explain some of the quantitative findings, and that Med/Surg providers are more typically affiliated with large, integrated health systems, which from a market perspective enables them to negotiate higher rates. Finally, the Company asserts that using Medicare rates would be inappropriate, because of differences between Medicare and commercial insurance markets in terms of benefit packages and covered populations.

Department examiners disagree. As noted above, 45 CFR section 146.136(c)(4)(i) requires parity “in operation” as well as in the standard or process being applied.

Although identical reimbursement rates are not required, the finding of consistently lower reimbursement levels for MH/SUD providers is highly indicative of a violation, and requires further explanation beyond simply an assertion that the same policies or processes apply to reimbursement practices for both MH/SUD and Med/Surg services.

The Department disagrees with the Company's claim that the BerryDunn Provider Reimbursement analysis does not take provider training levels into consideration. As explained in the Verified Report (specifically, see footnote 3 and the full Berry Dunn Provider Reimbursement report, which is attached as an appendix), BerryDunn's methodology looks to Medicare rates as a basis of comparison because these rates reflect resource requirements such as professional education and technical skill, as well as equipment and facility usage.

The Department also disagrees with the Company's assertion that market considerations justify the payment of lower rates to MH/SUD providers. The Company's position is that these providers are less likely to be affiliated with a large practice group, and thus have less bargaining leverage, leading these providers to accept lower rates. The Department disagrees that weak bargaining power would justify the payment of disparate reimbursement rates for MH/SUD and Med/Surg services given the requirements of MHPAEA.

The Department did not find or suggest that the Company would need to align its provider reimbursement rates with Medicare rates. Rather, as explained in the Verified Report, BerryDunn compared the ratios of the Company's commercial MH/SUD provider reimbursement rates and Med/Surg provider reimbursement rates, as reported by the Company to New Hampshire's all-payer claims database, to Medicare reimbursement rates for the same services. This analysis was designed to go beyond a simple review of statewide fee schedules to look at the Company's actual reimbursement practices. As noted above, this basis of comparison was selected because Medicare's method of developing payment levels is resource-based and applies a consistent standard to both MH/SUD and Med/Surg reimbursement calculations. Use of this methodology does not suggest that the Medicare rates themselves should be used.

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

4. **ASAM Criteria. Company assertion:** The Company asserts that its practices under RSA 420-J:16 are consistent with the wording of the statute in terms of reliance on the ASAM criteria in development of medical necessity and utilization review standards; that the contract examiners (BerryDunn) did not specify in what respects Optum's guidelines are more restrictive than the ASAM criteria; that BerryDunn found a high level of consistency (95.7%) with the ASAM guidelines in the reviewed claims; and that the

company felt it was inappropriate to reference a federal court's findings in a California case involving the relation between Optum's guidelines and the ASAM criteria.

Department examiners disagree with the Company's assertion that its practices are consistent with RSA 420-J:16, and recommend that the findings in the Verified Report remain as written. BerryDunn's ASAM report, which is included as an appendix to the exam report, fully describes the high level of consistency between the Company's benefit determinations and the ASAM guidelines. The BerryDunn ASAM report also describes in more detail the differences between the Optum guidelines and the ASAM criteria.

The Company has agreed to discontinue use of the Optum Level of Care Guidelines, so no further corrective action is needed with respect to this finding, other than submission of evidence that this change has been made.

5. **Health Claims Denied with Prior Authorization.** Company assertion: The Company asserts that its utilization management practices are consistent with MHPAEA, and that the issues identified by examiners were isolated incidents, not overarching systemic problems. The Company requests that this finding be removed from the report.

Department examiners disagree with the Company's request that this finding be removed from the report, and disagree that the practice is an isolated incident given that it is linked to the problems with Optum's medical necessity definition (see discussion above), and given the number of incidents identified during the exam. The Department's contract examiners expressed strong concern about inconsistencies between the utilization management practices for MH/SUD and Med/Surg, and recommended as corrective action measures that the Company review the entire universe for the examination period for the specific denial code in question; reprocess and pay incorrectly denied claims; reimburse members with interest, if necessary; correct any system configuration errors; and monitor/audit Optum on these issues.

Within 90 days of the effective date of the Final Order and Final Adopted Report, the Company shall submit a corrective action plan consistent with the above recommendations.

Thank you for your consideration of these recommendations.

Sincerely,



Jennifer J. Patterson, Esquire
Life & Health Director

Encl. – Summary of Recommendations Table

/mvb



*Submitted by Electronic Mail
and U.S. Mail*

June 27,
2019

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

RE: Response to Draft Verified Report of Examination - Harvard Pilgrim Health Care of New England, Inc. (NAIC No. 96717)

Dear Ms. Belanger,

Harvard Pilgrim Health Care of New England, Inc. (the “Company”) is in receipt of the draft Verified Report of Examination for the Company, dated May 28, 2019 (the “Report”) prepared by the New Hampshire Insurance Department (the “Department”). The Company disagrees with some of the findings in that Report, as set forth below in the Company’s rebuttal provided pursuant to RSA 400-A37, IV, and specifically and strongly disagrees with the Department’s assertions that the Company violated the Mental Health Parity and Addiction Equity Act (MHPAEA).

I. Phase I: Medical Management Standards (pgs. 16-17 of the Report)

The Company respectfully disagrees with the statement in the Report that Optum’s definition of medical necessity is more stringent than the Company’s definition of medical necessity.

While we acknowledge the minor wording differences between the Company’s and Optum’s definitions, the Company disagrees with the Department’s conclusion that specific elements of the required definition of medical necessity are missing in the Optum definition. The Report suggests that the Optum definition lacks an equivalent to the Company’s statement that treatment should be “representative of best practices in the medical profession.” However, Optum’s definition includes the standard that treatment should be “in accordance with Generally Accepted Standards of Medical Practice.”

Further, the Report claims that the Optum definition lacks the concept of treatment “demonstrated through scientific evidence to be effective in improving health outcomes”. However, the Optum definition requires that services be consistent with “standards that are based

on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, relying primarily on controlled clinical trials, or, if not available, observational studies from more than one institution that suggest a causal relationship between the service or treatment and health outcomes.” The Company asserts that, despite the minor wording differences, Optum’s medical necessity definition was not materially different than that of the Company.

This assertion was validated through the BerryDunn review of Optum’s application of the definition. The Department’s own report issued by BerryDunn¹ (in which hundreds of the Company’s and Optum’s claims were reviewed) concludes that Optum’s medical necessity decisions resulted in members being placed in the appropriate level of care nearly 96 percent of the time (a percentage to which the BerryDunn examiners noted was very good in its discussions with the Company; moreover, prior regulatory exams by the Department have found this percentage of accuracy to be compliant with other statutory requirements). If the Optum definition of medical necessity was more stringent than the Company’s definition, this high level of accuracy in the utilization review determinations made by Optum would not have been achieved.

For these reasons, the Company asserts that the definition of “medical necessity” utilized by Optum during the exam review period complied with New Hampshire law. The Department presented no evidence that this definition was applied more stringently for MH/SUD services than for M/S services. To the contrary the Report affirmed that members received the appropriate level of care for MH/SUD services nearly 96% of the time. Nevertheless, to avoid the possibility of confusion, going forward, the Company will use a single definition of medical necessity for MH/SUD and M/S services, referring back in all instances to the Company’s Benefit Handbooks and will no longer utilize Optum’s medical necessity definition.

For the reasons stated above, the Company strongly requests that this finding be removed from the Report.

II. Phase I: Formulary Design (pp. 17, 28-34 of the Report)

The Company respectfully asserts that the step therapy requirements utilized by the Company are applied in compliance with MHPAEA.

With regard to any non-quantitative treatment limitation (NQTL), the MHPAEA regulations clearly state that under the terms of the plan as written and in operation, the processes, strategies, evidentiary standards and other factors used in applying the NQTL to mental health/substance use disorder (MH/SUD) benefits in the classification must be comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards and other factors used in applying the limitation to medical/surgical (M/S) benefits in the same classification.² As noted

¹ *Market Conduct Examination, Analysis of Compliance with New Hampshire RSA 420-J:16 and Required Application of ASAM Criteria—BerryDunn, December 20, 2018*

² See 26 CFR 54.9812-1(c)(4), 29 CFR 2590.712(c)(4), and 45 CFR 146.136(c)(4) and 147.160.

in Question 3 of FAQ 34 (October 27, 2016) issued jointly by the Departments of Labor, Health and Human Services and the Treasury (collectively, the “Federal Agencies”):

The NQTL analysis does not focus on whether the final result is the same; instead, compliance depends on parity in application of the underlying processes and strategies. Among other things, there should not be arbitrary or discriminatory differences in how a plan or issuer applies those processes and strategies to medical/surgical benefits as compared to MH/SUD benefits. (emphasis added)

The key focus for any MHPAEA inquiry is not the end result, such as the percentage of MH/SUD drugs subject to step therapy requirements, as “disparate results alone³” do not mean that an NQTL violates MHPAEA. Instead, the critical aspect of any parity analysis is a comparison of the processes, strategies, evidentiary standards and other factors used in applying the NQTL to both MH/SUD and MS benefits.

The Report provides no evidence that the underlying processes, strategies, evidentiary standards, or other factors used to evaluate what drugs will be subject to step therapy were either not comparable or applied more stringently to MH/SUD drugs than to M/S drugs. Rather, the Report concludes that the step therapy protocols violated MHPAEA based solely on a review of formulary lists and step therapy requirements for specific medications, i.e., the *results* of the applications of the Company’s Pharmacy & Therapeutics (P&T) Committee process for determining when step therapy is necessary. The P&T Committee oversees both MH/SUD and M/S drugs on the Company’s formulary and is comprised of internal and external clinical experts, including independent primary care and specialty physicians and pharmacists practicing in the medical community. As stated in the P&T Committee’s Charter (“Charter”), the P&T Committee “serves in an advisory capacity to the Company on matters pertaining to the clinical management of drug use, including recommendations pertaining to drug selection, clinical practice guidelines, prior authorization guidelines, or coverage of specific drug therapies as they relate to medical necessity or appropriateness of use.” With respect to the selection of drugs for step therapy, the Charter specifically provides as follows:

Where there is a logical succession of drug therapy for a particular medical condition, step therapy may be recommended.

- a. In such a succession of agents, the most cost-effective preferred agent might be required to be used first with the prescriber moving to another agent next if the first drug was not successful or the patient was an inappropriate candidate or the patient had adverse effects.
- b. This process of moving to secondary agents may involve information from prescribers, or may be automated by computer review of a patient drug history of which drug(s) had been tried previously.

The selection of drugs for step therapy is part of a detailed drug evaluation process set forth in the Charter. This process identifies the evidentiary standards used by the Committee in its drug evaluation process (an algorithm that incorporates a review of published data from the medical

³ See 78 Fed. Reg. 68240, 68245 (Nov. 13, 2013)

literature, specialist consultant opinions, and information provided by pharmaceutical manufacturers). The strategies and factors used in its drug evaluation process are also identified in the Charter (including, but not limited to, pharmaeconomic studies which include quality of life issues, pharmacology, pharmacokinetics, safety profile, adverse effects, contraindications, clinical efficacy, drug-drug interactions, dosing, FDA approved indications, and comparison with current alternatives).

Importantly, at no point in the drug evaluation process described in the Charter is there any distinction drawn between MH/SUD and M/S drugs. There is only **one** evaluation process for all prescription drugs on the Company's formularies that is set forth in a **single** charter that establishes processes, strategies, evidentiary standards and other factors used in applying the step therapy NQTL, without regard to whether the drug is for a MH/SUD or a M/S condition. The singular process used, the identical strategies employed, and the common evidentiary standards supporting the application of the step therapy requirements demonstrate the Company's compliance with MHPAEA.

For the reasons stated above, the Company strongly requests that this finding be removed from the Report.

III. Phase 1: Provider Reimbursement – BerryDunn and RIA Reviews (pp. 18, 34-39)

For the reasons stated below, the Company respectfully disagrees that its provider reimbursement practices do not comply with MHPAEA and asserts that the Company's position is supported by the law and the sub-regulatory guidance from the Federal Agencies authorized by Congress to implement and interpret MHPAEA.

1. The NQTL provisions of MHPAEA require parity with respect to the process applied not to the outcomes.

As part of its finding, the Department states that it "is not convinced that MHPAEA is concerned only with parity in process, not parity in outcomes—i.e., actual payment levels." The Department's conclusion is not supported by the law and is contrary to the explicit regulatory and sub-regulatory guidance issued by the Federal Agencies to date.

In the MHPAEA final rule, the Federal Agencies explained how the NQTL requirements apply to provider reimbursement rates stating that:

"Plans and issuers **may consider a wide array of factors** in determining provider reimbursement rates for both medical/surgical services and mental health and substance use disorder services, such as service type; geographic market; demand for services; supply of providers; provider practice size; Medicare reimbursement rates; and training, experience and licensure of providers. The NQTL provisions require that these or other factors be applied comparably to and no more stringently than those applied with respect to medical/surgical services. **Again, disparate results alone do not**

*mean that the NQTLs in use fail to comply with these requirements.*⁴ (Emphasis added.)

This guidance gives plans broad discretion to consider a “*wide array of factors*” as part of the plan’s provider reimbursement methodology. In doing so, the law does not dictate the factors a plan may use, does not require that its selected factors be applied in the exact same way as other plans, and does not dictate the value a plan must ascribe to a particular factor. Because of this discretion, the Federal Agencies make it clear that “the NQTL analysis *does not focus on whether the final result is the same*; instead, compliance depends on parity in *application* of the underlying processes and strategies. Among other things, there should not be arbitrary or discriminatory differences in how a plan or issuer applies those processes and strategies to medical surgical benefits as compared to MH/SUD benefits.”⁵ (Emphasis Added). Those processes and strategies also need not be identical, but must be comparable. The position of the Federal Agencies has remained consistent over time and was set forth most recently in a proposed April 23, 2018 series of Frequently Asked Questions, which reiterated that health plans are “*not required to pay identical reimbursement rates for medical/surgical and MH/SUD providers*”.⁶ (Emphasis added).

Despite this clear guidance, the Department suggests that plans do not have broad discretion in the factors considered and methodology used to determine reimbursement rates. However, the 2007 Senate Committee Report on bill 558 (MHPAEA) was clear that the law was not meant to “prohibit group health plans from negotiating separate reimbursement or provider payment rates and service delivery systems, or managing the provision of mental benefits in order to provide medically necessary treatments under the plan.”⁷ In the regulatory rulemakings on NQTLs, the Federal Agencies deliberately and thoughtfully avoided setting forth (i) specific factors, or (ii) a specific methodology that a health plan is required to follow in setting its provider reimbursement rates as this would be seen as imposing rate regulation on providers. Congress had the option to impose payment parity between MH/SUD providers and M/S providers under MHPAEA or to dictate specific factors or methodologies that health plans are required to follow in setting provider reimbursement rates and, to date, has elected not to do so.

Finally, it is important to note that the Federal Agencies have indicated that further guidance on the provider reimbursement rate NQTL is forthcoming. In Section 13001(b) of the 21st Century Cures Act (2016) Congress directed the Federal Agencies to issue clarifying information and illustrative examples of methods, processes, strategies, evidentiary standards, and other factors that plans and issuers may use regarding the development and application of NQTLs such as “factors used in provider reimbursement methodologies (such as service type, geographic market, demand for services, and provider supply, practice size, training, experience, and licensure) as

⁴ 78 Fed Reg. 68246 (Nov. 13, 2013).

⁵ DOL, IRS, and HHS FAQs about Affordable Care Act Implementation Part 34 and Mental Health and Substance Use Disorder Parity Implementation, October 27, 2016.

⁶ DOL, IRS, and HHS Proposed FAQs about Mental Health and Substance Use Disorder Parity Implementation and the 21st Century Cures Act Part XX, April 23, 2018.

⁷ Sen. Rep. No. 110-53, 110th Cong., 1st Session (2007), at pg. 3.

such factors apply to network adequacy”. This reflected Congress’ recognition that the regulatory regime built under the NQTL rule lacks sufficient clarity to ensure meaningful compliance. To date, the Federal Agencies have issued proposed guidance on provider reimbursement rates (i.e., the proposed April 2018 FAQs) and are in the process of reviewing public comments on these difficult and complex questions. To the extent any such guidance required implementation of changes to its processes for setting reimbursement, the Company would do so in order to ensure continued compliance with MHPAEA.

2. The Company’s methodology used in setting its provider reimbursement rates for MH/SUD benefits are comparable to and are applied no more stringently than the methodology used in setting provider reimbursement rates for M/S benefits.

The processes, strategies, evidentiary standards, and factors used by the Company’s vendor, Optum, to set its provider reimbursement rates for MH/SUD services are comparable to the processes, strategies, evidentiary standards, and factors used by the Company to set provider reimbursement rates for M/S services. The Department has provided no evidence demonstrating otherwise. Comparable does not require that the processes, strategies, evidentiary standards and other factors be identical or equal in all respects.⁸ A definition of “comparability” should not be created by arbitrarily defining an “acceptable” set of outcomes or methodologies which a carrier or plan may use, particularly when Congress and the Federal Agencies have declined to do so.

The Company and Optum use the same factors, in a similar manner, when setting provider reimbursement rates. Even though the Company and Optum both utilize the same factors, variations in the market conditions for M/S services and for MH/SUD services provide a justifiable basis for the differential in ultimate payment rates.

For instance, most MH/SUD services are delivered by non-physician providers with wide variations in training while most M/S services are delivered by providers with significantly more education and training (i.e., physicians or physician extenders). Moreover, most M/S services are delivered by providers who are part of large, integrated health systems or other clinically integrated networks, while in contrast, MH/SUD services are delivered by smaller groups or solo practitioners. These market differences enable M/S providers to benefit from the leverage they can exert in the marketplace. The competitive marketplace distinctions are real and impact reimbursement industry-wide. We believe the Department’s conclusion fails to consider the market differences between MH/SUD services and M/S services.

The Department also appears to suggest that an alignment of the Company’s provider reimbursement rates with Medicare rates would, in its view, avoid a parity violation. This suggestion focuses on payment outcomes and fails to consider the distinctions between the federally regulated Medicare program and the competitive commercial health insurance marketplace. For example, unlike Medicare, the Company’s enrollees span the ages and are not

⁸ “Comparable” is defined to mean “similar; like” while “identical” is defined as “being the same” and “equal” is defined as “of the same measure, quantity, amount, or number as another” or “identical in mathematical value or logical denotation.” *Merriam-Webster Online Dictionary*.

almost solely over 65. In addition, unlike Medicare, which sets rates without allowing provider negotiation, the Company must negotiate rates with providers to stay competitive. Furthermore, the Company and Medicare operate under different regulatory requirements and budgetary considerations. As a result, the Company generally covers more and different services for its commercial health plan members than traditional Medicare covers and has different premium and cost sharing structures from Medicare.

The Company previously noted these distinctions to the Department and reiterates them now to demonstrate that Medicare's fee schedule is calibrated based on the utilization of Medicare beneficiaries, the benefits package offered by Medicare, and the Medicare budget and federal regulatory concerns. Likewise, the Company's fee schedule is calibrated based upon similar considerations, but for a commercial health plan market. For these reasons, we believe the Department's reference to Medicare in the context of this Report is misplaced.

In summary, there is no doubt that the Federal Agencies have given plans broad discretion to determine the specific factors it considers and the methodology it uses in setting provider reimbursement rates. Moreover, the Federal Agencies have made it clear that a disparity in the results of any such methodology is not determinative of a violation of MHPAEA, but, instead the focus should be on the *process, as applied*. Despite this explicit guidance, the Department has relied solely on results (the ultimate payment amount) in reaching its conclusion that there has been a violation under MHPAEA. The Company respectfully disagrees with the Department's conclusion and maintains that its processes for setting provider reimbursement rates complies with MHPAEA, consistent with the intent of the law.

For the reasons stated above, the Company strongly requests that this finding be removed from the Report.

IV. Phase I: ASAM Criteria Compliance – ER, RIA and BerryDunn Reviews (pp. 21-22, 39-42 of the Report)

The Company strongly disagrees with BerryDunn's characterization of the claims reviewed and the conclusions they made with respect to compliance with N.H. Rev. Stat. § 420-J:16 as set forth in its report.⁹

Under N.H. Rev. Stat. § 420-J:16, carriers providing substance use disorder benefits "**shall rely upon** ASAM criteria when determining medical necessity **and developing utilization review standards for levels of care** for substance use disorder services." (Emphasis added.) The Company disagrees that the statute requires plans to use the American Society of Addiction Medicine (ASAM) criteria **exclusively** in connection with utilization management of substance use disorder benefits, particularly since the statute expressly contemplates that a carrier will **develop** its own utilization review standards for these services. To the extent the statute required

⁹ Market Conduct Examination, Analysis of Compliance with New Hampshire RSA 420-J:16 and Required Application of ASAM Criteria—BerryDunn, December 20, 2018

strict use of the ASAM criteria it would have simply stated that plans shall use, rather than, rely upon, ASAM criteria, and certainly would not have addressed developing other utilization review standards.

Consistent with the statutory requirements, during the exam time period, Optum used its proprietary Level of Care Guidelines (LOGGs), which were based on ASAM criteria, for substance use disorder utilization management decisions. Nonetheless, the BerryDunn examiners noted that Optum's LOGGs did not "specifically reflect" the ASAM criteria and suggested that they were more restrictive.

The examiners failed to articulate what aspects of Optum's LOGGs were more restrictive than the ASAM criteria. Moreover, the examiners acknowledged that Optum's level of care determinations were appropriate nearly all of the time, and that, in some instances, Optum approved a higher level of care than what was required under the ASAM criteria (e.g. stating in relevant part that, "Overall, however, the BerryDunn examiners concluded that the outcomes of the reviewed claims appeared almost always consistent with ASAM"¹⁰).

After reviewing hundreds of claims, the BerryDunn examiners found that in nearly 96% of the reviewed claims, Optum's determinations were consistent with the ASAM level of care criteria. The examiners also noted that certain aspects of the clinical information in the claims records they reviewed demonstrated consistency with the six dimensions found in the ASAM guidelines. The Company asserts that these facts demonstrate that Optum's LOGGs were consistent with, and not more restrictive than, the ASAM criteria.

The Company also disagrees with the Department's inclusion of a summary of the Findings of Facts and Conclusions of Law issued in the *Wit vs. United Behavioral Health* and *Alexander vs. United Behavioral Health* matter on March 5, 2019 and questions the appropriateness of making reference to this unrelated court case in the Report. The case is limited in jurisdiction to decisions within the Northern District of California and the facts brought by the plaintiffs in that case. It has no bearing on New Hampshire law or this Report. Citation to the *Wit* case appears to be an attempt at justifying conclusions that were simply not demonstrated by the Department's examination findings. Optum's New Hampshire policies have and will continue to meet all applicable regulatory requirements. This was clearly substantiated by the BerryDunn findings showing that Optum's level of care determinations were consistent with the ASAM criteria.

For the reasons stated above, the Company strongly requests that this finding be removed from the Report. In the alternative, at minimum, the reference to the *Wit* case should be removed and acknowledge that the accuracy level of the Optum benefit determinations was 95.7%, by stating as follows, "the BerryDunn examiners concluded that the level of care determinations of the reviewed claims appeared almost always consistent with ASAM criteria, resulting in a 95.7% level of accuracy."

¹⁰ Page 41 of the Report.

V. **Phase II: Claims, Health Claims Denied with Prior Authorization (pp. 25-26 of the Report)**

The Company disagrees with the Department's assertion that Optum's prior authorization process, as applied to MH/SUD services, is not comparable to or is more stringent than the Company's prior authorization process for M/S services.

Optum's utilization management process, including the evidentiary standards used by Optum, complies with MHPAEA. The few individual issues identified by the examiner in this case were not caused by any overarching systemic problem related to noncompliance that requires corrective action, but instead, were isolated instances where Optum's and the Company's established processes and standards, which comply with MHPAEA, were unintentionally not followed (e.g. Optum incorrectly denied claims when maximum units were not exceeded). The utilization management process used by Optum and the Company ensure that individuals with appropriate clinical education and experience in their respective fields perform the review, and that such reviews apply comparable and no more stringent factors and processes in making benefit determinations.

Because the issues identified were outliers and do not signal the need for large scale corrective action, the Company strongly requests that this finding be removed from the Report.

The issues outlined in this letter are extremely important to the Company. We hope that the Department will carefully consider the concerns raised by the Company in making any final determinations as to the results of its market conduct exam. To the extent you have any questions or require clarification on any information provided in this response, please do not hesitate to contact me at (617) 509-5714. Thank you for your time.

Sincerely,

Christopher Flanagan
Senior Associate General Counsel

APPENDIX B: Examination Resources' Initial Data Request Including MHPAEA FR/QTL Worksheet

As a part of the initial data request, examiners requested that HPHC provide a response to the following requests for information and questions¹

MHPAEA Compliance Review

The MHPAEA Compliance Review will require the Company to submit detailed information on how the financial requirements, quantitative treatment limitations (“QTL”), and non-quantitative treatment limitations (“NQTL”) in the Company’s benefit plans comply with MHPAEA.

2. Please complete the attached MHPAEA FR,QTL Worksheet for each Non-Grandfathered plan, Grandfathered large group and individual plan, and any Transitional plan issued in or in effect during the examination period for which there is New Hampshire exposure.
3. MHPAEA NQTL Worksheet for each Non-Grandfathered plan, Grandfathered large group plan and individual plan, and any Transitional plan issued in or in effect during the examination period for which there is New Hampshire exposure. If a response provided to a question/request would apply to multiple plans, it would acceptable to provide a single response to the question provided the Company provides a listing of all plans to which the response applies.

Policy Forms

4. Provide a listing of and copies of all policy forms, amendments, riders, applications, Schedule of Benefits, Summary of Benefits and Coverage (SBC), disclosure and any other forms for Plans marketed and issued in New Hampshire by the Company during the examination period. If forms have been amended or withdrawn, or otherwise discontinued from use during the examination period, please include such information, as well as any information as to the nature and date of the change. If the forms have been filed electronically through SERFF, please provide the SERFF tracking number and date of approval of the filing. If there was a corresponding binder filing for the plan, please provide the SERFF tracking number for that binder filing.

5. Please provide a website link where consumers/enrollees may obtain plan documents and information regarding coverage of MH/SUD and M/S services.
6. Please provide a description of the process the Company has in place for individuals to obtain hard copies of plan documents and information.
7. How frequently does the Company update plan information and documents with respect to MH/SUD and M/S services?

Complaint Logs

8. Please provide the internal complaint logs of the Company for the examination period.

Grievances and Appeals

9. Provide an electronic listing of all grievances and appeals received during the examination period. The list should include: Appeal/Grievance Number or identifier, Insured's Name, Insured's DOB, Insured's Zip Code, Provider ID Code, Provider Zip Code, Procedure Code, ICD Code, Date Received, Mode of Receipt of Appeal, Date of Second Level Appeal or Grievance (if applicable), Date Closed, Final Disposition and Basis for Disposition. Please provide an indicator for all appeals for which an external review was requested and the status/disposition of the external review.
10. Please provide a copy of all internal processes, procedures, bulletins and guidelines regarding grievance and appeals procedures.
11. Please provide copies of all documentation and disclosures made available to policyholders regarding the grievance and appeals procedures, including expedited appeals procedures. If this information is presented through a secure website, please provide a username and password to allow access to the information.
12. How frequently are the grievance and appeals procedures updated for MH/SUD and medical/surgical services?

Claims

13. Provide a copy of all claims handling manuals, internal bulletins and guidelines issued by the Company with respect to the processing and payment of claims.

14. How frequently does the Company perform an internal audit on the claims process as a whole?
15. Please provide a copy of the most current internal claim audit report.
16. Please provide a copy of the claims forms utilized for health claims.

Denied Applicants

17. Please provide a list of all applicants that applied and were subsequently denied coverage during the Examination period. The data should include the Applicant Name, Applicant's Zip Code, Agent Name, Carrier ID, Type of Coverage, Product and Plan Name, and Reason for Denial.

Delegated Service Contracts

18. Please provide a copy of all contracts and service agreements in effect during the examination period for all utilization review, pre/post authorizations, claims processing or any support functions that were delegated to other entities relative to MH/SUD benefits.
19. Please provide a brief summary of each contract defining the delegated service.
20. If services are provided by the Company, please provide a diagram/flow chart of the internal process associated with the handling of MH/SUD benefits.
21. If the process differs for MH/SUD benefits from the standard process, please provide a full explanation of any deviations from the standard process.

APPENDIX C: Examination Resources' MHPAEA NQTL Worksheet

Plan Name: _____

Policy Form Number: _____

SERFF Tracking Number: _____

Market Coverage: _____

Plan Type: _____

Plan Identifier: _____

Pursuant to 45 CFR § 146.136 (c)(4)(i) of the MHPAEA regulation, a plan or issuer may not impose a NQTL on MH/SUD benefits in any classification unless, under the terms of the plan or coverage as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to the MH/SUD benefits in the classification are comparable to, and are applied no more stringently than those used in applying the limitation to medical/surgical benefits in the same classification.

The purpose of this NQTL Worksheet is to collect information that will enable the Department to review plans for compliance with federal mental health parity requirements. A separate NQTL worksheet will need to be completed for each benefit plan. If a response provided to a question/request would apply to multiple plans, it would be acceptable to provide a single response to the question provided the Company provides a listing of all plans to which the response applies.

Benefit Classification

The regulation identifies six benefit classifications in to which benefits shall be placed for parity analysis:

- Inpatient, in-network
- Inpatient, out-of-network
- Outpatient, in-network
- Outpatient, out-of-network
- Emergency care
- Prescription drugs

1. Please provide a description of the methods or criteria used to classify the plan's benefits into one of the six benefit classifications.

2. Does the plan sub-classify outpatient office visits?
3. Is coverage provided in all six benefit classifications for MH/SUD services? If no, which classification category is excluded and why?
4. Is coverage provided in all six benefit classifications for medical/surgical services? If no, which classification category is excluded and why?

Medical Management Standards

1. Please provide a detailed description of the criteria applied for all medical management standards and guidelines, including utilization reviews and case management standards and guidelines. Please provide a description of the process for the development and updating of the standards and guidelines. Provide a copy of all written policies and procedures regarding medical management standards and guidelines.
2. What factors are used to determine the MH/SUD and medical/surgical services selected for concurrent review? What evidentiary standards support their use? How frequently are the reviews required?
3. Do the same personnel perform utilization review for medical/surgical benefits and MH/SUD benefits? Please provide a detailed description of the individuals performing these reviews, including the individuals' qualifications.
4. Please provide a detailed list of covered benefits that require preauthorization, listed by benefit classification. Additionally, please include any applicable penalty for non-compliance with preauthorization requirements.
5. Does the plan impose any exclusions or limitations based on failure to complete a course of treatment? If so, please identify the covered benefits (including identification of benefit classification) to which this limitation or exclusion applies.
6. Are there any benefits that require the submission of a treatment plan to obtain or continue receiving coverage? If so, please identify the applicable benefits (including identification of benefit classification) and provide a description of the requirements applied with respect to providing and maintaining a treatment plan.
7. Please provide all utilization review and case management information and disclosures available to policyholders and explain how this information is accessed (I.e. via website, customer service request, etc.). Please separately identify if the information applies to MH/SUD and/or medical/surgical services.

8. How frequently are the requirements regarding utilization reviews updated?
9. Was American Society of Addiction Medicine (ASAM) criteria used in developing the utilization review standards for levels of care for substance use disorder services? If so, please provide a copy of the policies and procedures for incorporating the criteria, and provide four to six exhibits of the utilization of the criteria.

Medical Necessity Criteria

1. Please provide a detailed description of the medical necessity or appropriateness used for MH/SUD benefits. What criteria are applied to make a medical necessity/appropriateness determination? Does this criteria differ from that applied to medical/surgical benefits? Please provide a copy of all written policies and procedures regarding the company's medical necessity and appropriateness criteria applicable to benefits.
2. Does the Plan use ASAM criteria when determining medical necessity for substance use disorder services?

Experimental/Investigational Treatments

1. How does the plan define "experimental" and/or "investigational" services? Is the same definition used for medical/surgical and MH/SUD treatments?
2. Are clinical trials and/or experimental or investigational services allowed for MH/SUD services? Are clinical trials and/or experimental or investigational services allowed for medical/surgical services?
3. Please provide the requirements for consideration for clinical trials and/or investigational services for MH/SUD and medical/surgical services. Please include any limitations or restrictions for these requirements.

Referrals

Does the plan require a referral to specialty care provider from a primary care provider? Please identify the benefits (listed by benefit classification) for which a referral is required.

Network Design and Development

Providers

1. Provide a description of the plan's network admission, credentialing, and network closure standards for MH/SUD providers and medical/surgical providers. Please provide a copy of the application used for accepting providers in to the network.
2. What are the credentialing standards for licensed non-physician providers? Specify type of provider and standards; e.g., nurse practitioners, physician assistants, psychologists, clinical social workers.
3. What are the credentialing/contracting standards for unlicensed personnel; e.g., home health aides, qualified autism service professionals and paraprofessionals?
4. Are any provider or facility types excluded from the network?
5. Provide information regarding accessibility issues with in-network providers to include options for members when an in-network provider for MH/SUD services is not available.
6. Does the plan include any geographic restrictions that limit availability, the scope, or duration of benefits? If yes, please identify the benefit, the applicable geographic restriction and the criteria used as a basis for applying the restriction.
7. Does the plan require certification or licensing for facilities or medical providers for the treatment of mental health/substance use disorders?
8. Does the Plan place restrictions of the types of provider specialties that can provide certain MH/SUD benefits?

Network Adequacy

1. Please identify what professional provider specialties included in the plan'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 terms. Identify the network(s) that this finding applies to if the policy differs by network. You may also identify the provider specialties that are not included in this category if the list is shorter.
2. 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.
3. Please identify what percent of primary care providers (PCP) are covered under an arrangement that delegates credentialing to the provider entity.

4. How frequently does the Company perform distribution analysis to determine if additional providers could be added to the network(s)?

Reimbursement Rates

1. Please provide a fee schedule for all medical/surgical providers.
2. Please provide a fee schedule for all MH/SUD providers.
3. Provide a description of the Company's process for determining the fee schedule and reimbursement rates for MH/SUD providers and medical/surgical providers. Are the payment levels based on the Medicare Fee Schedule and do they fully utilize Medicare payment policies? The description should provide a detailed explanation of bases or system you use to establish reimbursement rates. Provide a copy of documents which supports the methodology used. If applicable, please include percentiles of reimbursement rates, etc. Provide a sample for each methodology used. If payments are based on the Medicare system, please identify whether the conversion factor the Company uses (when applied to the RBRVS) differs between MH/SUD and medical/surgical providers.
4. How much does provider specific negotiating leverage influence MH/SUD and medical/surgical provider payment rates?
5. How frequently are the MH/SUD and medical/surgical fee schedules updated?
6. Does the Company use its own data to establish in network and out-of-network reimbursement rates? If the company uses data provided by an outside vendor, please include a list of the outside vendors utilized.
7. Approximately what percent of PCPs are paid at a statewide fee schedule and what percent 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.
8. Approximately what percent of MH/SUD providers are paid at a statewide fee schedule , and what percent 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.

Provider Directory

1. Provide an electronic listing in Microsoft Excel format of all network providers by specialty, county and zip code. Please specifically identify all MH/SUD providers.
2. Please provide the website link to access the network's provider directory.
3. How frequently is the provider directory updated?

Out-of-Network Providers

1. Please provide all information regarding coverage for and access to out-of-network providers/specialist, including all penalties for utilizing an out-of-network provider.
2. 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.
3. 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. .

Out-of-Network Emergency Services

1. 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.
2. Please provide all information including processes and procedures for review and payment of services performed by an out-of-network emergency provider/specialist.

Formulary Design for Prescription Drugs

1. Provide a copy of the prescription drug formulary for the plan. Please ensure:
 - a. Medications within the formulary are grouped in alphabetical order by therapeutic class.
 - b. A definition and/or explanation of each formulary tier is provided.
 - c. A detailed description and definitions for utilization controls, including but not limited to quantity/dosage controls, prior authorization, and step therapy is provided.

- d. Tier coverage (including applicable copays) and utilization controls for each medication (by dosage, if applicable) is provided.
2. Please provide the dates the Company last submitted the formulary to the Department.
3. Provide a copy of the Company's policies and procedures regarding the exception process for obtaining coverage of drugs not included on the plan's prescription drug formulary.
4. Provide detailed information regarding the date the formulary was created and the Company's policies and procedures for updating the formulary.
5. If prescription drugs are tiered, please describe your process for placing MH/SUD and medical/surgical medication into a particular tier.
6. Does the plan apply any fail first or step therapy requirements to prescription drug benefits? If so, please identify the prescription drug and provide a detailed description of the fail first or step therapy requirement and the criteria used as a basis for applying the requirement.
7. Does the plan apply a separate deductible or out-of-pocket limit for prescription drugs? If so, please provide the amount of the applicable deductible and/or out-of-pocket limit.

Autism Coverage

1. Please provide a copy of the internal guidelines regarding coverage for autism services. Provide all requirements and considerations, including any applicable limitations or restrictions, with respect to the coverage of autism services.
2. Please provide the policy language outlining coverage for autism services.

APPENDIX D: Regulatory Insurance Advisors' 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
ClmCoplay	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
ClmCoplay	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

**APPENDIX E: Regulatory Insurance Advisors' Medication Assisted Treatment (MAT)
Interrogatories**

Medication Assisted Treatment (MAT)

Please provide comprehensive information regarding the following requests:

1. Please provide information on how the carrier provides coverage for methadone, buprenorphine, buprenorphine/naloxone, naloxone, and naltrexone.
2. For what FDA approved indications does the carrier cover these medications?
3. What dose and/or refill limitations are applied to these covered medications?
4. Please provide all information regarding annual or lifetime limits on MAT for methadone and/or buprenorphine.
5. Were 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 during the examination period?
6. 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 currently?
7. 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?
8. What medical necessity or medical appropriateness standard is applied to the coverage of MAT for methadone and/or buprenorphine?
9. Does the Company provide Office-Based Opioid Therapy (OBOT) and/or Opioid Treatment Program (OTP)?
 - If so, what is the level of OBOT and/or OTP coverage, the process for receiving OBOT and/or OTP, and the requirements for treatment?
 - If OBOT and/or OTP are excluded services, please provide exclusion language and the rationale behind the exclusion.

New Hampshire Insurance
Department

Market Conduct Exams
Provider Reimbursement Strategy Analysis
Behavioral Health Parity
Harvard Pilgrim Health Care
Final Report

Submitted by:

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Submitted on:

December 7, 2018

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

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

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

providers, but provided no insight into the actual rate-setting process for either service type. The application of the criteria and evidence upon which reimbursement levels were set is not documented in any way in the Carrier's responses. The responses therefore provided no evidence ameliorating the findings of the claims data analysis that the Carrier's MH/SUD and M/S reimbursement rates differ, with MH/SUD reimbursement rates being relatively lower relative to Medicare than M/S rates. Absent evidence to establish that this rate differential is compliant with the law, these results provide evidence that MH/SUD rates are set in a more stringent fashion, which would constitute a MHPAEA parity violation. Out of approximately \$90 million in physician services analyzed for this report (which does not include radiology, anesthesiology, or pathology services), \$123,404 was paid to psychiatrists.

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

The report proceeds in the following sections:

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

2.0 Introduction and Background

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

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

2.1 Claim Reimbursement Analysis: BerryDunn's Approach

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

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

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

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

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

2.2 Review of Policies and Procedures

In order for a carrier to be compliant with MHPAEA with regard to provider reimbursement, processes, strategies, and evidentiary standards used to set provider reimbursement rates, as written and in operation, must be applied comparably, and no more stringently, to MH/SUD provider reimbursement as to M/S reimbursement. Optum provides MH/SUD management services for the Carrier, and the Carrier provided responses and documentation for both itself and Optum.

As part of its review, BerryDunn reviewed the HPHC Policy Regarding Reimbursement for Covered Health Services the completed MHPAEA NQTL Worksheet.

BerryDunn submitted two additional sets of interrogatories, requesting responses for the following:

- Any additional information regarding factors used in determining provider reimbursement
- The analytical framework/formula used to apply the factors for M/S versus MH/SUD

3.0 Data Sources and Quantitative Analysis Methodology

3.1 Data Sources

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

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

For the policy and procedure review, BerryDunn began by reviewing all documentation and interrogatories already received from the Carrier by the other examination consulting firm assisting NHID 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.¹ 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,¹ to allow comparisons of commercial-to-Medicare ratios by provider specialty. Medicare reimburses these professional services using the RBRVS.² 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)³ and the

¹ 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.

Inpatient Psychiatric Facility Prospective Payment System (IPF PPS),⁴ respectively, which were developed with comparable methods and standards.

The MHPAEA service classification also includes Emergency and Pharmacy categories.⁵ Payers typically reimburse emergency department claims without regard to the behavioral versus physical nature of the complaint (i.e., without regard to diagnosis). Therefore, payment parity between MH/SUD and M/S emergency department care should be the norm in the market. Medicare pharmacy coverage is provided to members by commercial payers, whose contracts with pharmacy benefit managers and/or pharmaceutical companies are proprietary. Further, pharmaceutical companies set the prices of drugs based on a variety of factors unrelated to the behavioral versus physical health status of the conditions their products treat. For these reasons, this study did not test reimbursement parity for Emergency and Pharmacy services.

3.2.2 Step 2: Pricing Professional Services

Professional services are generally billed on the CMS-1500 standard bill form (required by CMS), and priced by Medicare using the RBRVS.⁶ In order to compute the commercial-to-Medicare reimbursement ratios, it was necessary to compute what Medicare what 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. All other things 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.⁷ The RVUs assigned to the practice expense category are dependent on whether or not the procedure was performed in a facility or non-facility setting.⁸ 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.⁹ 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.¹⁰

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

ⁱⁱ CPT® Modifiers 50, LT, and RT

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

reimbursed at 150% of the standard physician fee schedule rate for a unilateral procedure,^{iv} while assistant at surgery procedures are reimbursed at 16% of the standard physician fee schedule rate.¹¹

BerryDunn took several steps to make the analysis tractable without impacting the validity of the conclusions. BerryDunn grouped services into CMS specialties based on NPI taxonomy. This analysis modifies the CMS provider specialty taxonomy for reporting purposes. Major specialties were included, while several less-common specialties and the hospital-based specialties were excluded from the report.^v The “Primary Care” specialty as defined for this analysis is the combination of the Pediatrics, Internal Medicine, Family Medicine, and General Practice specialties. Furthermore, only procedures performed by physicians were included for M/S services, while all services, except MH/SUD add-on codes,^{vi} performed by all MH/SUD provider license types (physician, PhD psychologist, Master of Social Work (MSW), and other licensed counselors), were included. Note that the inclusion of the add-on codes would have produced far lower ratios of commercial-to-Medicare payment rates for MH/SUD services than are presented in this report. Non-physician providers are far more central to service delivery in behavioral health, and reimbursement for non-physicians in M/S services can be complicated in ways that, if not handled correctly, could bias the analysis. The importance of the non-physicians for behavioral health services led BerryDunn to report each separately in the results. Accordingly, these are presented in aggregate and by education level in the results. Medicare reimburses non-physician providers at a percentage of the RBRVS. For example, clinical social workers are reimbursed at 75% of the psychiatrist rate,¹² these discount factors are reflected in the results.

3.2.3 Step 3: Pricing Inpatient Services

Medicare reimburses inpatient facility claims using a variety of PPSs based on the type of facility providing the services. For this analysis, BerryDunn focused only on acute inpatient and psychiatric inpatient events, which fall under the IPPS and IPF PPS, respectively. Under both systems, Medicare assigns price on an episodic basis.^{vii} As with procedures in the Physician

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

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

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

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

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 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.¹³ This weight is multiplied by the standard reimbursement rate, referred to as the Operating Standardized Amount¹⁴ to arrive at a Medicare episode reimbursement amount. The Operating Standardized Amount encompasses both the direct and indirect cost of treatment during an episode.¹⁵ Medicare also includes a capital amount, the Capital Standard Federal Payment Rate, which was excluded from this model¹⁶ under the assumption that, unlike Medicare, commercial carriers are only paying for the services performed and not for capital expenditures such as electronic medical records (EHR) or quality reporting incentive programs. In any case, the capital portion of the rate is approximately 3%, 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.¹⁷ 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.¹⁸ 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.¹⁹ Such an episode is reimbursed at the Federal Per Diem Rate.

IPFs are identified by Medicare using their CMS certification number (CCN).²⁰ 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	\$ 59,675,345	2.83	2.23
Inpatient Psychiatric	\$ 3,905,526	1.30	1.12

Both the inpatient and professional claims analyses show a large discrepancy in commercial-to-Medicare payment ratios between M/S services and MH/SUD services, with MH/SUD inpatient episodes showing a much lower commercial-to-Medicare reimbursement ratio (1.30 for MH/SUD episodes vs. 2.83 for M/S episodes) and MH/SUD professional services showing the lowest commercial-to-Medicare reimbursement ratio, 1.01, among all professional specialties. For comparison, consider the M/S primary care ratio of 1.40, the M/S evaluation and management services ratio of 1.65, and the gastroenterology ratio of 1.89. BerryDunn notes that of the almost \$60.5 million of service spending and \$4.5 million of MH/SUD services summarized in Table 2, payments to Psychiatrists total \$123,004.

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

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

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

Professional Specialty	Commercial	Commercial-to-Medicare Payment Ratio	
	Allowed Medical Expense	Weighted Average	Median
Allergy & Immunology	\$ 4,946	1.02	1.10
Colon & Rectal Surgery	\$ 245,162	1.70	1.88
Dermatology	\$ 1,078,058	1.46	1.42
Evaluation and Management	\$ 37,194,928	1.65	1.60
Gastroenterology	\$ 1,611,162	1.89	1.99
Neurological Surgery	\$ 465,313	1.63	1.90
Neurology	\$ 97,910	1.88	1.97
Obstetrics & Gynecology	\$ 4,009,518	1.60	1.47
Ophthalmology	\$ 393,641	1.41	1.27
Oral & Maxillofacial Surgery	\$ 18,269	1.59	1.70
Orthopaedic Surgery	\$ 5,071,773	1.62	1.46
Otolaryngology	\$ 960,090	1.33	1.11
Physical Medicine & Rehabilitation	\$ 135,477	1.70	1.84
Plastic Surgery	\$ 489,152	1.43	1.29
Primary Care	\$ 623,648	1.40	1.21
Psychiatry	\$ 4,671,617	1.01	0.95
<i>MD/DO</i>	\$ 123,004	1.22	1.32
<i>MSW</i>	\$ 1,207,935	1.01	0.95
<i>Other</i>	\$ 1,844,025	1.00	0.95
<i>Psychologist</i>	\$ 1,496,653	1.02	0.92
Surgery	\$ 2,292,097	1.59	1.62
Thoracic Surgery (Cardiothoracic Vascular Surgery)	\$ 334,512	1.76	1.92
Urology	\$ 802,828	1.71	1.81

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

In order for the disparities identified in Tables 1 and 2 to be MHPAEA-compliant, the Carrier’s processes, strategies, and evidentiary standards used to set provider reimbursement rates, as written and in operation, must be applied comparably to and no more stringently to MH/SUD

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

provider reimbursement as they are to medical/surgical M/S reimbursement. In order to assess this comparability and stringency, BerryDunn asked the Carrier targeted interrogatories, requested provider reimbursement methodology policies and procedures, and reviewed the Carrier's responses.

The Carrier's interrogatory response indicates the following factors are used for M/S services and MH/SUD services to establish provider reimbursement rates:

- Medicare RVUs
- Historic base rates
- Geography
- Market conditions
- Services covered
- Fee schedule budget

The Carrier indicates neither it nor Optum applies the factors based on individual provider type or physician specialty but rather on a procedure code basis. Payment adjustments made by the Carrier or Optum based on individual provider type occur either in advance (e.g., Optum's fee schedule maintains separate rates by license level) or at the time of claim adjudication (e.g., the Carrier has a payment policy that pays 85% of the physician rate for nurse practitioner services.) The process used to set the reimbursement rates for MH/SUD and M/S professionals with different license levels must be comparable in order to be compliant with MHPAEA.

MHPAEA's Final Rule indicates that a wide array of factors may be considered in determining provider reimbursement rates for both M/S services and MH/SUD services, such as service type, geographic market, demand for services, supply of providers, provider practice size, Medicare reimbursement rates, and training, experience, and licensure of providers. Therefore, the factors listed by the Carrier are in alignment with the Final Rule. However, The MHPAEA NQTL provisions require that these or other factors be applied comparably to and no more stringently to MH/SUD services than to M/S services. Disparate provider reimbursement rates (i.e., relatively higher reimbursement rates for M/S providers than MH/SUD providers) alone do not mean that the NQTLs in use fail to comply with these requirements²¹ if the process used to determine the rates is comparable across service types as described above.

The Carrier describes the following process for setting provider reimbursement rates including:

- Evaluating current fee schedule rates for existing codes against available market data
- Ensuring the current fee schedule rate aligns with the associated resource use for a service by taking into account the current Medicare RVUs for the service
- Adjusting the current fee schedule rates, as necessary, to take into account market conduct conditions (e.g., supply/demand for a particular service or provider license level), geography, and the annual fee schedule budget

While the above steps describe a comparable process (i.e., it is used for both M/S and MH/SUD), the process allows for some variability in results. BerryDunn asked follow-up interrogatories—specifically asking whether there is an objective analytic framework or formula used for factors such as geography or market conditions. No such objective analytic framework or formula was provided.

The Carrier indicated that 10% of primary care providers (PCPs) are paid at a statewide fee schedule and approximately 90% are paid above the statewide fee schedule, while approximately 35% of MH/SUD providers are paid at the statewide fee schedule and 65% are paid above the statewide fee schedule. Furthermore, provider negotiating leverage is estimated to impact the Carrier's provider reimbursement rates by 30% to 55% and Optum rates by 10% to 35%. The Carrier explained this difference by indicating the M/S providers tend to be more closely aligned with large integrated health care systems or large physician practices that contract for M/S services on an aggregated basis (e.g., the contract may cover hospital services, physician services and, possibly, post-acute services such as home health and hospice). The Carrier indicates MH/SUD providers tend to be independent and not affiliated with any large healthcare system or practice.

While the Carrier reports that fee schedules for both MH/SUD and M/S are updated annually, during the period relevant to this market conduct exam, the Carrier updated its fee schedule twice, and Optum did not make changes to its fee schedule.

The Carrier's responses to these requests listed factors considered in setting reimbursement rates and stated that these factors were used similarly for MH/SUD and M/S providers, but provided no insight into the actual rate-setting process for either service type. The responses therefore provided no evidence ameliorating the claim analysis findings that the Carrier's MH/SUD and M/S reimbursement rates differ, with MH/SUD reimbursement rates being lower relative to Medicare than M/S rates, a possible MHPAEA parity violation.

4.1.3 Assessment of Stated Policy Using Provider Supply Data

The appendix to this report contains an assessment across states of providers per capita for MH/SUD and common medical specialties.²² These results do not appear to be consistent with the stated policy of the Carrier to adjust reimbursement to address market supply issues. MH/SUD providers have far lower payment levels relative to Medicare than other specialties, but the per capita supply of MH/SUD providers are notably below national averages. At the same time, New Hampshire ranks near the top of the country in supply of surgeons, OB/GYNs, and Pediatricians while their reimbursement rates far exceed Medicare levels. This would seem to contradict the Carrier's stated policies.

5.0 Conclusion

A claims analysis of commercial-to-Medicare provider reimbursement ratios show that the Carrier reimburses MH/SUD providers at rates very near the Medicare rates, but nearly all M/S

provider specialties at rates much higher than Medicare. Since Medicare reimbursement rates are resource-based, this result places the burden on the Carrier to provide documentation that demonstrates its specific analysis of both MH/SUD and M/S provider reimbursement levels, supporting a conclusion that the structure complies with MHPAEA.

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

Appendix

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

Endnotes

¹ “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>.

² 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>.

³ 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>.

⁴ 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>.

⁵ 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>.

⁶ “RBRVS Overview.” Accessed June 2018. <https://www.ama-assn.org/rbrvs-overview>.

⁷ 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>.

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.

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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.

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- ¹¹ Medicare Claims Processing Manual Chapter 12 – Physicians/Nonphysician Practitioners. Updated May 31, 2018. Accessed June 2018. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c12.pdf>.
- ¹² Mental Health Services. Published January 2015. Accessed June 2018. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Mental-Health-Services-Booklet-ICN903195.pdf>.
- ¹³ Centers for Medicare and Medicaid Services. ICD-10-CM/PCS MS-DRG v36.0 Definitions Manual. Accessed 16 October 2018: https://www.cms.gov/ICD10Manual/version36-fullcode-cms/fullcode_cms/P0001.html.
- ¹⁴ 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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- 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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¹⁹ Medicare Claims Processing Manual Chapter 3 – Inpatient Hospital Billing. Updated 4 October 2018. Accessed June 2018. <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c03.pdf>.

²⁰ 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>.

²¹ 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>.

²² Source: United States Department of Labor Bureau of Labor Statistics. Occupational Employment Statistics Query System. Accessed 30 October 2018: <https://data.bls.gov/oes/#/home>.



New Hampshire Insurance
Department

Market Conduct Examination

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

Harvard Pilgrim Health Care

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 Harvard Pilgrim Health Care 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 in the prior authorization process. State RSA 420-J:16 became effective on January 1, 2017, and requires, “Whenever substance use disorder services are a covered benefit under a health benefit plan subject to this chapter, the health carrier providing such benefits shall rely upon ASAM criteria when determining medical necessity and developing utilization review standards for level of care for substance use disorder services.”⁴

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

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

- The Carrier’s responses to interrogatories, requests for information (e.g., policies and procedures), and data calls
- A review of a random sample of 126 claims, representing 52 unique members, to determine whether ASAM was used

Findings: Interrogatory, Request for Information, Data Call Review

1. *Proprietary guidelines are not transparent and appear more restrictive than ASAM.* In an interrogatory response, the Carrier indicated that ASAM is used to make medical necessity determinations. The introductions to Optum’s LOC Guidelines[®] (LOGGs[®]) state that these guidelines are intended to be “objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices and support members’ recovery, resiliency, and well-being. They are derived from generally accepted standards of behavioral health practice. They are guidelines and consensus statements” from professional and governmental sources, including the Centers for Medicare and Medicaid Services, the American Association of Community Psychiatrists, the American Psychiatric Association, ASAM, and others. The LOGGs state that “exceptions may be made to the Level of Care Guidelines such as when there is a superseding contractual requirement or regulation.” ASAM principles are not specifically reflected in the LOGGs, nor are the LOGGs specific to the six ASAM dimensions and associated risk rating of each dimension. The LOGGs, in interpretation,

appear to be more restrictive in the move toward individual outcomes of care, social determinants, and recovery domains related to the holistic care of members, as compared to ASAM. See Appendix D for a comparison of ASAM's residential LOC 3.5 to the Carrier's Residential LOCG.

2. Although the LOCG and ASAM criteria demonstrate differences, in 95.7% of all reviewed claims, members were placed in appropriate LOC.

Findings: Medical Claim Review

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

1. *Risk score is not reflected in clinical conclusions.* The findings of the clinical review indicate that clinical information related to the six dimensions of ASAM are included in narrative, but the associated risk is not necessarily identified as influential in making a clinical determination.
2. *Review documentation does not reflect a cohesive clinical assessment.* The utilization reviewers do not analyze and synthesize the existing member clinical data, obtained through the provider, into a cohesive clinical picture that demonstrates and documents the need for a specific LOC.
3. *Reviewers do not assess treatment alternatives.* During the clinical claims review, there was no documented evidence that utilization reviewers actively queried providers related to member treatment options, particularly with Medication Assisted Treatment (MAT), an evidence-based practice. For specific relevant members, MAT may have been a critical treatment option, given the history of a member's opioid use disorder (OUD). There was also no documentation that a utilization reviewer sought an internal consultation from a physician in terms of MAT.
4. *Inconsistent attention to ASAM Dimensions 4, 5, and 6.* There were 15 cases in which a utilization reviewer posed questions or followed up with a provider related to family involvement, probation/parole involvement, safety of children in the home, recovery supports, or housing. These questions are part of ASAM Dimensions 4, 5, and 6, and are critical to member recovery.

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

- Section 2.0 provides an introduction and background of the present targeted examination.

- Section 3.0 discusses the purpose and goal of the exam.
- Section 4.0 describes the process used to conduct the exam.
- 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 the ASAM criteria when determining medical necessity and conducting utilization review, including clinical detail related to the prior authorization process. This is required under the State RSA 420-J: 16.¹

ASAM provides a structured approach to create comprehensive and individualized treatment plans.² Treatment plans are developed through a multidimensional patient assessment (see Appendix A) over five broad levels of treatment: 0.5, 1, 2, 3, and 4 (see Appendix B). Levels of treatment are based on the degree of direct medical management provided, as well as the structure, safety, and security provided. 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 Examination

In the State and across the country, substance abuse is growing at a significant rate. To promote opportunities for recovery for individuals with SUDs, the State legislature collaborated with providers, associations, and insurance providers to define the LOCs 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:15-18³ relative to the appropriate use of the 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

The process used by BerryDunn consisted of several separate steps that are described in this section of the report.

4.1 Interrogatories, Data Calls, and Requests for Information

BerryDunn reviewed information collected by the examination firm. Following this review, BerryDunn requested additional information through interrogatories, data calls, and requests for

information for the time period January 1, 2017, through June 30, 2017. The following information was requested.

4.1.1 Clinical Operations

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

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

4.1.2 Orientation and Training of Clinical Staff

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

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

4.1.3 Quality

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

- Results of annual or semi-annual inter-rater reliability (IRR) data for physician advisors and utilization reviewers who make utilization review 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 using 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 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 LOCs 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. Through this reference, six dimensions of the ASAM were identified, and a five-point risk rating was included, to identify the degree of member risk to accompany each dimension. The ASAM MNC were used for each represented ASAM LOC to validate that the member was in the correct LOC and that 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 SUD and co-occurring disorder, including physical health concerns
- Social determinants
- Presenting problem
- Utilization reviewer opportunities

- Discharge planning or transition to the next appropriate LOC
- ASAM Multidimensional Assessment (six dimensions) and level of risk (including any imminent risk) for each dimension for each prior authorization
- ASAM criteria that justifies admission
- Denials
- Consultations with physician advisors
- Member recovery needs
- Overall case comments

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

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. The Carrier submitted 52 unique member records containing from 1 to 11 prior authorization events.

5.0 Results of Examination

5.1 Interrogatories, Data Calls, and Requests for Information

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

5.1.1 Clinical Operations

In the interrogatory submission, the Carrier states it uses ASAM to make medical necessity determinations. Optum's LOCGs[®], a set of proprietary documents, state that these guidelines are intended to be "objective and evidence-based behavioral health guidelines used to standardize coverage determinations, promote evidence-based practices and support members' recovery, resiliency, and well-being. They are derived from generally accepted standards of behavioral health practice. They are guidelines and consensus statements" from professional and government sources, including the Centers for Medicare and Medicaid Services, the American Association of Community Psychiatrists, the American Psychiatric Association, ASAM and others. The LOCGs state that "exceptions may be made to the Level of Care Guidelines such as when there is a superseding contractual requirement or regulation."

ASAM principles are not specifically reflected in the LOCGs, nor are the LOCGs specific to the six ASAM dimensions and associated risk rating of each dimension. The LOCGs, in interpretation, appear to be more restrictive in the move toward individual outcomes of care,

social determinants, and recovery domains related to the holistic care of members as compared to ASAM.

The submitted materials do not clearly describe the withdrawal management (WM) and residential ASAM LOCs through a crosswalk with the Carrier's LOCs. (See the results of claims review for further information and clarification.)

The interrogatory deliverables contained specific information related to the collection of clinical information for utilization review. The identified data elements are consistent with ASAM.

Per document Clinical Operations_#12, ASAM LOCs, ASAM level 3.3 is not provided within the benefit as obtained from the ASAM crosswalk.

5.1.2 Orientation and Training of Clinical Staff

Evidence of ASAM training is contained in the interrogatory deliverables. An ASAM PowerPoint presentation used for both orientation and ongoing training was included.

5.1.3 Quality

In the interrogatory related to clinical denials, of 69 denials, all discuss or recommend alternative LOCs. Of the total, 38 were residential requests, and all were referred to IOP.

ASAM IRR for 2017 was included. The IRR rate was 98.7% agreement for LOC placement for behavioral health. Mental health and SUD cases are combined.

The utilization reviewer-to-member ratio was 1:55,381. Utilization reviewers complete, on average, 15 behavioral health reviews per day, which is reasonable considering the care coordination needed and risk associated with this population.

5.2 Clinical Record/Claim Review

5.2.1 Provider Distribution

Members received services from 22 providers. During an episode of care, one unique member may have received services from multiple providers as the individual moved through the continuum of care.

- Of 22 providers, 9 provided only 2.1 (IOP) to 12 unique members.
- Farnum served 15 unique members and represented 22 reviews at four distinct LOCs.
- Hampstead served 13 unique members and represented 38 reviews at four distinct LOCs.
- Phoenix House served seven unique members and represented 11 reviews for three distinct LOCs.

- Portsmouth Regional, Gosnold, Brattleboro Retreat, Baldpate, and NE Behavioral Health served from one to four members in IP detox.
- Of the 117 claims, 74 reflected residential or WM LOCs.
- The following ASAM LOCs were represented in the sample: OP, IOP (ASAM 2.1), Partial (ASAM 2.5), 3.2 WM in 2.5, Partial Hospital Program; Residential 3.5 and 3.7, and 3.7 WM. These LOCs require a prior authorization.

5.2.2 Care Management Documentation

The Carrier submitted a total of 117 claims (reviews), representing a total of 52 unique members. Each file contained from 1 to 11 LOCs.

Table 1: Types of Reviews

Overview		
	Number of Reviews	Comments
Total Reviews	117	
Prior Auth	110	Members were stepped up or down to LOCs within treatment episodes, so there were multiple prior authorizations related to members moving along a continuum.
State Mandated WM (No Prior Auth Required)	5	
OP	2	Does not require prior auth.

5.2.3 Documentation

The Carrier provided a crosswalk to identify current LOCs related to the corresponding ASAM standard LOCs. In some instances related to residential services, it was difficult to differentiate between the 3.5 and 3.7 LOCs during the clinical review. In the documentation, residential care was identified as 3.5, RTC, SA Residential, SA Rehab, and Residential Rehab. Other LOCs in the crosswalk were clearly identifiable during the review. Utilization reviewers were able to differentiate among WM LOCs, and used inpatient detox and residential detox as defined by LOCG.

Utilization reviews capture clinical information and document member assessments. However, a clinical template that drives discussion related to the six ASAM dimensions, and the risks associated with each dimension, may be helpful to utilization reviewers for determining ASAM MNC for the LOC appropriate for the member. There was no evidence of any reference to ASAM. Neither utilization reviewers nor physicians used language consistent with ASAM while

making medical necessity determinations, but did use language consistent with Optum's LOCGs.

It does appear that an ASAM-consistent format is being used to collect clinical data based upon the six dimensions. It is not always clear that concomitant risk associated with the dimensions is documented. There is a field where a utilization reviewer is able to check, "Met criteria/guidelines" in the defined electronic medical record (EMR) tab, but there is no specific relationship between the tab and ASAM MNC as designed. There was also little documented evidence that utilization reviewers were fully assessing biopsychosocial needs and recovery needs.

As stated, clinical information related to the six dimensions are found in narrative, but the associated risk is not necessarily identified as influential in making a clinical determination. In some detoxification/WM cases, the utilization reviewer did speak to risk, but this was not consistent. The utilization reviewers do not analyze and synthesize the existing member clinical data, obtained through the provider, into a cohesive clinical picture, demonstrating the need for the specific LOC. For example, using ASAM level 3.5 to demonstrate a member must meet specifications in each of the six dimensions.⁵ The clinical determination should reference the detail as found below.

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

5.2.4 Utilization Review Process/Decision-Making

Cases appeared to be routinely discussed with physicians at predetermined case staffing appointments. In these instances, utilization reviewers provided documented evidence of analysis and synthesis of cases to support the clinical determination. However, there are examples of high-risk cases where there was no documented evidence of physician consultation:

- A 61-year-old member was admitted to residential detox (3.7 WM) with a history of DTs and hypertension. Vital signs were significantly elevated. He had been drinking both large amounts of beer and other alcohol daily for two years. His risk severity was not assessed related to ASAM. He complained of chest pain after admission and was admitted to a hospital-based LOC (4.0 WM) to complete detox. A physician was not

consulted prior to admission to determine appropriateness. The utilization reviewer documents that the member had a history of DTs, but then states the member did not have a history of withdrawal symptoms. This is an ASAM Dimension 1 risk concern.

- A member was stepped down to a 3.7 WM program on April 19, 2017, after having been treated in a hospital (4.0) WM management program on April 12, 2017. This member did not appear to be appropriately placed in a second WM setting based upon a comparison to ASAM Dimension 1 criteria, with associated risk for withdrawal scored at 2. A physician was not consulted by the utilization reviewer prior to authorization. This is an ASAM Dimension 1 risk concern.
- A member was stepped down to residential treatment from inpatient mental health treatment with a diagnosis of bipolar disorder and OUD after a suicide attempt. The member's current psychotropic medication regime is unclear in documentation, although the utilization reviewer's note states the provider is stabilizing the member's medications. The member had been on Haldol and Lithium, but the documentation related to medication continuation is unclear. There is no reported evidence of a current blood Lithium level. The member also exhibited increased liver enzymes. There is no evidence in documentation that the utilization reviewer reviewed this case with a physician. This raises concerns on ASAM Dimensions 1, 2, and 3.

In 12 unique member cases, utilization reviewers generally attempted to follow up on outstanding issues, including physical health concerns, medication management, social determinants, MAT, and prompts related to trauma informed care. Assessment of trauma was consistently documented in these cases.

Other than these 12 cases, there were few instances in which a utilization reviewer queried a provider and updated the initial review related to ongoing family involvement, probation/parole involvement, recovery options, discharge planning (other than identifying the next LOC), care of children in the home, or appropriate housing options. In some cases, utilization reviewers did prepare follow-up questions for the next utilization review; however, there was little indication of follow-through to obtain the information. Utilization of ASAM Dimensions 4, 5, and 6 is critical to member recovery.

In many cases, there was no documented evidence that utilization reviewers actively queried providers related to member treatment options, particularly with MAT, an evidence-based practice. For specific members, MAT may have been a critical treatment option, given a history of OUD. There was also no documentation that a utilization reviewer sought an internal consultation from a physician in terms of MAT other than the 12 cases identified above.

There were two cases in which members were discharged from care due to relapse during treatment. These members were abruptly discharged from care with no apparent follow-up or outreach. One member was discharged and taken to a bus stop by the provider. There seemed

to be no outreach from the utilization reviewer to either the provider or the member in these cases.

Table 2 is an overall summary of the 117 claims reviewed.

Table 2: Authorizations

Authorizations						
LOC Documented	Number of Reviews	Percentage Meeting Optum LOCG Consistent With ASAM	LOC Indicated	LOC Authorized	Unclear LOC	Comments
State Mandate	5					Four out of five cases, based on ASAM, should have been lower levels of detox and were authorized as hospital-based, primarily related to the point of arrival.
Medical Detox	2	100%				
Inpatient Detox	1	0%	Unknown	Inpatient Detox	1	No criteria documented.
	31	96.8%	ASAM 3.7 WM	Inpatient Detox		
		96.8%	ASAM 3.7 WM	Inpatient Detox		31 members met criteria for 3.7 WM in medically monitored detox. Optum LOCGs describe this LOC as hospital-based detox, a “hospital-based program which provides 24-hour/7-day nursing care, medical monitoring, and physician availability; assessment and diagnostic services, and active behavioral health treatment services

Authorizations						
LOC Documented	Number of Reviews	Percentage Meeting Optum LOCG Consistent With ASAM	LOC Indicated	LOC Authorized	Unclear LOC	Comments
						<p>for the purpose of completing a medically safe withdrawal from alcohol or drugs.</p> <p>Inpatient Detoxification is typically indicated when the “why now” factors that precipitated admission indicate that the member is at risk of severe withdrawal symptoms or serious medical complications stemming from withdrawal such as seizures, and requires detoxification in a safe and stable living environment that provides the intensity of nursing care and monitoring offered in Inpatient Detoxification.”</p> <p>ASAM describes this as medically monitored detox. Although members admitted to this LOC were not all at risk of serious</p>

Authorizations						
LOC Documented	Number of Reviews	Percentage Meeting Optum LOCG Consistent With ASAM	LOC Indicated	LOC Authorized	Unclear LOC	Comments
						medical complications, they were in need of 24/7 medical monitoring.
Residential Detox	4	75%	4.0	Residential Detox		One member met criteria for hospital-based, medically managed detox as per ASAM (4.0).
			3.2	Residential Detox		Three members, based upon utilization reviewer documentation, described appropriateness for lower level of detox but no beds available. All adequately documented.
Residential	21	100%	Residential Rehab (3.5 or 3.7)	SA Residential Rehab; SA Residential Adult; RTC; Residential	21	Met Optum LOCG for residential rehab at either ASAM 3.5 or 3.7 LOC. They met LOCG for residential rehab, although the ASAM differentiation between 3.5 and 3.7 residential LOCs are not clearly aligned with LOCG.

Authorizations						
LOC Documented	Number of Reviews	Percentage Meeting Optum LOCG Consistent With ASAM	LOC Indicated	LOC Authorized	Unclear LOC	Comments
3.2 WM in Partial Hospital Program(2.5)	1	100%	3.2 WM	3.2 WM in Partial Hospital Program/ Boarding		
2.5	19	94.7%	2.5			18 members met criteria for ASAM and LOCG.
			2.5	None		One member met ASAM criteria for Partial that was denied.
2.1	32		3.2 WM	IOP		Three members were denied inpatient detox and IOP recommended. Members met criteria for 3.2 WM.
		90.6%				29 members met criteria for IOP.
1.0	2					These claims were appropriate step-down claims for OP and did not require prior authorization.

5.2.5 Denials

The clinical case review of denials found no ASAM specifically used or referenced in clinical documentation. Instead, the specific LOCGs are referenced. In a comparison of the ASAM MNC and the LOCGs for specific LOCs including Partial and 3.5, there are differences in either the LOCGs or the interpretation of those guidelines that may affect LOC placement.

Eight denials were reviewed. None of the denials included references to specific ASAM, but did cite LOCGs. In one case, there was no documented evidence supported by a physician.

Table 3: Denials

Denials					
LOC	Total	Physician Review	Appropriate Documentation of ASAM?	Full/Partial Denial	Correct Application of ASAM
Inpatient Detox	3	Yes	Optum LOCG-appropriate denial related to LOCG.	Full	Denied appropriately and used specific LOCG.
			ASAM criteria suggest 3.2 WM. Inpatient detox denial appropriate but IOP not clinically indicated.	Full	Denied and IOP offered; met ASAM criteria for 3.2 WM.
			Optum LOCG-appropriate denial related to LOCG.	Full	Denied and IOP offered; met ASAM criteria for 3.2 WM.
Residential Detox	1	Yes	Optum LOCG-appropriate denial related to LOCG.	Full	Member was receiving inpatient detox and was denied for residential detox with IOP recommended.
Residential	2	Yes	Optum LOCG-appropriate denial related to LOCG.	Full	Documentation states it does not meet Optum guidelines and describes elements of six dimensions in narrative.
RTC	1	Yes	Optum LOCG-appropriate denial related to LOCG.	Full	Denied after one week of treatment at this level.
2.5	1	Yes	No physician documentation.	Full	Member met ASAM criteria for Partial. Partial denied.

In three residential denials, the documentation included language specifically stating that there was no evidence of acute medical or psychiatric conditions to warrant placement at the

requested LOCs. ASAM MNC does not require acuity or substantive risk in medical or psychiatric conditions, but does allow for the medical or psychiatric conditions to be stabilized if they are present. The goal of ASAM's 3.5 programs is to "promote abstinence from substance use, arrest other addiction and antisocial behaviors, and effect change in participants' lifestyles, attitudes and values." There is emphasis on Dimensions 4, 5, and 6 and the risk associated with those dimensions, particularly with regard to residential LOC.

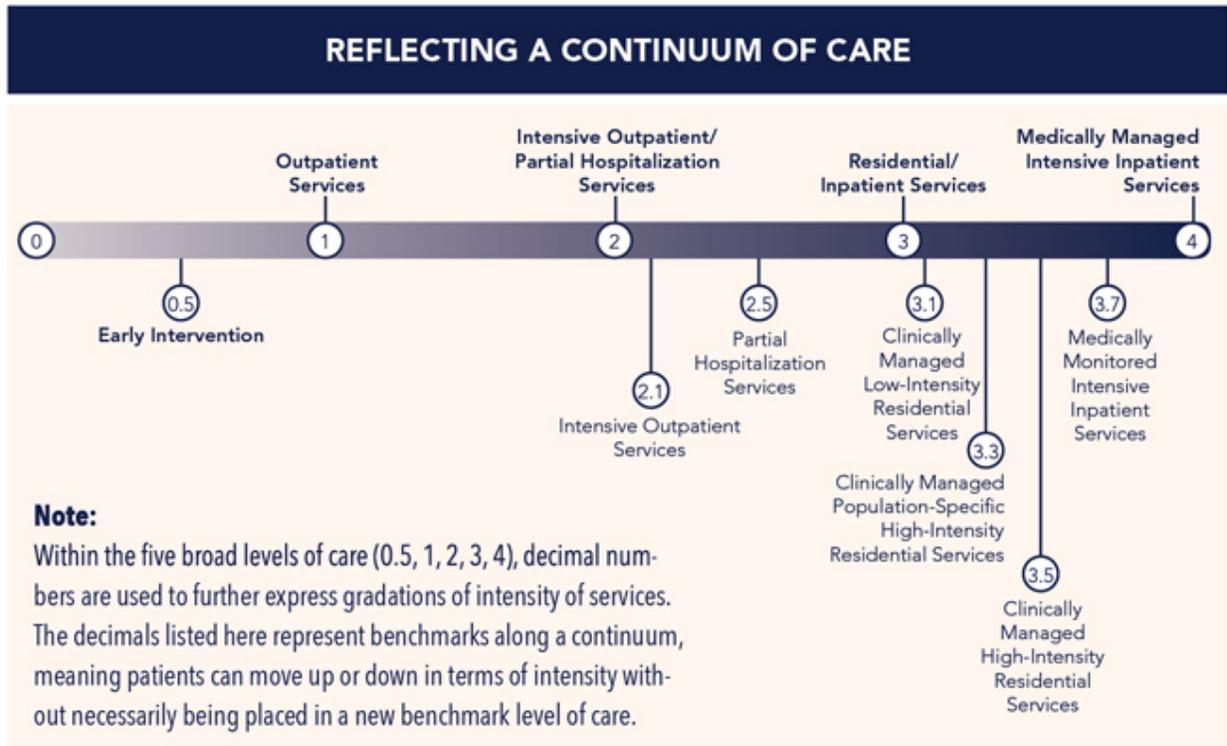
6.0 Conclusion

Although the Carrier's interrogatories indicated it utilizes ASAM, the Carrier also uses proprietary guidelines, in addition to ASAM, that are not transparent and appear more restrictive. The review supports additional clinical staff training, and consistent use of, all the ASAM LOC and dimensions. Reviewers are not consistent in their attention to ASAM Dimensions 4, 5, and 6. Reviewers do not appear to discuss treatment alternatives with providers (e.g., MAT). A clinical template that drives ASAM discussion related to the six dimensions and risk associated with each dimension would be helpful to utilization reviewers in determining ASAM MNC related to LOC appropriate for the member. Although the LOCG and ASAM criteria demonstrate differences, in 95.7% of all reviewed claims, members were placed in appropriate LOC.

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

DTs – Delirium Tremens (shaking, confusion, hallucinations)

IP – Inpatient

IOP – Intensive Outpatient

IRR – Inter-rater Reliability

LOC – Level of Care

MAT – Medication Assisted Treatment

MNC – Medical Necessity Criteria

OUD – Opioid Use Disorder

OP – Outpatient

SUD – Substance Use Disorder

WM – Withdrawal Management

Appendix D: Comparison of ASAM’s Residential LOC 3.5 to the Carrier’s Residential LOCG Guidelines

ASAM Dimension	ASAM MNC	HP MNC
		<p>Common Criteria for all levels of care</p> <p>The member is eligible for benefits;</p> <p style="text-align: center;">AND</p> <p>The member’s condition and proposed services are covered by the benefit plan.</p> <p style="text-align: center;">AND</p> <p>Services are within the scope of the provider’s professional training and licensure.</p> <p style="text-align: center;">AND</p> <p>The member’s current condition cannot be safely, efficiently, and effectively assessed and/or treated in a less intensive level of care due to acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors.</p> <p style="text-align: center;">AND</p> <p>The member’s current condition can be safely, efficiently, and effectively assessed and/or treated in the proposed level of care. The assessment and/or treatment of acute changes in the member’s signs and symptoms and/or psychosocial and environmental factors require the intensity of services provided in the proposed level of care.</p> <p style="text-align: center;">AND</p> <p>Co-occurring behavioral health and medical conditions can be safely managed.</p> <p style="text-align: center;">AND</p> <p>Services are the following:</p>

ASAM Dimension	ASAM MNC	HP MNC
		<p>Consistent with generally accepted standards of clinical practice</p> <p>Consistent with services back by credible research soundly demonstrating that the services will have a measurable and beneficial health outcome, and are therefore not considered experimental;</p> <p>Consistent with Optum’s best practice guidelines;</p> <p>Clinically appropriate for the member’s BH conditions based on generally accepted standards of clinical practice and benchmarks.</p> <p style="text-align: center;">AND</p> <p>There is a reasonable expectation that services will improve the member’s presenting problems within a reasonable period of time.</p> <p>Improvement of the member’s condition is indicated by the reduction or control of the acute signs and symptoms that necessitated treatment in a level of care</p> <p>Improvement in this context is measured by weighing the effectiveness of treatment against evidence that the member’s signs and symptoms will deteriorate if treatment in the current level of care ends. Improvement must also be understood within the broader framework of the member’s recovery, resiliency and wellbeing;</p> <p style="text-align: center;">AND</p> <p>Treatment is not primarily for the purpose of providing social, custodial, recreational, or respite care.</p> <p style="text-align: center;">AND</p>
	The patient who is appropriately admitted to a Level 3.5 residential program meets	

ASAM Dimension	ASAM MNC	HP MNC
	specifications in each of the six dimensions.	
Dimension 1: Acute intoxication and/or withdrawal potential	No signs or symptoms of withdrawal or the withdrawal needs can be managed in this setting.	1.2 There is no risk of withdrawal, or the signs and symptoms of withdrawal can be safely managed.
Dimension 2: Biomedical conditions and complications	<p>The patient's status is characterized by one of the following:</p> <p>Biomedical problems, if any, are stable and do not require 24 hour medical or nurse monitoring</p> <p>or;</p> <p>A current biomedical condition is not severe enough to warrant inpatient treatment but is sufficient to distract from treatment or recovery efforts. The problem requires medical monitoring which can be provided by the program or through an established arrangement with another provider.</p>	
Dimension 3: Emotional, behavioral, or cognitive conditions and complications	<p>The patient's status in Dimension 3 is characterized by (a), and one of (b), or (c), or (d), or (e), or (f).</p> <p>The patient's mental status (including emotional stability and cognitive functioning) is assessed as sufficiently stable to permit the patient to participate in the therapeutic interventions provided and to benefit from treatment</p> <p>and</p> <p>The psychiatric condition is stabilizing but the patient is unable to control his or her use of substances and/or antisocial behaviors, with probability of imminent danger. The dysfunction is so severe that it precludes participation in a less structured and intensive level of care;</p> <p>or,</p>	<p>AND</p> <p>1.3 The factors leading to admission and/or the member's history of response to treatment suggest that there is imminent or current risk of relapse which cannot be safely, efficiently, and effectively managed in a less intensive level of care.</p> <p>Examples include:</p> <p>1.3.1 A co-occurring mental health condition is stabilizing but the remaining signs and symptoms are likely to undermine treatment in a less intensive setting.</p> <p>1.3.2 The member is in immediate danger of relapse, and the history of treatment suggests that the structure and support provided in this level of</p>

ASAM Dimension	ASAM MNC	HP MNC
	<p>The patient demonstrates repeated inability to control his/her impulses to use substance, is in imminent danger of relapse, with likelihood of harm to self, others, or property. The level of dysfunction is of such severity that it precludes participation in treatment in the absence of 24 hour support and structure;</p> <p>or,</p> <p>The patient demonstrates antisocial behavior patterns (as evidence by criminal activity that have led or could lead to significant criminal justice problems, lack of concern for others, and lack of regard for authority expressed through distrust, conflict or opposition and which prevents movement toward positive change and precludes participation in a less structured and intensive level of care;</p> <p>or,</p> <p>The patient has significant functional deficits which are likely to respond to staff interventions. These symptoms and deficits, when considered in the context of his/her home environment, are sufficiently severe that the patient is not likely to maintain mental stability and/or abstinence if treatment is provided in a non-residential setting. These deficits may be habilitative in nature and may include residual psychiatric symptoms, chronic addictive disorders, history of criminality, marginal intellectual ability, limited educational achievement, poor vocational skills, inadequate anger management, poor impulse control and history of sexual, physical, or emotional trauma, complicated by Dimensions 2-6.</p> <p>or,</p>	<p>care is needed to control the recurrence.</p> <p>AND</p> <p>1.4 The factors leading to admission cannot be safely, efficiently, or effectively assessed and/or treated in a less intensive setting due to acute changes in the members signs and symptoms, (See Dimension 6)</p>

ASAM Dimension	ASAM MNC	HP MNC
	<p>The patient's concomitant personality disorders are of such severity that the accompanying dysfunctional behaviors provide opportunities to promote continuous boundary setting interventions.</p>	
<p>Dimension 4: Readiness to change</p>	<p>The patient's status in Dimension 4 is characterized by at least one of the following:</p> <p>Because of the intensity and chronicity of the addictive disorder or the patient's mental health problems, he or she has limited insight/awareness of the need for continuing care or the existence of his/her substance use or mental health problem and need for treatment, and has limited readiness to change;</p> <p style="text-align: center;">or,</p> <p>Despite experiencing serious consequences or effects of the addictive disorder or mental health problem, the patient has marked difficulty in understanding the relationship between substance use, addiction, mental health, or life problems and his/her impaired coping skills and level of functioning, often blaming others for his her addiction problems;</p> <p style="text-align: center;">or,</p> <p>The patient demonstrates passive or active opposition to addressing the severity of his/her mental health or addiction problem, or does not recognize the need for treatment. Treatment increases the readiness to change and lack of follow through with treatment poses a danger of harm to self or others from risk of relapse;</p> <p style="text-align: center;">or,</p> <p>The patient requires structured therapy and a 24 hour milieu to promote</p>	

ASAM Dimension	ASAM MNC	HP MNC
	<p>treatment progress and recovery, because motivational interventions which will enable him/her to develop insight into the role he or she plays in his/her substance use and/or mental condition, and empower him/her to make behavioral changes;</p> <p>or,</p> <p>The patient's perspective impairs his/her ability to make behavior changes without repeated, structured, clinically directed motivation interventions which will enable him/her to develop insight into the role he/she plays in her/her substance use and/or mental condition, and empower him/her to make behavioral changes which can only be delivered in a 24 hour milieu;</p> <p>or,</p> <p>Despite recognition of a substance use or addictive behavior problem and the relationship between his/her substance use, addiction and life problems, the patient expresses little to no interest in changing. Because of the intensity or chronicity and history of high risk criminality, he/she posed imminent serious life consequences, i.e., imminent risk to public safety, abuse or neglect of children, and /or a continued pattern of risk of harm to others (assault, burglary, DUI while under the influence);</p> <p>or,</p> <p>The patient attributes his/her substance use or mental health problem to other persons or external events rather than to a substance use or mental disorder. The patient requires clinically directed motivational interventions that will enable him/her to develop insight into the role he/she plays in his/her health condition and will encourage behavioral changes.</p>	

ASAM Dimension	ASAM MNC	HP MNC
	Required interventions are not feasible or likely to succeed at a less intensive level of care.	
Dimension 5: Relapse, continued use, or continued problem potential	<p>The patient's status in Dimension 5 is characterized by at least one of the following:</p> <p>The patient does not recognize relapse triggers and lacks insight into the benefits of continuing care, and is not committed to treatment. His/her continued substance use poses an imminent danger of harm to self or others in the absence of 24 hour monitoring and structured support;</p> <p>or,</p> <p>The patient's psychiatric condition is stabilizing. However, despite his/her best efforts, the patient is unable to control the use of substances and/or antisocial behaviors, with probability of harm to self or others. The patient has limited ability to interrupt the relapse process of continued use, or to use peer supports when at risk for relapse to his/her addiction or mental disorder. Continued use poses harm to self/others.</p> <p>or,</p> <p>The patient is experiencing psychiatric or addiction symptoms such as drug craving, inability to postpone immediate gratification, and other drug seeking behaviors. This poses an imminent danger of harm to self or others in the absence of 24 hour monitoring and support. The introduction of pharmacologic support is indication to decrease psychiatric or addictive symptoms, such as cravings, that will enable the patient to delay immediate gratification and reinforce positive recovery behaviors;</p>	

ASAM Dimension	ASAM MNC	HP MNC
	<p style="text-align: center;">or,</p> <p>The patient is in imminent danger of relapse or continued use, with dangerous emotional, behavioral, or cognitive consequences as a result of a crisis situation;</p> <p style="text-align: center;">or,</p> <p>Despite recent, active participation in treatment at a less intensive level of care, the patient continues to use substances or to deteriorate psychiatrically, with imminent serious consequences, and is at high risk of continue substance use or mental deterioration in the absence of close 24 hour monitoring and structured treatment;</p> <p style="text-align: center;">or,</p> <p>The patient demonstrates a lifetime history of repeated incarceration with a pattern of relapse to substances and uninterrupted use outside of incarceration, with imminent risk of relapse to substances or mental health problems and recidivism to criminal behavior posing an imminent risk of harm to self or others r/t the cycle of relapse, reoffending, incarceration, release, relapse.</p>	
<p>Dimension 6: Recovery/living environment</p>	<p>The patient's status in Dimension 6 is characterized by at least one of the following:</p> <p>The patient has been living in an environment that is characterized by a moderately high risk of neglect; initiation or repetition of physical, sexual, or emotional abuse; or substance use so endemic that the patient is assessed as being unable to achieve or maintain recovery at less intensive levels of care;</p> <p style="text-align: center;">or,</p>	<p>AND 1.4 (con't) and/or psychosocial and environmental factors. Examples include:</p> <p>1.4.1 Acute impairment of behavior or cognition is interfering with activities of daily living to the extent that the welfare of the member or others is endangered.</p> <p>1.4.2 Psychosocial and environmental problems threaten the member's safety or undermine engagement in a less intensive level of care.</p>

ASAM Dimension	ASAM MNC	HP MNC
	<p>The patient's social network includes regular users of substances such that recovery goals are assessed as unachievable at a less intensive level of care;</p> <p>or,</p> <p>The patient's social network is characterized by significant social isolation or withdrawal, such that the recovery goals are assessed as inconsistently unachievable at a less intensive level of care;</p> <p>or,</p> <p>The patient's social network involves living with an individual who is a regular user, addicted user or dealer, or the living environment is so highly invested in substance that his/her recovery goals are assessed as unachievable;</p> <p>or,</p> <p>The patient is unable to cope for even limited periods of time outside of 24 hour care. He/she needs staff monitoring to learn to cope with Dimension 6 problems before being transferred safely to a less intensive setting.</p>	

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, et al., 2013, pp.254-259.

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>.