ORDER

BY THE HONORABLE ROGER A. SEVIGNY
INSURANCE COMMISSIONER OF THE
STATE OF NEW HAMPSHIRE

IN THE MATTER OF:

Anthem Health Plans of New Hampshire, Inc., NAIC #53759
Mathew Thornton Health Plan, Inc., NAIC #95527

TARGETED MARKET CONDUCT EXAMINATION REPORT– SUD BENEFITS
Docket No.: INS No. 15-072-MC

WHEREAS, the New Hampshire Insurance Department ("the Department") conducted a targeted market conduct examination of the above-referenced insurance company ("the Company") regarding its handling of substance use disorder ("SUD") benefits during the period January 1, 2015 through September 30, 2015, and the examination resulted in a Verified Market Conduct Examination Report ("Verified Report") as of October 28, 2016.

WHEREAS, the Verified Report contains the findings and recommendations of the Examiners.

WHEREAS, the Company received a copy of the Verified Report, and, by correspondence dated December 2, 2016 and December 15, 2016 submitted a Rebuttal to the Verified Report to the Department.

WHEREAS, by an Order executed by the Commissioner on December 27, 2016, the Department adopted the Verified Report pursuant to RSA 400-A:37, IV (b) (1) with modifications as noted in that Order.

WHEREAS, the Company did not request a closed meeting with the Commissioner pursuant to RSA 400-A:37, IV (c) (2).

WHEREAS, the Adopted Report has been modified slightly at the request of examiners to clarify the examiners' explanation of market conditions with respect to network adequacy, a change which does not alter the examiners' findings with respect to the Company's practices.

NOW THEREFORE, in accordance with RSA 400-A:37, IV (c)(4), the Adopted Report, as modified, is hereby accepted and filed, and shall be deemed final.

It is **SO ORDERED**

New Hampshire Insurance Department

Date: February 7, 2017

Roger A. Sevigny, Commissioner

STATE OF NEW HAMPSHIRE

COUNTY OF MERRIMACK

Joelien J Atwater, being duly sworn, upon her oath deposes and says:

That she is an examiner employed by the Insurance Department of the State of New Hampshire;

That an examination was made of the affairs of the

Anthem Health Plans of New Hampshire, Inc.

Organized and authorized under laws of the State of **New Hampshire**,

Vested by **Roger A. Sevigny**, Commissioner of Insurance of the State of New Hampshire;

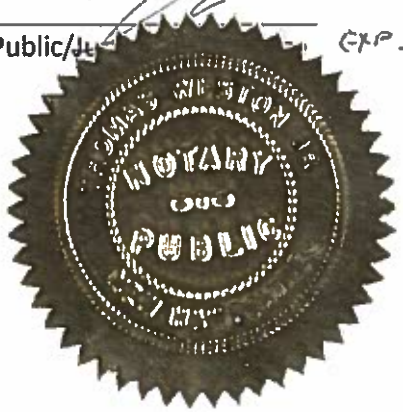
That she was the examiner-in-charge of said examination and that the attached report of the examination is a true and complete report of the condition of the above named Company as of October 28, 2016 as determined by the examiners.

Examiner-In-Charge

Subscribed and sworn to before me this
27th Day of October, A.D. 2016

Notary Public/Ju

Exp 3/25/2020



NEW HAMPSHIRE INSURANCE DEPARTMENT

MARKET CONDUCT TARGETED EXAMINATION

OF

ANTHEM HEALTH PLANS OF NEW HAMPSHIRE, INC., NAIC# 95527

MATTHEW THORNTON HEALTH PLAN, INC., NAIC# 53759

1155 ELM STREET, SUITE 200

MANCHESTER, NEW HAMPSHIRE 03101

FOR THE PERIOD OF JANUARY 1, 2015 THROUGH SEPTEMBER 30, 2015

REGARDING THE HANDLING OF SUBSTANCE USE DISORDER BENEFITS AND MENTAL HEALTH PARITY

FINAL

AS OF

FEBRUARY 7, 2017

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Scope

Pursuant to RSA Chapter 400-A:37, the New Hampshire Insurance Commissioner (Commissioner) issued an examination warrant for the purpose of examining Anthem Health Plans of New Hampshire, Inc. and Matthew Thornton Health Plan, Inc.'s (collectively, Anthem) administration of benefits for Substance Use Disorder and Addiction (SUD) treatment services.

The goal of the examination was to ascertain how carriers regulated by the New Hampshire Insurance Department (Department) are providing coverage for SUD treatments and to ensure that benefits are consistently applied within the requirements of state and federal law and are not subject to more stringent requirements than for Medical/surgical benefits during the examination period of January 1, 2015 through September 30, 2015.

Specifically, this examination encompassed all regulatory requirements under RSA Title XXXVII that apply to the health carrier's practices for the handling of SUD services under both New Hampshire and federal law, including but not limited to:

1. 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 (MHPAEA) that relate to the business of insurance, including federal regulations adopted under MHPAEA, 45 CFR Section 146.136, Parity in mental health and substance use disorder benefits (federal parity rule)[1];
2. RSA 420-N:5, which authorizes the Commissioner to enforce the consumer protections and market reforms set forth in the Affordable Care Act (ACA) including the ACA's amendments to MHPAEA;
3. RSA 415:18-a, requiring coverage for mental or nervous conditions and treatment for chemical dependency under group health plans;
4. RSA 420-B:8-b, requiring Health Maintenance Organizations (HMOs) provide coverage for mental and nervous conditions and chemical dependency;
5. RSA 417-E:1, requiring coverage for certain biologically-based mental illnesses that is in parity with coverage for physical illness; and
6. 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

[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 recent and 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.

420-J:8-a, requirements for prompt pay; RSA 420-J:4 governing provider credentialing and RSA 420-J:6, regarding utilization review.

The examination was conducted in two phases. Phase I included sending interrogatories to obtain initial information regarding the following areas: Delegated Service Contracts, Network Adequacy, Pre-Authorizations, Grievances/Appeals and Claims. Phase II included a series of interrogatories to verify Medication Assisted Treatment (MAT) practices and overall compliance with both quantitative and non-quantitative requirements of the MHPAEA.

For the purposes of this examination, the Department contracted with the following as outside examiners (1) an Independent Review Organization (IRO) that provided the medical expertise of addiction specialists; (2) a mental health parity expert; and (3) a pharmacist to assist with the interpretation of the documentation provided with respect to pharmacy benefits.

Phase I

On December 4, 2015, the Department sent interrogatories and a Behavioral health Survey to Anthem. Anthem was requested to provide a detailed response to the survey and interrogatory questions as they relate to fully-insured group and individual health benefit plans. When referencing small and large groups, the Department requested that the responses encompass employer/group contracts with a brick and mortar work location in the state of New Hampshire with one or more New Hampshire employees.

Anthem was required to provide information relative to the following operational areas:

- Delegated Service Contracts
- Network Adequacy
- Pre-authorizations
- Grievances and Appeals
- Claims

Interrogatory responses were requested, received and reviewed by the Department's examiners and contracted examiners. The examiners interacted with the carrier for any follow-up questions or identified deficiencies.

The Department's primary objective in conducting Phase I of the examination was to evaluate whether the carrier is covering SUD benefits no less favorably than Medical/surgical benefits. The goals and objectives in conducting the Examination included but were not limited to the following:

1. Evaluate the carrier's delegated service contracts to ensure that if the carrier has delegated SUD utilization or case management reviews, that:
    - The delegated entity has the appropriate expertise to perform SUD reviews;
    - The delegated entity has applied clinically appropriate criteria and guidelines; and,
    - The criteria and guidelines utilized do not impose any limitations on SUD services that are more stringent than those applied to Medical/surgical services.
2. Evaluate the carrier's provider network to determine whether there are a sufficient number of providers, including providers that specialize in Behavioral health/SUD services, and to ensure that consumer access to services is available without unreasonable delay.
    - Review and test the carrier's website for ease of use and accuracy of on-line directory
3. Evaluate the carrier's entire universe of SUD pre-authorization denials during the examination period to ensure that denials were appropriate based on medically sound criteria.
4. Test 100% of the carrier's SUD grievances and appeals during the examination period to determine:
    - If the grievance/appeal determination was made in accordance with clinically appropriate criteria and guidelines, contractual obligations and all applicable state and federal laws; and
    - That all adverse benefit determination letters included information regarding any right to external review and all required contact information.
5. Measure the carrier's claims in order to quantify volumes of claims for SUD claims for services in comparison to claims for Medical/surgical services.

Phase II

This phase consisted of two major components: Medication Assisted Treatment (MAT) and carrier compliance relative to the MHPAEA and the federal parity rule. This included an in depth review by a contracted pharmacist of Anthem's practices for MAT to establish a baseline for the program.

The Department's primary objective in conducting the examination was to evaluate whether the carrier is covering Behavioral health benefits no less favorably than Medical/surgical benefits. The goals and objectives in conducting Phase II of the Examination included but are not limited to the following:

1. Identify all market segments that are subject to MHPEA to determine that the carrier is not limiting coverage or benefits inappropriately in any market.
2. 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 all allowed variances outlined in 45 CFR § 146.136.
3. Determine that the Behavioral health benefits provided in the classifications identified by 45 CFR §146.136 (a)(c)(2)(ii)(A); in-network inpatient, out-of-network inpatient, in-network outpatient, out-of-network outpatient, emergency and pharmacy, are paid in parity with benefits in the same classification under Medical/surgical.
4. Evaluate the carrier's quantitative and non-quantitative benefit limits to ensure that limitations are consistently applied through Behavioral health and Medical/surgical benefits and that any quantitative limitations imposed meet the two-thirds threshold of the substantially all requirement outlined in 45 CFR § 146.136 (a)(c)(3)(i).
5. Evaluate the carrier's Medical Necessity policies and procedural requirements to ensure that the carrier is not imposing more restrictive requirements and determinations on Behavioral health treatments than on Medical/surgical.
    a. Evaluate the Medical Necessity requirements to determine that the guidelines are clearly outlined and presented to consumers in a format compliant with all applicable statutes and regulations.
6. Evaluate the carrier's Precertification/pre-authorization policies and procedural requirements to ensure that the carrier is not imposing more restrictive requirements and determinations on Behavioral health treatments than on Medical/surgical.
7. Evaluate the carrier's reimbursement fee schedule to determine if the reimbursement fees are consistently applied to Behavioral health and Medical/surgical, and to determine that any fee updates are consistently applied to both Behavioral health and Medical/surgical providers.
8. Evaluate the carrier's Usual and Customary allowances to determine that benefit reductions are not applied more strictly to Behavioral health than to Medical/surgical benefits.
9. Measure the carrier's claims to quantify volumes of SUD claims for services in comparison to Medical/surgical services which include Behavioral Health.

In the MAT portion of Phase I and II, interrogatories were sent to the carrier by the pharmacist and detailed responses were requested. The information received was reviewed by the pharmacist with oversight by the Department's examiners. The

examiners and contracted pharmacist worked with the carrier to answer follow-up questions or discuss deficiencies.

In Phase II's area of Mental Health Parity compliance, on May 17, 2016, the contractors acting on behalf of the Department sent interrogatories based on Anthem's responses to the Behavioral Health Survey the carrier had completed as part of the initial phase of the examination. Anthem was requested to provide a detailed response to the interrogatory questions as they relate to fully-insured group and individual health benefit plans. On June 23, 2016, follow-up interrogatories were sent.

Specifically, Anthem was required to provide information relative to the following:

Medication Assisted Treatment (MAT)

- Formularies to determine the number of SUD medications offered
- Documentation to ensure that inappropriate age limitations were not imposed through discriminatory benefit designs for MAT medications
- Processes and policy language presented to the consumer that explain how to request an exception for coverage of medications not covered under the plans formulary
- Documentation regarding the dosage and refill limits for methadone, buprenorphine, buprenorphine/naloxone, naloxone and naltrexone
- Documentation regarding lifetime or annual limits for methadone, buprenorphine, buprenorphine/naloxone, naloxone and naltrexone
- Preauthorization, re-authorization or step therapy processes or any other utilization review requirements specific to methadone and/or buprenorphine
- Information regarding penalties or exclusions of coverage for failure to complete a course of treatment specific to methadone and/or buprenorphine
- Medical necessity standards applied to methadone and/or buprenorphine

Mental Health Parity and Addiction Equity Act (MHPAEA):

- Market segments served by the carrier which are subject to MHPAEA
- Variances in requirements for Medical/surgical benefits and Behavioral Health benefits
- Classification and sub-classification of benefits for both Medical/surgical Medical/surgical and Behavioral Health in the following categories
    - In-network inpatient
    - Out-of-network inpatient
    - In-network outpatient

        - Out-of-network outpatient
        - Emergency
        - Pharmacy
- Quantitative and Non-quantitative Treatment limits for both Medical/surgical benefits and Behavioral Health benefits
        - Medical Necessity Requirements including notifications provided to members outlining the Medical Necessity Requirements for both Medical/surgical and Behavioral Health
        - Precertification/Pre-authorization requirements for both Medical/surgical and Behavioral Health including policy language
        - Provider reimbursement rates and fee schedules for both Medical/surgical and Behavioral Health
        - Processes and Procedures for determining Usual and Customary and frequency of updates of such for both Medical/surgical and Behavioral Health; and
        - Claims volume for both Medical/surgical and Behavioral Health

Interrogatory responses were requested, received and reviewed by the Department's examiners and contracted examiners. The examiners interacted with the carrier for any follow-up questions or identified deficiencies.

Company Profile

Anthem Health Plans of New Hampshire, Inc. (“AHPNH”) and Matthew Thornton Health Plan, Inc. (“MTHP”) are New Hampshire domiciled insurance companies. Anthem Health Plans of New Hampshire, Inc. is a wholly-owned subsidiary of ATH Holding Company, LLC (“ATH Holding”), and Matthew Thornton Health Plan, Inc. is a wholly-owned subsidiary of Anthem Health Plans of New Hampshire, Inc.

ATH Holding is a wholly-owned subsidiary of Anthem, Inc., a publicly traded company (NYSE: ANTM) and one of the largest health benefits companies in terms of membership in the United States, serving 38.6 million medical members as of December 31, 2015, as reflected in Anthem’s latest Annual Report.

The Companies’ Financial Statements for the year ending December 31, 2015 reflect that there were 129,340 covered lives (AHPNH), and 104,878 covered lives (MTHP). The Financial Statements also reflect that the Companies realized net underwriting gains of $25.9 million from $465.5 million in net premium (AHPNH), and $52.2 million from $514.6 million in net premium (MTHP).

Executive Summary

The following summary of this targeted market conduct examination of the carrier is intended to provide a high-level overview of the examination results. The report includes sections which detail the scope of the examination, tests conducted, findings and observations. Appendices include the Interrogatories and Data Requests sent to Anthem.

One of the most predominant observations Examiners wish to note is the overall shortage in New Hampshire of available SUD and Behavioral Health providers in which to contract.

The examination included the following areas of review: Delegated Service Contracts, Network Adequacy, Pre-Authorizations, Grievances/Appeals, Claims, and Medication Assisted Treatment specific to SUD, as well as Parity between Behavioral Health and Medical/surgical services. Based upon our review of the information received from the carrier, the following is a summary of our findings/observations:

Delegated Services

Anthem does not delegate any services related to SUD or Behavioral Health treatment.

Network Adequacy

Deficiencies in the availability of servicing providers were identified, based upon New Hampshire Network Adequacy Standards RSA 420-J:7 and N.H. Code of Admin. R. Ins. Part 2701. These deficiencies are a result of a lack of providers in this area in New Hampshire.

The examiners will be requesting further information including documentation in regards to how the carrier demonstrates it handles requests from members in service areas that do not have adequate contracted providers available.

Web-site ease of access

Examiners will require that Anthem provide a corrective action plan to the Department within 30 days of finalization of the report to address the timelines associated with providing a current listing of all SUD and Behavioral Health providers, as well as update their website to prominently display an accurate, up-to-date listing of all SUD and Behavioral Health providers.

Provider Directory accuracy

As a result of the network adequacy deficiencies, examiners extended their review to carrier website ease-of-use for identification of Behavioral Health providers and to confirm the accuracy of the listing.

The examiners will be requesting that Anthem provide the Department with their policies and procedures for quality oversight of the on-line provider directory which must demonstrate:

- How Anthem ensures accurate listings are published on their website;
- The method and frequency of verification; and
- The most recent verification results and any corrective actions put in place to correct deficiencies.

Pre-Authorizations

The Department contracted with a certified independent review organization (IRO) that provided 16 addiction specialists, to conduct a review of all pre-authorization medical necessity denials. This review consisted of 100% of all denials for SUD benefits during the examination period of January 1, 2015 through September 30, 2015. The IRO felt additional benefits should have been provided for six of the 34 pre-authorizations reviewed.

Examiners are recommending follow-up with all six consumers to determine present treatment status and to ensure they have received all appropriate treatment under their benefit contract.

In addition, the medical director of the IRO was asked to review the criteria used for the evaluation of Medical Necessity for SUD treatment and confirm that it is consistent with current medical standards. The medical director stated, “It is my medical opinion that the protocols are medically reasonable.”

Grievances and Appeals

A review of all SUD Grievances and Appeals letters for the scope of the exam was conducted for compliance with RSA 420-J:5.

No compliance issues were identified.

Claims

Examiners quantified the overall volume and percentage of SUD claims in relation to Medical/surgical claims, but did not evaluate claim accuracy and timeliness. The data

provided shows that SUD claims accounted for 1.6% of the overall processed claim volume for the examination period, while the SUD total billed charges equated to 3.88% of the total billed charges.

Medication Assisted Treatment

The Department contracted with a registered pharmacist to create a set of interrogatories designed to provide a baseline of Anthem's MAT program in New Hampshire.

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

Examiners will require that Anthem provide information regarding the clinical basis for dosing limitations for methadone and Evzio as they are contrary to the manufacturer's guidelines. This documentation must be provided within 30 days of the final report.

Mental Health Parity

For purposes of this report, this section refers to the services to which the parity laws are applicable interchangeably as either Mental Health or Behavioral Health benefits, categories which also include SUD. Many documents presented by the carrier use the term Behavioral Health rather than Mental Health. This term is used as an all-encompassing term that not only includes promoting well-being by preventing or intervening in mental illness such as depression or anxiety, but also has as an aim preventing or intervening in substance abuse or other addictions. However, because the term "Mental Health" is used in MHPAEA, the report does on occasion use the term "Mental Health" rather than "Behavioral Health." In several areas, the Parity review focuses on concerns of parity with respect to SUD services more narrowly, rather than looking at all areas that would fall under Mental Health or Behavioral Health.

A Mental Health Parity review was completed on the carrier's internal processes and procedures to determine compliance with NH parity laws as well as the updated federal regulation implementing MHPAEA, 45 CFR §146.136. To complete the review, examiners looked at the responses received to the original Mental Health Parity Survey, follow-up interrogatory responses and the carrier's documented procedures. This review was performed to identify potential areas where procedures and protocols as well as

access to Behavioral Health benefits were less favorable than the procedures and protocols for Medical/surgical benefits.

The following information identifies the areas of review, the determinations, and recommendations for various parity comparisons.

Market Review

Examiners requested information on the markets in which the carrier writes business that is subject to MHPAEA. Examiners then reviewed the markets for both Medical/surgical and Behavioral Health coverage to ensure there were no disparities or gaps in coverage in each market.

Anthem's practices as they relate to each market are consistent and compliant with the identified regulations.

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

Quantitative Treatment limits

In accordance with the federal mental health parity rule (45 CFR § 146.136 (a)(3)(i)(A)), examiners reviewed the carrier's policies and procedures in applying quantitative limits.

Under the rule, quantitative treatment limitations are those for which the extent of benefits provided are based on accumulated amounts, such as an annual or lifetime day or visit limit.

A review of documents provided indicates that the carrier applies quantitative limitations consistently between Mental Health benefits and Medical/surgical benefits. Policies reviewed did not include a process for corrective action should a disparity be identified.

Examiners will recommend that Anthem establish procedures to address disparities when identified. This procedure should include analysis and steps for corrective action. Anthem must provide a copy of the procedures established to the Department within 30 days of the final report.

Non-Quantitative Treatment Limits

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

- Medical management standards limiting or excluding benefits based on medical necessity or medical appropriateness, or based on whether the treatment is experimental or investigative;
- Formulary design for prescription drugs;

- Network tier design for plans with multiple network tiers (such as preferred providers and participating providers);
- Standards for provider admission to participate in a network, including reimbursement rates;
- Methods for determining usual, customary, and reasonable charges;
- 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);
- Exclusions based on failure to complete a course of treatment; and
- Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for services provided under the plan or coverage)

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

Medical Management Policies and Procedures

Examiners reviewed Anthem's Medical Management-Medical Policy and Clinical Utilization Guidelines applicable to Mental Health and Medical Surgical benefits.

Examiners identified a concern with document Admin.00002-Preventive Health Guidelines. This document outlines preventive services that are considered medically necessary. The document does not provide coverage for Depression Screening, which is a required preventive service under 42 USC § 300gg-13, and must be allowed without cost sharing when provided by an in-network provider.

Examiners will require that Anthem update the Admin.00002-Preventive Health Guidelines document to include coverage for Depression Screening as required by 42 USC § 300gg-13. Anthem must also provide a copy of the updated document to the Department within 60 days of the final report.

Consumer Medical Management Policy/Guideline Access

The examiners determined that the carrier has developed robust Medical Necessity criteria for both Behavioral Health and Medical/surgical services. One exception noted is that while the Medical Policies and Clinical Utilization Management Guidelines are available on-line for reference, they were not easily obtained.

Examiners will require Anthem to ensure that Medical Necessity information, including Utilization Review policies and Clinical Guidelines are easily accessible to consumers on the carrier's website.

Policy Development and Updates

Examiners reviewed methodologies that the carrier utilizes to create, amend, or update policies and procedures. The purpose of this section of the review was to determine if the carrier was utilizing the most up-to-date policies and procedures based on current medical standards, and ensuring that the policies and procedures for Behavioral Health are updated as frequently, if not more frequently than the policies and procedures established for Medical/surgical benefits.

Examiners found no exceptions.

Precertification and Pre-Authorization

In order to determine parity between precertification and pre-authorization requirements for both Behavioral Health and Medical/surgical benefits, examiners reviewed all of the carrier's internal processes for both areas as well as samples of policy language from a large group, small group and individual plan.

Examiners determined that the carrier has established precertification and pre-authorization requirements consistently between Behavioral Health and Medical/surgical benefits. Specific precertification and pre-authorization requirements were not easily located on the carrier's website.

Examiners also determined that the Guidelines reviewed state that consumers should contact the appropriate state's customer service number for requirements or when verifying eligibility.

Examiners will require Anthem to ensure that precertification and pre-authorization information is easily accessible to consumers on the carrier's website.

Examiners will require that Anthem update the precertification guidelines to direct consumers to contact the customer service number on the back of their identification card for requirements or when verifying eligibility.

Provider reimbursement rates and fee schedules

The examiners reviewed 10 Evaluation & Management codes to determine the reimbursement fees allowed for the provider. The fee schedule provided confirms that the reimbursement tiers are 100% for an MD, 85% for APRN, 80% for PhD, 75% for MS.

Examiners did not validate the reimbursement fee schedule; however have concerns about the impact of the reduced fees at the PhD level.

Examiners will require that Anthem provide evidence that the disparity in reimbursement fees is not a parity violation.

Examiners will schedule a targeted review of the credentialing criteria used for each of the above specialties to include any directives provided by NCQA Standards and test the process within each credentialed specialty.

Processes and Procedures for determining Usual and Customary

The examiners reviewed the processes and procedures for determining usual and customary (UCR) reimbursement rates. It was determined that the carrier updates its fee schedules (Medical/surgical and Behavioral Health) annually or more frequently. The fee schedules are based on resource-based relative values by CMS, incorporate Berenson-Eggers Type of Service, as well as employer group demands and concerns.

Examiners determined that the carrier reviews their Behavioral Health and Medical/surgical fee schedules in the same manner whenever the regular updates occur.

Examiners found no concerns.

Examiners would like to acknowledge Mr. Stephen Buchanan, Anthem's Compliance Officer, for his cooperation and expedient responses to the examiners and contracted examiners requests for information.

FINDINGS

DELEGATED SERVICE CONTRACTS

Standard 6

The regulated entity is adequately monitoring the activities of any entity that contractually assumes a business function or is acting on behalf of the regulated entity.
NAIC Market Regulation Handbook – Chapter 16, page 222

Regulatory Authority

RSA 402-H:6 Responsibilities of the Insurer.

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

The examiners requested all contract provisions and the supporting documentation of all delegated services to determine the handling of SUD Utilization Management (UM) and operational processes and procedures.

Anthem has its own UM servicing entity within its corporate structure and does not delegate services related to the management of SUD.

Examiners' Comment

Delegated Service compliance does not apply.

NETWORK ADEQUACY

Standard 1

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

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

Regulatory Authority

RSA 420-J:7 Network Adequacy.

I. A health carrier shall maintain a network that is sufficient in numbers, types, and geographic location of providers to ensure that all services to covered persons will be accessible without unreasonable delay.

IV. Annually, the health carrier shall submit a report to the commissioner demonstrating compliance with the rules for network adequacy.

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

Specific requirements for Network Adequacy under RSA 420-J:7 and Ins 2701.06 Standards for Geographic Accessibility are as follows:

For at least 90% of the enrolled population within each county or hospital service area, the travel time interval to a provider of outpatient mental health services shall be no greater than 25 miles or 45 minutes travel time. Within the same service area, access to a general inpatient psychiatric facility, emergency mental health providers and short term facility for substance abuse treatment must be within 45 miles or 60 minutes of travel time.

Exceptions to the geographic requirements may be permitted if a carrier can establish that there are an insufficient number of qualified providers or facilities available in the county or hospital service area, if there is a community mental health program approved by the commissioner of DHHS (Department of Health and Human Services) and the program has been deemed to provide a level of geographic access that is at least equal to the customary practice and travel arrangements and the carrier has taken reasonable steps to mitigate any detriment to their enrollees.

Examiners requested the carrier to provide the following information for review and analysis during this examination:

- A listing of all contracted providers including,
  - The type of services they provide in relation to SUD
  - Which providers are accepting new patients
  - Patient capacity for outpatient and inpatient settings
- Two (2) GEO Access reports
  - One (1) report specific to SUD providers throughout New Hampshire

- One (1) report specific to all of Anthem's existing membership

Network capability for SUD Inpatient, SUD Intensive Outpatient and SUD Rehabilitation services was reviewed to identify deficiencies in the availability of servicing providers based on New Hampshire Network Adequacy Standards RSA 420-J:7 and Ins. 2701.06. Current NH law does not require that carriers document the availability of specialty care providers including SUD providers. The examiners requested SUD-specific provider availability for the examination period and Anthem reported the following deficiencies:

- SUD Inpatient
- SUD Intensive Outpatient and;
- SUD Rehabilitation

In addition to the detail provided by the carrier for network adequacy during the examination period, the 2015 Network Adequacy report filed with the Department by Anthem on February 15, 2016, Mental Health Facility deficiencies were noted for both the Broad and Pathway networks.

Anthem stated in the filing submission, "for products utilizing Anthem's Broad Network, deficiencies are concentrated in the more rural counties of New Hampshire including Carroll, Coos and Grafton for specialist services, Coos for facility services and Carroll, Coos and Grafton for mental health services. There is an additional county for Cheshire for Indemnity Traditional in the area of Involuntary Psychiatric admissions."

"With regard to deficiencies for professional provider specialty services, the same deficiencies exist in the Pathway Network that exists with regard to Anthem's Broad Network."

Examiners' Recommendation

As a result of the current opioid crisis facing New Hampshire and the increasing number of members whose coverage includes SUD treatment services under the ACA and the NH Health Protection Program, the examiners require that Anthem submit further information including documentation, in regards to how the carrier demonstrates it handles requests from members in service areas that do not have adequate contracted providers available. This information must be submitted to the Department for review and approval within 60 days of the final report. Emphasis shall be placed on Behavioral Health and SUD providers.

Examiners' concerns regarding network deficiencies and current consumer complaints prompted an additional review of the website for ease of access and the network via the on-line provider directory. Although this testing fell outside of the examination period

due to the need to complete “live” testing, it was appropriate due to regulatory authority under *CFR Title 45, Part 156 Subpart C §156.230 (b) (2)*.

Company Response

On December 2, 2016 and December 15, 2016, Anthem responded to the verified report with the following information.

“Anthems outreach to non-contracted Behavioral Health and SUD providers to encourage participation in the Anthem network has expanded the number of in-network providers.

Anthem will submit to the Department a Corrective Action Plan which includes policies and procedures addressing long standing network deficiencies in certain rural New Hampshire counties.”

Examiners’ Comment

Examiners will review the Corrective Action Plan when submitted.

Website consumer ease of access

Regulatory Authority

CFR Title 45, Part 156 Subpart C §156.230 (b) (2) For plan years beginning on or after January 1, 2016 a QHP issuer must publish an up-to-date, accurate and complete provider directory, including information on which providers are accepting new patients, the provider’s location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM. A provider directory is easily accessible when –

(i) The general public is able to view all of the current providers for a plan in the provider directory on the issuer’s public Web site through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number; and

(ii) If a health plan issuer maintains multiple provider networks, the general public is able to easily discern which providers participate in which plans and which provider networks.

Examiners expanded the review to include a test of Anthem’s current website for accessibility and ease of consumer use which resulted in the following observations:

- The first selection choice for searching did not include Behavioral Health or SUD. Consumers must choose “medical” in order to drill down to locate a Behavioral Health or SUD provider.
- Examiners were unable to locate a Psychiatrist who specializes in treating adults in three counties; Rockingham, Hillsborough and Coos
    - Changing the “patient population” from adult to “no preference” did yield results
- Search criteria do not retrieve all eligible providers
    - Board certified addiction counselor is only retrieved under Family Medicine and not under Behavioral Health

Examiners’ Recommendation

Examiners will recommend that Anthem provide a corrective action plan to the Department within 30 days of finalization of the report to address the timelines associated with providing a current listing of all SUD providers in both the broad and Pathways networks, as well as update their website to prominently display an accurate, up-to-date listing of all SUD providers and Behavioral Health providers.

Company Response

Anthem responded to the verified report on December 2, 2016 and December 15, 2016 and stated the following;

“Non-members (or Members) using the online public Find a Doctor tool must on the first screen select the type of care (Medical, Dental or Vision) and the name of the network they wish to search, and on the second screen they may then select Behavioral Health from a variety of provider types.

Anthem is reviewing the feasibility of adding footnote language to the online Find a Doctor Tool for users utilizing the Guest search function that will indicate that “Medical Care includes Behavioral Health & Substance Use Disorder Services”.”

Examiners’ Comment

Examiners will be looking for confirmation that the language has been added to the website and will review the corrective action plan upon receipt.

Provider directory accuracy

Examiners reviewed the search results produced and conducted outreach to listed providers with the following outcomes:

- Search results identified individual providers with multiple service locations
- Inaccuracies of data
    - Provider credentials M.D. versus MD resulted in duplicate listing
    - Provider is not at the practice or phone number listed in the directory

In addition to reviewing the on-line directory, examiners reviewed the Anthem on-line Provider Manual; Provider Administration – Credentialing and Maintenance, Demographic Changes section. This document asks providers to submit, on a Provider Maintenance Form, any changes related to their practice and demographic information.

Examiners' Recommendation

The examiners will require that Anthem provide the Department with their policies and procedures for quality oversight of the on-line provider directory and maintenance of provider demographic changes which must document:

- How Anthem ensures accurate listings are published on their website
- The method and frequency of review and verification and;
- The most recent verification results and any corrective actions put in place to correct deficiencies

Examiners will request that Anthem provide all supporting documentation of maintenance activity from July 1, 2016 through September 30, 2016, which shall include, but not be limited to:

- Volumes of provider maintenance forms received
- Volumes of provider maintenance forms processed
- Timeliness of provider maintenance forms processed
- Volumes of provider maintenance forms received, but not yet processed

After review of the quality oversight program and the data and documentation provided, examiners will recommend conducting a more extensive test of the on-line provider directory.

Company Response

In response to the verified report, Anthem submitted the following information on December 2, 2016 and December 15, 2016;

"See Exhibit 1 for Anthem's Provider Finder Audit Procedures and Guidelines. Procedures and Guidelines were implemented to ensure accuracy of information and to provide quality oversight, utilizing a comprehensive data validation audit program."

Anthem also provided data specific to provider maintenance activity as required.

Examiners' Comment

No further action is required; exhibits submitted demonstrate compliance. All supporting documentation will be maintained as confidential under RSA 400-A:37.

Examiners' Recommendation

Examiners will recommend that Anthem review and consider the potential adoption of the 2016 National Committee on Quality Assurance (NCQA) provider directory audit process rules effective July 2016.

We further recommend that the carrier consider the DirectAssure™ program from the Council for Affordable Quality Healthcare (CAQH) or a similar program to assist with review and attestation of provider demographic information.

Company Response

Anthem responded to the verified report on December 2, 2016 and December 15, 2016 with the following information;

"The NCQA provider directory audit process standard was introduced for accreditations occurring July 2016 and after. Anthem's next NCQA review will occur in 2018, at which time this standard will be included.

The CAQH provider directory service that collects, updates, and maintains provider directories currently lacks the ability to accommodate certain essential data elements in Anthem's system, and will not be able to do so for at least another year. Anthem continues to explore this sort of service with CAQH and other vendors."

Examiners' Comment

No further action is required.

Follow-up to onsite visit

The Examiner-in-Charge met with representatives of Anthem on March 18, 2016 to discuss the current process for outreach to providers for the contracting process. Anthem indicated that in light of the current opioid crisis, they would outreach to non-contracted providers to begin dialog regarding the contracting and credentialing process. On September 26, 2016, Anthem forwarded the following updates:

Provider contracting efforts in 2016 have expanded the Anthem SUD/Behavioral Health network as follows:

- 95 standard professional Behavioral Health/SUD contracts
- 5 additional individually negotiated contracts
    - West Central Services (effective 1/1/16)
    - Metro Treatment of NH (Three methadone treatment centers effective 1/1/16)
    - Green Mountain Treatment Center (effective 3/7/16)
    - Live Free Recovery Consultants (effective 5/1/16)
    - Walden Behavioral Care LLC (effective 6/1/16)

During the meeting, Anthem's Behavioral Health Medical Director discussed an initiative in Connecticut, called the Anthem Connecticut Addiction Recovery Pilot Program. The Medical Director discussed the success of this program with the possible consideration of initiating this program in New Hampshire. The following update was provided by Anthem on September 26, 2016:

Aware Recovery Care Program

- Program coming to NH members in October 2016.
- Description of program: 1 year duration, includes team based care from an addiction psychiatrist, registered nurse, mental health therapist if needed and a certified recovery advisor (peer support specialist). Services provided in the member's home and community and feature technologies such as mobile alcohol Breathalyzer and GPS monitoring.
- Members are referred directly from community providers and from facility based substance use providers.
- Anthem and Aware developed admission criteria and medically necessary care is approved for the full 1 year duration of treatment in 6-month increments.
- As of March 2016, following the launch of the Connecticut Pilot in August 2015, 27 members had enrolled.

Preliminary outcomes from Aware include ***90% retention*** in treatment and ***80% abstinence***.

Examiners' Recommendation

Examiners will request that Anthem provide an impact statement regarding the addition of the above providers to their network adequacy and its effect on network deficiencies.

Company Response

On December 2, 2016 and December 15, 2016, Anthem responded with the following information;

"Anthem will be producing NH Geo Access reports within the next 60 days and will conduct an analysis to determine the impact the addition of the new BH/SUD providers in 2016 may have had on network deficiencies. On completion of the analysis Anthem will submit the requested impact statement to the Department.

The Aware Recovery Care Program began operations in NH on December 1, 2016. Actual member enrollments in the program began the week of December 12th following completion of provider credentialing. The program will be fully operational with Anthem on January 1, 2017."

Examiners' Comment

No further action is required.

PRE-AUTHORIZATION

Standard 1

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

Standard 2

NAIC Standard #2 - The health carrier operates its utilization review program in accordance with applicable state statutes, rules and regulations.
NAIC Market Regulation Handbook, Chapter 20, page 565

Regulatory Authority

RSA *415-A:4-a Minimum Standards for Claim Review; Accident and Health Insurance.* – Any carrier that offers group health plans and employee benefit plans shall establish and maintain written procedures by which a claimant may obtain a determination of claims and by which a claimant may appeal a claim denial.

It was established as part of the scope of the exam that the Department would require medical expertise to determine the appropriateness of the pre-authorization denials as well as to ascertain whether the protocols used by Anthem meet acceptable standards of care. For the purpose of these reviews, the Department represented the consumers associated with the pre-authorization denials.

An Independent Review Organization (IRO) with medical reviewers specializing in Addiction and SUD was retained by the Department to conduct the reviews of all denied pre-authorizations. This review was undertaken to determine, on a case by case basis,

if the carrier issued denials appropriately due to lack of medical necessity or because the treatment (proposed or provided) would be inconsistent with generally accepted medical protocols.

The IRO provided the Department with a detailed report indicating the number of requests appropriately denied, those that were questionable, and those in which the reviewer disagreed with the carrier rationale for denial. The reviewer provided a description of the reason(s) that a claim denial determination was questionable or inappropriate.

The pre-authorizations under review were transmitted electronically through a secured platform from the Department to the IRO and final determinations were sent back to the Department via secured e-mail.

All data was transmitted by Joelien Atwater, Examiner-in-Charge (EIC) of this examination and returned back to the EIC for confidentiality purposes.

H.H.C. Group, a URAC accredited and NH certified independent review organization was the IRO retained as the medical reviewer for this examination. They are also contracted with the Department to handle consumer external reviews under RSA 420-J:5-a – 5-e.

All records reviewed, including medical information will remain confidential under RSA 400-A:37 Examination Law, and are subject to restrictions as stated in the Business Associates Agreement executed between the Department and H.H.C. Group.

Examiners requested 100% of all pre-authorization requests for SUD services that were denied during the period under examination, January 1, 2015 through September 30, 2015 for a total of 34 pre-authorization denials.

The IRO was asked to consider the following questions in their review:

1. Are the medical records and accompanying information sufficient to answer the following questions?
2. Please determine if the recommended or requested health care service is considered medically necessary.
3. Do you agree or disagree with carriers' final determination for denial?

Recommendation

Based on H.H.C. Group's determinations, the examiners require that Anthem immediately perform additional outreach to the consumer to determine the status of any

treatment plans for all requests in which the IRO disagreed with the carriers' final determination.

A separate document will be provided to Anthem that will identify the specific pre-authorization case in question. A corrective action plan for each consumer impacted will be required to document resolution of treatment and shall be reported to the Department.

Case #1 – Disagree – "The continued IOP treatment is necessary to prevent relapse and reduce the risk of return to heroin use."

Case #2 – Disagree – "Review of records notes that other dimensions of ASAM criteria are met for residential stay."

Case #3 – Disagree – "Given the specific plan and performance of suboxone detoxification based on clinical opiate withdrawal scale (COWS), medical supervision in a residential program was medically necessary."

Case #4 – Disagree – "The claimant does meet ASAM criteria for partial hospitalization services in dimensions 4 and 6."

Case #5 – Disagree – "The residential detox treatment was necessary. The patient has a long standing history of opioid dependency using heroin and other drugs."

Case #6 – Disagree – "This patient has a relatively longstanding history of opioid dependence and other multiple drug dependencies. I feel that inpatient residential treatment is necessary to prevent relapse to opioids and other drugs."

Company Response

Anthem responded to the verified report on December 2, 2016 and December 15, 2016 with the following information;

"Because Anthem is confident that denials were appropriate and consistent with Anthem Clinical Guidelines and because we believe that such outreach would be clinically inappropriate, Anthem respectfully requests that the Department withdraw its member outreach requirement.

During the exit interview, the Department requested information regarding the present membership status of the referenced members. In addition to their current enrollment status, Anthem also reviewed any appeal or review rights those members may have exercised. The review yielded the following:

- Three of the six members are no longer enrolled with Anthem
- Two of the six members did not exercise their appeal rights

- While four members accessed a first level appeal they did not pursue further review, either internal or external"

Examiners' Comment

The Examiners grant Anthem's request to withdraw the requirement for consumer outreach for all requests in which the IRO disagreed with the carriers' final determination.

Anthem's response to the verified report satisfies the Department's request to evaluate the current membership and enrollment status of the consumers in which the IRO disagreed with the carrier's determination.

Protocol Review

The Department also asked the IRO to determine whether the protocols used by Anthem for SUD meet acceptable standards of care and are in alignment with The American Society of Addiction Medicine (ASAM) criteria.

H.H.C's response to the Department's request is as follows:

"Recent treatment has moved away from diagnosis-based treatment to one that is more holistic. The American Society of Addiction Medicine (ASAM) has some of the most widely respected and followed treatment guidelines. The latest edition of the ASAM Criteria support treatment that is interdisciplinary and individualized according multiple dimensions of factors such as withdrawal risk, biomedical conditions, psychiatric and cognitive conditions, readiness to change, relapse potential, and living environment. Although all three protocols do not draw from the ASAM Criteria verbatim, they either explicitly recommend or allow for a quality of treatment that is in accordance with ASAM. It is my medical opinion that the protocols are medically reasonable". (sic)

Examiners' Comment

Examiners have determined that no further action is required as protocols are medically reasonable per the IRO review. The Department is encouraged that Anthem will be able to comply with New Hampshire statutory requirements effective 1/1/17 with regards to the implementation of ASAM protocols.

GRIEVANCES AND APPEALS

Standard 2

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

Standard 3

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

Regulatory Authority

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

The examiners requested an excel spreadsheet list and all supporting documentation of all upheld and overturned grievances/appeals for SUD services. The following data points were required:

- Method of receipt (mail, fax, etc.)
- Source of the request (member, provider)
- Date of receipt
- Date of 2nd level appeal request (if applicable)
- Date of final determination

A total of 21 grievances and appeals were received and reviewed for compliance with RSA 420-J:5 by the examiners during the examination period of January 1, 2015 through September 30, 2015. 100% of the appeal determination letters received were fully compliant. Examiners observed the following:

- 95% of the requests were received from the provider
- 100% of the expedited requests were upheld
- 75% of the total requests were from the same provider

- 20% were partial or fully overturned
- None went to external review
- 17 were standard requests
- 4 were expedited requests

Examiners' Comment

The examiners found no exceptions.

CLAIMS

Quantitative Analysis

In order to quantify the SUD claim activity for the time period under examination, the examiners requested data relative to the total number of claims processed and the total billed amount of the claims processed for both SUD and Medical/surgical benefits.

The claims request was split into two separate requests; claims for ICD codes within the 304 (drug dependence, opioid dependence) coding criteria (SUD claims) and all other ICD codes (Medical/surgical claims).

For SUD claims, Anthem provided two separate data sets: professional/facility claims and pharmacy claims. For the Medical/surgical claims, the carrier produced three claim file types: pharmacy, professional or facility.

Summary

Total claims activity provided by Anthem, for the examination period of January 1, 2015 through September 30, 2015 shows that 484,221 claims were processed for a total of $332,841,262.77 in billed charges and $32,448,275.06 in claims amount paid.

It should be noted that the total billed of $332,841, 262.77 is subject to provider contractual arrangements and the total paid amount of $32,448,275.06 is subject to consumer out-of-pocket obligations in accordance with their contract.

Type of Claim	Volume	Total Billed	Total Paid
SUD	7,747	$12,912,750.53	$1,457,038.40
Med/Surgical	476,474	$319,928,512.24	$30,991,236.66
Total	484,221	$332,841,262.77	$32,448,275.06

The above totals are reflected in the tables below for comparison. Of the total amount billed for Medical/surgical claims and SUD claims, SUD claims equated to 3.88% of the total billed charges.

In addition, the SUD claims volume was 1.6% of the total volume of claims processed during the examination period.

Denied Claims

Type of Claims	Number of Claims	Total Billed Amount
Substance Use Disorder	829	$1,699,568.53
Medical/surgical	94,996	$154,793,439.35

Paid Claims

Type of Claim	Number of Claims	Total Billed Amount	Total Paid Amount
Substance Use Disorder	6,918	$11,213,182.00	$1,457,038.40
Medical/surgical	381,478	$165,135,072.89	$30,991,236.66

Examiners' Observations

SUD claims data was provided for both of Anthem's claims processing systems, one used for individual and small group coverage, and the other for large group coverage. The breakdown of detail included totals for deductible, co-insurance and co-payments.

- Seventy-seven percent of the total out of pocket dollar amounts can be attributed to individual and small group products. The remaining 22% are for large group products.
- SUD claims comprise 1.09% of total billed charges for denied claims and .87% of the denied claims volume for the examination period.

Medication Assisted Treatment

The Department contracted with a registered pharmacist to create a set of interrogatories designed to provide a baseline of Anthem's Medication Assisted Treatment program in New Hampshire.

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

The resources used by the pharmacist to complete the MAT baseline evaluation can be found in Appendix F.

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

Anthem demonstrated compliance by providing an excel spreadsheet listing the covered indications for their National, Preferred, Essential and NH Select formularies.

Anthem was asked to clarify coverage for the NH Select formulary and examiners determined that the carrier met the required number of medications covered in each category and class. Anthem covers the required number of medications to meet this standard.

Examiners' Comment

The examiners found no exceptions.

Age Limitations
The pharmacist also reviewed the availability of prescriptions to ensure that inappropriate age limitations were not imposed through discriminatory benefit designs.

Anthem indicated that there is an age restriction in place for Suboxone and Subutex as well as Belbuca. This restriction is supported by the FDA labeled indications that state the safety and efficacy for those particular medications in patients below the age of 16 has not been established. Examiners determined that the age limitations are appropriate.

Examiners' Comment

The examiners found no exceptions.

Formulary Exception Process
Examiners reviewed policy language provided to the enrollee that describes the process for an enrollee to request an exception for coverage of medications that are not covered under the formulary.

Examiners' Comment

The examiners found no exceptions.

Dosage and Refill limit

Anthem's coverage of methadone maintenance is 60 mg/day and is below manufacturer guidelines which indicate that clinical stability is achieved at doses between 80 and 120 mgs/day.

Anthem's dosing limits for Evzio auto injection is limited to 2 injectors per month. The manufacturer's packing insert states that "dose may be repeated every 2 to 3 minutes until emergency medical assistance becomes available".

Examiners' Recommendation

Examiners will require that Anthem provide information regarding the clinical basis for these limitations as they are contrary to the dosing guidelines. This documentation must be provided within 30 days of the final report.

Company Response

Anthem responded to the verified report on December 2, 2016 and December 15, 2016 with the following information;

"Anthem limits long acting opioids to 200 morphine equivalents (ME) per day. 60 mg of methadone equates to 200-250 ME per day. Higher quantities can be approved through override criteria for terminal patients and those with cancer related pain. Methadone is a highly addictive medication and has a high risk for overdose as it is more potent than morphine. This limitation is a safety measure to protect our members from unnecessary exposure to a potentially harmful drug.

Anthem limits Evzio to 6 injections in 3 months, so 6 injections could be filled at once. Evzio comes as a device which includes the auto-injector along with the drug naloxone. There are some patients for which naloxone is not effective in stopping the effects of opioids. In these patients the absence of a response from the drug administration is observable after 2-3 doses. In addition this drug does have a street value and is readily marketable. The limit on Evzio ensures patients have adequate quantity to be treated while also inhibiting possible misuse of the drug."

Examiners' Comment

Anthem's response regarding Evzio was reviewed by the contracted pharmacist who commented as follows;

"Anthem limits Evzio to 6 injections/3 months allows for the cumulative dose. However, the limit on every 3 months is not acceptable. The usual dosage- Initial dose is 2 mg and may repeat at 2- to 3-minute intervals. Following reversal, additional dose(s) may need to be administered at a later interval (ie, 20 to 60 minutes) depending on the

type/duration of opioid. If no response is observed after 10 mg (cumulative dose) has been administered, question the diagnosis of narcotic-induced or partial narcotic-induced toxicity. The 10 mg cumulative dose indicates 21/2 packages or 5 injections.

Based on this information, 6 units/per 30 days would allow for the 10mg cumulative dose to be given; however, this is per 90-day period. This medication would typically be prescribed to a patient with a high risk of opioid overdose."

The pharmacist recommends that a 10mg cumulative dose be permitted per month, per the package insert and clinical information available.

Lifetime/Annual Limits
Anthem documented in their response to the interrogatory that they do not impose lifetime or annual limits for methadone or buprenorphine.

Examiners' Comment

The examiners found no exceptions.

Pre-authorization for Methadone and Buprenorphine
Anthem gave detailed documentation on each of the pre-authorization requirements associated with methadone and buprenorphine demonstrating the requirements for coverage. The pharmacist found no exceptions to Anthem's documented protocols.

Examiners' Comment

The examiners found no exceptions.

Penalties or Exclusions for Failure to Complete a Course of Treatment
Anthem documented in their response to the interrogatory that they do not impose penalties or exclusions of coverage for the failure to complete a course of treatment applicable to methadone and/or buprenorphine.

Examiners' Comment

The examiners found no exceptions.

Medical Necessity Standards for Methadone and Buprenorphine
Anthem has responded with supporting documentation that outlines the medical necessity and appropriateness of MAT relative to methadone and buprenorphine. Anthem provided a copy of Clinical UM Guideline CG-BEH-04, Substance-Related and Addictive Disorder Treatment. The pharmacists' scope of the examination did not include a review of the clinical guidelines for medical appropriateness.

Examiners' Comment

Examiners found no exceptions.

Examiners' Comment

The Consumer Division notified the Market Conduct Division of a letter to be issued by the carrier and press release issued on May 25, 2016 announcing the Anthem Pharmacy Home program, which began on April 1, 2016. The Market Conduct Division determined that a review of the letter to the consumer and the contract language filed with the Department for compliance was warranted. The examiners determined that this program directs members considered to be at risk for potential misuse of opioid medications to a single in-network pharmacy. Anthem indicated they are attempting to collaborate with prescribers as many medical information systems are not integrated. No compliance issues were identified.

Mental Health Parity

Standard 3

The group health plan complies with the requirements of the federal Mental Health Parity Act of 1996 (MHPA) and the revisions made in the Mental Health Parity and Addiction Equity Act of 2008.

Market Regulation Handbook, Chapter 20 – page 508

Regulatory Authority

29 USC § 1185a parity in mental health and substance use disorder benefits

(a)(1) Aggregate lifetime limits

(a)(2) Annual limits

(a)(3) Financial requirements and treatment limitations

(A) In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that –

(i) the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive that the predominant financial requirements applied to substantially all medical and surgical benefits covered by the plan (or coverage), and there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits; and

(ii) the treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the plan (or coverage) and

there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits.

(a)(4) Availability of plan information

(a)(5) Out-of-network providers

45 CFR § 146.136 (c)(3)(iii)(C) states: *Sub-classifications permitted for office visits, separate from other outpatient services.* For purposes of applying the financial requirement and treatment limitation rules of this paragraph (c), a plan or issuer may divide its benefits furnished on an outpatient basis into the two sub-classifications described in this paragraph (c)(3)(iii)(C). After the sub-classifications are established, the plan or issuer may not impose any financial requirement or quantitative treatment limitation on mental health or substance use disorder benefits in any sub-classification that is more restrictive than the predominant financial requirement or quantitative treatment limitation that applies to substantially all medical/surgical in the sub-classification using the methodology set forth in paragraph (c)(3)(i) of this section. Sub-classifications other than these special rules, such as separate sub-classifications for generalists and specialists, are not permitted. The two sub-classifications permitted under this paragraph (c)(3)(iii)(C) are:

(1) Office visits (such as physician visits), and

(2) All other outpatient items and services (such as outpatient surgery, facility charges for day treatment centers, laboratory charges, or other medical items).

A Mental Health Parity review was completed on the carrier's internal processes and procedures to determine compliance with NH parity laws as well as the updated federal regulation implementing MHPAEA, 45 CFR §146.136. To complete this review, examiners looked at Anthem's response to the Behavioral Health Survey the Department sent in December of 2015, follow-up interrogatory responses and the carrier's documented procedures. This review was performed to identify areas where procedures and protocols and access to Mental Health benefits were potentially less favorable than the same for Medical/surgical benefits. The following information identifies the areas of review, the determinations, and recommendations for various parity comparisons.

Market Review

Examiners reviewed each of the markets for both Medical/surgical and Mental Health coverage to ensure there were no disparities or gaps in coverage in any particular market.

Anthem markets health plans within the individual, small group and large group markets subject to MHPAEA.

The review indicates that Anthem incorporates different requirements for MHPAEA compliance between the group and individual markets. For group markets, Anthem utilizes the additional outpatient sub-classification outlined and allowed by 45 CFR §

136 (c)(3)(iii)(C) which permits separate classification of office visits from other outpatient services. For Anthem's individual market, the sub-classification provision was not used in determining compliance.

Examiners' Comment

Examiners found no exceptions.

Quantitative Treatment Limits

In accordance with the federal parity rule, examiners reviewed the carrier's policies and procedures in applying quantitative treatment limits. Under the rule, quantitative treatment limits are those for which the extent of benefits provided is based on accumulated amounts, such as annual or lifetime day or visit limits.

The purpose of the review was to inquire into whether limitations and standards were being applied consistently between Behavioral Health and Medical/surgical benefits and to ensure that the carrier has processes in place to determine all financial limitations met quantitative requirements outlined in 45 CFR§146.136 (a)(3)(i)(A) (e.g., two-thirds/substantially all).

A review of documents provided indicates that the carrier applies quantitative limitations consistently between Mental Health benefits and Medical/surgical benefits. The carrier presented documents that state they review quantitative limits on an annual basis for both Mental Health and Medical/surgical benefits. Examiners also reviewed the carrier's analytical tool entitled "FMHP Final Rule Methodology for Calculating FR and QTL's" to ensure that it truly analyzes limitations and cost sharing and to indicate that quantitative limitations are applied consistently through Mental Health benefits and Medical/surgical benefits, as well as identifying disparities where additional analysis is needed.

Examiners' Recommendation

Examiners will recommend that Anthem establish procedures to address disparities when identified. This procedure should include analysis and steps for corrective action. Anthem must provide a copy of the procedures established to the Department within 30 days of the final report.

Company Response

Anthem responded to the verified report on December 2, 2016 and December 15, 2016 with the following information;

"Anthem parity policies and procedures are regularly reviewed and are currently being updated. The current revision will incorporate recent guidance released by HHS/DOL/IRS pertaining to claims administration and data that can be used in

performing the federal mental health parity quantitative analysis. A copy of the revised document will be provided to the Department when available."

Examiners' Comment

No further action is required.

Non-Quantitative Treatment Limits

In accordance with the federal parity rule, (45 CFR §146.136 (a)(3)(i)(A)), examiners reviewed the carrier's policies and procedures in applying and non-quantitative treatment limits. Under the rule, non-quantitative limits include but are not limited to:

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

Examiners also reviewed the carrier's policies and procedures regarding non-quantitative limits, including network admissions, reimbursement rates, and tiered benefits. An analysis of documents provided by Anthem shows that the carrier provides a tiered benefit plan for Medical/surgical benefits; however, Behavioral Health care professional providers are not tiered and as such are automatically placed in the preferred (Tier 1) category. All providers, including both Medical/surgical and Mental Health (Behavioral Health) are required to meet the carrier's credentialing guidelines to become Anthem's providers.

Examiners reviewed the Anthem Blue Cross and Blue Shield provider manual[2] to ensure that requirements being presented for credentialing of Mental Health specialists were not more stringently applied than the standards applied to Medical/surgical specialists. Additionally, in an effort to expand access to Mental Health Benefits, Anthem has also extended provider certification to Certified Behavioral Analysts, Certified Addiction Counselors, and Substance Abuse Practitioners. It was determined that the same standards were applied consistently between the providers. No additional exceptions were identified.

Examiners' Comment

Examiners found no exceptions.

Medical Management Policies and Procedures

Medical Management standards were reviewed to determine that access to coverage, medical necessity requirements, utilization reviews, and precertification requirements for Mental Health and Medical/surgical benefits were consistently applied and did not incorporate more stringent factors for Mental Health benefits that would limit or discourage access for treatment. Comprehensive information, including findings and recommendations is provided below for each identified area.

Examiners also ensured that the requirements outlined in NH RSA 420-J were applied to the Medical Management standards and that Utilization Review requirements established to conform to the standards of either the Utilization Review Accreditation Commission (URAC) or the National Committee for Quality Assurances (NCQA) and are subject to all applicable rules issued pursuant to RSA 420-E:7.

In reviewing the medical necessity requirements, examiners performed a comprehensive review of Anthem's Medical Management-Medical Policy and Clinical Utilization Management Guidelines applicable to Mental Health and Medical/surgical processes and procedures. The reason for this comprehensive review was to determine if the carrier was imposing greater requirements for medical necessity determinations on Mental Health benefits than were imposed on Medical/surgical benefits. In addition, the review also identified the criteria for creating policies and procedures, and ensured that the appropriate expertise from credentialed professionals was taken into

[2] **https://www.anthem.com/provider/noapplication/f0/s0/t0/pw_b154811.pdf?refer=ahpprovider&state=nh**.

consideration in updating and amending any policies and procedures, and that the updates were timely and accurate according to medical standards. The review determined if timeframes for reviewing and updating policies and procedures were consistently applied, therefore ensuring that the most current policies and procedures were taken into consideration for both Behavioral Health benefits and Medical/surgical benefits.

In reviewing the policies and procedures to determine accuracy, examiners paid special attention to the methodology behind the creation of the policies to ensure that the policies were created based on appropriate medical recommendations and guidelines.

Medical Policies

In regards to Anthem's Medical Policies, examiners reviewed five (5) general Administrative policies, including policies on:

- Medical Policy Formation
- Preventive Health Guidelines
- Medical Necessity Criteria
- Investigational Criteria, and
- Review of Services for Benefit Determination in the Absence of a Company Applicable Medical Policy or Clinical Utilization Management Guideline.

These policies were determined to be applicable to both Mental Health and Medical/surgical benefits. Examiners identified a concern with document Admin.00002-Preventive Health Guidelines. This document outlines preventive services that are considered medically necessary. The document does not provide coverage for Depression Screening, which is a required preventive service under 42 USC § 300gg-13, and must be allowed without cost sharing when provided by an in-network provider.

Also included in the carrier's Medical Policies were the policies and procedures regarding Behavioral Health. The examiners reviewed a total of eight (8) Behavioral Health Medical Policies to determine if procedures and access for Mental Health services were being more stringently applied than the procedures and access for Medical/surgical benefits. The policies reviewed included:

- Opioid Antagonists Under Heavy Sedation or General Anesthesia as a Technique of Opioid Detoxification;
- Transcranial Magnetic Stimulation;
- Vagus Nerve Stimulation;
- Activity therapy for Autism Spectrum Disorders and Rett Syndrome;
- Screening and Testing for Autism Spectrum Disorders and Rett Syndrome;
- Adaptive Behavioral Treatment for Autism Spectrum Disorder;
- Medical and Other Non-Behavioral Health Related Treatment for Autism Spectrum Disorders, and Rett Syndrome;
- Hippotherapy.

Examiners did not have any concerns with the policies presented and determined that the policies were not incorporated more stringently than the general policies applied to Medical/surgical benefits.

Examiners' Recommendation

Examiners will require that Anthem update policy document Admin.00002-Preventive Health Guidelines to include coverage for Depression Screening as required under 42USC §300 gg-13. Anthem must provide a copy of the updated document to the Department within 30 days of the final report.

Company Response

Anthem responded to the verified report on December 2, 2016 and December 15, 2016 with the following information;

"Depression screening has now been expressly added to the general list of conditions & preventive care services found in the Index of Medical Policy ADMIN.00002 as of October 4, 2016. See Exhibit 2"

Examiners' Comment

No further action is required; exhibits submitted demonstrate compliance. All supporting documentation will be maintained as confidential under RSA 400-A:37.

Clinical Utilization Management Guidelines
In regards to the carrier's Clinical Utilization Management Guidelines, the examiners reviewed the general Administration Guideline regarding Clinical Utilization Management (UM) Guidelines for Pre-Payment Review Medical Necessity Determinations when no other Clinical UM Guidelines exist. It was determined that these guidelines are consistently applied to both Mental Health benefits and Medical/surgical benefits.

Examiners reviewed 14 Behavioral Health Clinical Utilization Management Guidelines to determine if procedures and access for Mental Health services were being more stringently applied than the procedures and access for Medical/surgical benefits. The policies reviewed included guidelines regarding the following:

- Psychiatric Disorder Treatment;
- Custodial Care;
- Substance Related and Addictive Disorder Treatment;
- Eating and Feeding Disorder Treatment;
- Drug Testing on Screening in the Context of Substance Use Disorder and Chronic Pain;
- Psychological Testing;
- Neuropsychological Testing;
- Assertive Community Treatment (ACT);

- Basic Skills Training/Social Skills Training;
- Mental Health Support Systems;
- Psychosocial Rehabilitative Services;
- Targeted Case Management;
- Intensive In-Home Behavioral Health Services; and
- Home Health

The guidelines outline criteria and requirements for obtaining Mental Health services. Medical Necessity determinations are divided into two categories: Severity of Illness and Continued Stay. In order for services to be determined Medically Necessary, the patient must meet specific categories of criteria. The criteria outlined are consistent with medical guidelines established by professional organizations such as American Psychiatric Association, American Psychological Association, Mental Health Association and the National Association on Mental Illness. No exceptions were noted in the review of the Clinical Utilization Management Guidelines.

Examiners' Comment

Examiners found no exceptions.

Policy Development and Updates

Examiners also reviewed methodologies that the carrier utilizes to create, amend, or update policies and procedures to ensure that the carrier is developing procedures consistently with NH RSA 420-J:6 VI. The clinical review criteria used by the health carrier or its designee utilization review entity shall be:

a) Developed with input from appropriate actively practicing practitioners in the health carrier's service area;
b) Updated at least biennially and as new treatments, applications and technologies emerge;
c) Developed in accordance with the standards of national accreditation entities;
d) Based on current, nationally accepted standards of medical practice; and
e) If practicable, evidence-based;

and ensure that the policies and procedures for Behavioral Health are updated as frequently, if not more frequently than, the policies and procedures established for Medical/surgical benefits.

It was determined that the carrier retains control of policy development internally by designated committees, including input from internal and external experts. The Office of Medical Policy & Technology Assessment (OMPTA) develops medical policy and clinical UM guidelines (collectively, Medical Policy) for the carrier. The principal component of the process is the review and development of medical necessity and/or

investigational policy position statements, or clinical indications for certain new medical services and/or procedures, or for new uses of existing services and/or procedures.

The carrier also has the Medical Policy & Technology Assessment Committee (MPTAC), a multi-disciplinary group which acts as an authorizing body for medical policy and clinical Utilization Management (UM) guidelines, which in turn serve as a basis for coverage decisions. The MPTAC is composed of physicians from various medical specialties, clinical practice environments and geographic areas. Voting memberships includes external physicians in clinical practices and participating in networks; external physicians in academic practice and participating in networks; internal medical directors; and Chairs of MPTAC Subcommittees. This group also includes a non-voting member, who is the internal legal counsel. MPTAC also has a designated subcommittee dedicated to Behavioral Health. This subcommittee incorporates specialists in the related field. MPTAC meets three times per year to discuss the need for updating current procedures and processes, and initiating new procedures and processes, based on such medical guidance as clinical literature, medical operations associates, medical directors, claims operations, external reviews, technology vendors, and other technology assessment entities. Decisions are made by a majority vote of MPTAC voting members present.

The examiners determined that the carrier has developed robust Medical Necessity criteria for both Mental Health and Medical/surgical benefits.

Examiners' Comment

Examiners found no exceptions.

Consumer Medical Management Policy/Guideline Access

Examiners noted that while the Medical Policies and Clinical Utilization Management Guidelines are available on-line for reference, they were not easily obtained.

Examiners' Recommendation

Examiners will require Anthem to ensure that Medical Necessity information, including Utilization Review policies and Clinical Guidelines are easily accessible to consumers on the carrier's website.

Within 30 days of the final report, Anthem must provide the Department with the instructions that outline the steps a consumer must take in order to obtain a Utilization Review policy or Clinical Guideline from the carrier's website.

Company Response

Anthem responded to the verified report on December 2, 2016 and December 15, 2016 with the following information;

“To enhance the consumer experience Anthem will introduce a new search function on Anthem.com in late 2016 that will provide quick and easy access to Anthem medical policies and guidelines. The search capability will be available on the public website, and will not require that the user be logged in as a member.

In addition to making it easier to access Medical Policies and Clinical Guidelines, Anthem’s enhanced search function will also allow easier and faster access to information pertaining to Anthem precertification and preauthorization guidelines.”

Examiners’ Comment

Anthem must provide the Department with the instructions that outline the steps a consumer must take in order to obtain a Utilization Review policy or Clinical Guideline from the carrier’s website.

Precertification/Pre-Authorization

A *prior-authorization* requirement means that the carrier will not pay for a service unless the provider (a physician or hospital, usually) gets permission to provide the service. Sometimes this permission is to ensure that a patient has benefit dollars remaining (for example, a carrier may limit a patient to 12 chiropractor visits in a calendar year), other times it is to ensure that a specific kind of service is eligible for payment under the patient's contract. Authorization can be also granted retroactively, for example, a patient or hospital may have a 24-hour window to notify a carrier after receiving emergency care.

A *pre-certification* requirement means that a carrier must review the medical necessity of a proposed service and provide a certification number before a claim will be paid. This is often true with services such as elective surgeries. Usually, a representative with the carrier must review a physician's order and the medical record to agree that a proposed procedure is medically appropriate.

In order to determine parity between Precertification and pre-authorization requirements for both Behavioral Health and Medical/surgical benefits, examiners reviewed the carrier’s internal processes for both areas as well as samples of policy language from a large group, small group and individual plan. The carrier applies the same processes to Behavioral Health as Medical/surgical benefits.

In response to the interrogatories presented, precertification requirements were presented as Exhibit B “Anthem Blue Cross and Blue Shield in New Hampshire

Precertification Guidelines" which identifies and outlines the designated medical treatments that require Precertification and pre-authorization. This document identifies information to obtain Behavioral Health Precertification for services of:

• Inpatient Behavioral health and substance abuse admissions
• Partial hospital program (PHP)
• Intensive outpatient programs (IOP)
• Intensive in-home services
• Transcranial magnetic stimulation (TMS)
• Applied behavior analysis (ABA)

For Behavioral Health issues, the carrier has professionals available 24 hours a day, seven days a week.

The guidelines state that precertification for psychological testing and outpatient services varies by product and plan and that the member should contact the appropriate state's customer service number for requirements or when verifying eligibility, however the guidelines do not specifically identify the state's customer service number. Additionally, in searching the carrier's website (https://www.anthem.com/health-insurance/home/overview) specific information regarding precertification and pre-authorization requirements could not be easily located.

Examiners' Recommendation

Examiners will require Anthem to ensure that precertification and pre-authorization information is easily accessible to consumers on the carrier's website.

Examiners will require that Anthem update the precertification guidelines to include a reference that consumers should be directed to the customer services number included on the consumers' identification card. Anthem must provide a copy of the updated precertification guideline language to the Department within 30 days of the final report.

Company Response

Anthem responded to the verified report on December 2, 2016 and December 15, 2016 with the following information;

"To enhance the consumer experience Anthem will introduce a new search function on Anthem.com in late 2016 that will provide quick and easy access to Anthem medical policies and guidelines. The search capability will be available on the public website, and will not require that the user be logged in as a member.

In addition to making it easier to access Medical Policies and Clinical Guidelines, Anthem's enhanced search function will also allow easier and faster access to information pertaining to Anthem precertification and preauthorization guidelines."

Examiners' Comment

No further action is required.

Consumer Contract Language

In response to the interrogatories presented, the examiners reviewed the carrier's policy language for pre-authorizations for Large Group, Small Group, and Individual plans. These documents outline the Prior Approval mechanisms for:

- Pre-service claims (non-urgent),
- Pre-service urgent claims relating to both the Extension of an Ongoing Course of Treatment and a Question of Medical Necessity
- Post service claims received.

Examiners determined that the carrier has established precertification and pre-authorization requirements consistently between Behavioral health and Medical/surgical benefits.

Examiners' Comment

Examiners found no exceptions.

Provider reimbursement rates and fee schedules

The examiners reviewed the policies and procedures utilized to update reimbursement rates and fee schedules. Documentation reviewed shows that the carrier reviews its fee schedules utilizing the Centers for Medicare & Medicaid Services (CMS) Resource Based Relative Value Scale (RBRVS) methodology as well as recent trends in services and utilization and employer groups' demands to assist in the development of the Maximum Allowable Benefit (MAB).

The examiners reviewed 10 Evaluation & Management codes to determine the reimbursement fees allowed for the provider. This review of the fee schedule provided evidence that the reimbursement tiers are 100% for a Medical Doctor (MD), 85% for an Advanced Practice Registered Nurse (APRN) 80% for Doctor of Philosophy (PhD) and 75% for Masters Level Clinician (MS).

As a result of this review of the reimbursement fee schedules and the variances in the reimbursement by varied credentials, examiners are unable to determine why these variances represent industry standards. Examiners have determined that an additional review of the Credentialing criteria and NCQA directives should be completed.

Examiners' Recommendation

Examiners will require that Anthem provide detail as to why the disparity in reimbursement fees is not a parity violation.

Examiners will schedule a targeted review of the credentialing criteria used for each of the above specialties to include any directives provided by NCQA Standards and test the process within each credentialed specialty.

Company Response

On December 2, 2016 and December 15, 2016, Anthem responded with the following information;

"The variation of reimbursement rates based on provider licensure relates to the level of professional training and scope of services of the licensee. An MD has more clinical training and can perform a wider array of clinical services that a PhD, and a PhD in turn, has more training an can provide a wider array of clinical services than a Master's level BH provider . Importantly, and MD has authority to prescribe medications, authority which properly serves as a basis for making a reasonable distinction.

While in some instances CMS makes no distinction between MD and PhD for reimbursement for certain services, they do recognize, per the CMS RVU development tables, that an MD has a higher Practice Expense per hour of service than does a PhD, and likewise, a PhD has a high Practice Expense per hour of service than a Masters level provider. The Practice Expense per hour tables can be located on CMS.gov in the Physician reimbursement section.

Consistent with other payer information of which Anthem is aware, PhDs and Masters level mental health providers are generally paid at a step-down approach. This practice is consistent with the step-down rationale for nurse practitioners or physician assistants being paid at 85% of the MD medical fee schedule by CMS, or nurse anesthetists being paid at a lower rate that the anesthesiologist."

Examiners' Comment

No further action is required.

Processes and Procedures for determining Usual and Customary

The examiners reviewed the processes and procedures for determining Usual and Customary reimbursement rates. It was determined that the carrier updates its fee schedules (Medical/surgical and Behavioral Health) annually or more frequently. The fee schedules are based on resource-based relative values by CMS, incorporate Berenson-Eggers Type of Service, as well as employer group demands and concerns.

Examiners documented that the carrier determines usual and customary fees for Behavioral Health and Medical/surgical in the same manner whenever the regular updates occur.

Examiners' Comment

Examiners found no exceptions.

APPENDIX A: MENTAL HEALTH PARITY SURVEY

The New Hampshire Insurance Department requested each carrier provide a detailed response to the following questions as they relate to full-insured group and individual health benefit plans. When referencing small and large groups, the employer/group contract must be situated in the state of New Hampshire with one or more New Hampshire employees.

1. List all markets in which you currently write business subject to MHPAEA (individual/small group/large group).
    a. Do you have the same or different requirements for MHPAEA compliance within each market?
    b. If the requirements are different between markets, describe the difference.

2. The MHPAEA final rule 1 differentiates between six different classifications of benefits:
   (1) Inpatient, in-network; (2) inpatient, out-of-network; (3) outpatient, in-network; (4) outpatient out-of-network; (5) emergency care; and (6) prescription drugs. MHPAEA requires that services within a particular classification be treated the same for mental illness and substance use disorders as they would be for medical and surgical conditions.
    a. How do you determine into which classification a particular benefit belongs?
    b. Please provide a detailed description of the process you utilize in categorizing benefits into the six different classifications.

3. To comply with MHPAEA's general parity requirement, a plan may not apply any "financial requirement" or treatment limitation" to mental health or substance use disorder benefits in any classification that is more restrictive than the "predominant" financial requirement of treatment limitation of that type applied to "substantially all" medical/surgical benefits in the same classification.
    a. Please describe the process that you use to determine whether the "substantially all" test is met.
    b. Please describe the process that you use when developing a plan design to determine the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits in each classification. Include an explanation of how you ensure that financial limitations and treatment limitations are not more restrictive for mental health/substance use disorder benefits than limitations for medical/surgical benefits in the same classification.

c. Provide a detailed example of your process using your plan with the most enrollees in New Hampshire (please specific market).

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

a. Provide a description of how you develop NQTLs applicable to mental health and substance use disorders. Include in this description a demonstration of how the processes, strategies, evidentiary standards and other factors used in applying an NQTL to mental health/substance use disorder benefits are comparable to and applied no more stringently than medical/surgical benefits in each classification.
b. How do you provide the policyholder with information pertaining to NQTLs?

5. Medical Necessity Criteria

a. Do you use a Private Review Agent (PRA) to determine the medical necessity or appropriateness of mental health/substance use disorder benefits? If so, what carrier to you use?
b. Is that carrier different that the PRA you use for medical/surgical benefits? If so, what steps does your carrier take to ensure that the medical necessity or appropriateness criteria used by your PRA for mental health/substance use disorder benefits is consistent with the necessity or appropriateness criteria used by your PRA for medical/surgical benefits?

6. Formulary Design for Prescription Drugs

    a. Describe your process for placing mental health/substance use disorder and medical/surgical medications into tiers.
    b. Explain how your determine when to apply each NQTL to mental health/substance use disorder and medical/surgical medications.
    c. Explain your process for grievance and appeals related to mental health/substance use disorder claims.
7. Provider Networks
    a. Provide a description of your network admission, credentialing, and network closure standards for mental health/substance use disorder providers and medical/surgical providers.
    b. Provide a description of your process for determining the fee schedule and reimbursement rates for mental health/substance use disorder providers and medical/surgical providers.
    c. Provide information regarding accessibility issues with in-network providers to include options for members when an in-network provider for mental health/substance use disorders is not available.

APPENDIX B: INTERROGATORIES – MENTAL HEALTH PARITY

1. For all variations of Group and Individual coverage, please provide the cost-sharing schedule and office visits, including copays relating to Mental Health benefits, as well as Medical Surgical benefits. Please provide a full detailed explanation of any variances between Mental Health and Medical Surgical benefits.
2. How frequently are the fee schedules reviewed, and how often are they updated? Please provide the last date of reimbursement rate updates.
3. Please provide examples of information and disclosures presented to the policyholder regarding Non Quantitative Treatment Limitations (NQTL's), including a username and password to access the on-line consumer portal.
4. Please provide a list of all services for which "Fail First" treatment requirements are in place, and include a detailed explanation of any "Fail First" processes for Mental Health/Substance Use Disorder Treatments and for Medical/Surgical and Pharmacy benefits
5. Do you currently use ASAM screening and assessment tools for prevention of, or early intervention in addiction? If so, please provide your policies and procedures for incorporating the tools, and provide four-six exhibits of the utilization of the tools.

For Medical Management Standards, please provide the following information:

1. Medical Necessity Requirements:
    - Including all documented processes and procedures, manuals and criteria utilized in determining Medial Necessity
    - Additionally, please include all notifications that are provided to members outlining the Medical Necessity Requirements when requested;
2. Precertification/Preauthorization requirements:
    - Including processes and procedures, and criteria for both Medical/Surgical and Mental Health.
    - Additionally, please include policy language regarding Precertification/Preauthorization for Medical/Surgical and Mental Health for the most popular Large Group, Small Group and Individual Plans;
3. Provider reimbursement rates, and fee schedules for both Medical/Surgical and Mental Health reimbursements;
4. Usual and Customary (U&C) fee schedule;

- Processes and procedures for determining U&C and the frequency of U&C updates for both Medical/Surgical and Mental Health services; and,

5. Utilization Management Practices:
    - Including the Utilization Program's Proof of Registration with the Department of Insurance as required by RSA 420-E:7 and Chapter 2001.04 of the New Hampshire Code;
    - Advisement of Appeal Rights due to an adverse Utilization Review determination.

APPENDIX C: DATA REQUESTS

The following data was requested from each Carrier:

Delegated Service Contracts

- Please provide a copy of all Third Party Administrator contracts and Service agreements in effect as of January 1, 2015 for all Utilization Review, pre/post authorizations, claims processing or any support functions presently delegated to other entities relative to Substance Use Disorder (SUD).
- Please provide a brief summary of each contract defining the delegated service.
- If services are provided by the carrier, please provide a diagram/flow chart of the internal process associated with the handling of SUD.
- If the process differs for SUD from the standard process, please provide a full explanation of any deviations from the standard process.

Network Access

- Please provide a list of all contracted providers, and the type of service they provide that are presently utilized within your network to perform SUD services to include (hospitals, rehabilitations centers, specialists, etc.) Also, document availability of each provider by indicating which providers are presently accepting patients and patient capacity within inpatient and outpatient settings.
- Please provide (2) two separate GEO Access reports. One report should demonstrate network providers for SUD treatment throughout New Hampshire and the other report should show all of your existing membership.

Pre-authorizations

- Please provide a list of all services requiring a pre-authorization for SUD and Medical Surgical requests.
- Please provide an Excel spreadsheet listing all Inpatient and Outpatient pre-authorizations to include any/all SUD requests for services received for in and out of network from January 1, 2015 through September 30, 2015 that were full or partial denials for SUD.
- Please include the following data within the Excel spreadsheet provided:
    - Patient ID#
    - Procedure/Service Type
    - Provider Name
    - Date Received (20YY/MM/DD)
    - Type of Request – urgent, expedited, standard, etc.
    - Type of Review – pre-authorizations, reconsideration, etc.
    - Date(s) of Service (20YY/MM/DD)

- Type of Service
- Place of Service
- Method of Receipt – physician/specialty provider, patient or other
- Date of Request (20YY/MM/DD)
- Date of Clinical Request for additional information (20YY/MM/DD)
- Date of Clinical Information Received (20YY/MM/DD)
- Date of Medical Director Review (20YY/MM/DD)
- Date of Final Determination (20YY/MM/DD)
- Type of Adverse Determination – Full or Partial Denial
- Method of Notification
- Explanation of the final adverse determination

Appeals/Grievances

- Please provide an Excel spreadsheet reporting all upheld/reversed and overturned appeals/grievances for SUD. (Include how it was requested – mail, fax, telephonic or other). Identify who made the request – provider, consumer, lawyer, etc.
- Date Request Received (20YY/MM/DD)
- Dates for second level appeal or grievance if applicable (20YY/MM/DD
- Date Final Determination was initiated (20YY/MM/DD)
- Date Final Determination was completed (20YY/MM/DD)
- Also attach the following:
  - An electronic copy of the initial request to include any subsequent request.
  - An electronic copy of the final determination letter to include any relevant supporting documentation
- Please provide within the Appeals/Grievance spreadsheet an indicator of those appeals that an external review was requested. Include the final status of the external review and the final notification letter(s).
- If a separate report on external reviews is available, please provide a copy.

Claims

- Please provide an Excel spreadsheet of all denied claims for ICD codes within the 304 coding criteria (ICD Code 204 is classified as Dependency)
- Please provide an excel spreadsheet of all paid claims for ICD codes within the 304 coding criteria.
- The following data should be included within each spreadsheet:
  - Member ID#
  - Date of Birth (20YY/MM/DD)
  - Date of Service (20YY/MM/DD)

- ICD Code
- CPT Code
- Date Received (20YY/MM/DD)
- Date Processed (20YY/MM/DD)
- Date Denied/Partial Denial/Paid (20YY/MM/DD)
- Amount Billed
- Amount Paid
- Coinsurance amounts applied
- Denial Code (disposition code)
- Explanation of Denial Code(s)

Behavioral Health Parity Survey

A Behavioral Health Parity Survey was also requested.

APPENDIX D: INTERROGATORIES – MAT

1. Does the Company cover the following medications used for MAT:
    a. Methadone
    b. Buprenorphine
    c. Buprenorphine/Naloxone
    d. Naloxone
    e. Naltrexone

2. For what FDA approved indications does the Company cover for the following FDA approved medications:
    a. Methadone
    b. Buprenorphine
    c. Buprenorphine/Naloxone
    d. Naloxone
    e. Naltrexone

3. What are the dose and/or refill limits applied to the covered medications?
4. Does the Company impose any lifetime or annual limits on MAT for methadone and/or buprenorphine?
5. Are there preauthorization, reauthorization or step therapy processes or other utilization management requirements (limitations on drug screenings, requirements that a physical examination be performed, etc.) applicable for MAT for methadone and/or buprenorphine?
6. 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?
7. What medical necessity or medical appropriateness standard is applied to the coverage of MAT for methadone and/or buprenorphine?

APPENDIX E: DATA REQUEST – MAT

Please provide electronic files for all non-Mental Health and Substance Use Disorder denied claims received by the Company during the examination period (01/01/15 through 09/30/15). The following data should be included within the files:

- Claim Number
- Member ID Number
- Date of Birth (20YY/MM/DD)
- Date of Service (20YY/MM/DD)
- Type of Service
- ICD Code
- CPT Code (all code categories)
- HCPCS Level II Code
- Date Received
- Date Processed
- Date Denied/Partial Denial
- Amount billed
- Amount paid
- Coinsurance amounts applied
- Denial Code (disposition code)
- Explanation of Denial Code(s)
- Data dictionary describing each field abbreviation and the format of the field (column).

Separately list each line item. In addition, provide separate listings for Professional, Hospital and RX claims. When providing the data, please ensure the data is provided in delimited or fixed length ASCII text.

APPENDIX F: – Reference material for Medication Assisted Treatment Review

CDC.gov

A Treatment Improvement Protocol (TIP 43): Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs -U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (HHS, SAMHSA).

DATA 2000- Title XXXV, Section 3502 of the Children's Health Act.

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

APPENDIX G: MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

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

(a) *Meaning of terms.* For purposes of this section, except where the context clearly indicates otherwise, the following terms have the meanings indicated:

Aggregate lifetime dollar limit means a dollar limitation on the total amount of specified benefits that may be paid under a group health plan (or health insurance coverage offered in connection with such a plan) for any coverage unit.

Annual dollar limit means a dollar limitation on the total amount of specified benefits that may be paid in a 12-month period under a group health plan (or health insurance coverage offered in connection with such a plan) for any coverage unit.

Coverage unit means coverage unit as described in paragraph (c)(1)(iv) of this section.

Cumulative financial requirements are financial requirements that determine whether or to what extent benefits are provided based on accumulated amounts and include deductibles and out-of-pocket maximums. (However, cumulative financial requirements do not include aggregate lifetime or annual dollar limits because these two terms are excluded from the meaning of financial requirements.)

Cumulative quantitative treatment limitations are treatment limitations that determine whether or to what extent benefits are provided based on accumulated amounts, such as annual or lifetime day or visit limits.

Financial requirements include deductibles, copayments, coinsurance, or out-of-pocket maximums. Financial requirements do not include aggregate lifetime or annual dollar limits.

Medical/surgical benefits means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law, but does not include mental health or substance use disorder benefits. Any condition defined by the plan or coverage as being or as not being a medical/surgical condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the International Classification of Diseases (ICD) or State guidelines).

Mental health benefits means benefits with respect to items or services for mental health conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any condition defined by the plan or coverage as being or as not being a mental health condition must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the ICD, or State guidelines).

Substance use disorder benefits means benefits with respect to items or services for substance use disorders, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. Any disorder

defined by the plan as being or as not being a substance use disorder must be defined to be consistent with generally recognized independent standards of current medical practice (for example, the most current version of the DSM, the most current version of the ICD, or State guidelines).

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, days in a waiting period, or other similar limits on the scope or duration of treatment. Treatment limitations include both quantitative treatment limitations, which are expressed numerically (such as 50 outpatient visits per year), and nonquantitative treatment limitations, which otherwise limit the scope or duration of benefits for treatment under a plan or coverage. (See paragraph (c)(4)(ii) of this section for an illustrative list of nonquantitative treatment limitations.) A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation for purposes of this definition.

(b) *Parity requirements with respect to aggregate lifetime and annual dollar limits.* This paragraph (b) details the application of the parity requirements with respect to aggregate lifetime and annual dollar limits. This paragraph (b) does not address the provisions of PHS Act section 2711, which prohibit imposing lifetime and annual limits on the dollar value of essential health benefits. For more information, see § 147.126 of this subchapter.

(1) *General* -

(i) *General parity requirement.* A group health plan (or health insurance coverage offered by an issuer in connection with a group health plan) that provides both medical/surgical benefits and mental health or substance use disorder benefits must comply with paragraph (b)(2), (b)(3), or (b)(5) of this section.

(ii) *Exception.* The rule in paragraph (b)(1)(i) of this section does not apply if a plan (or health insurance coverage) satisfies the requirements of paragraph (f) or (g) of this section (relating to exemptions for small employers and for increased cost).

(2) *Plan with no limit or limits on less than one-third of all medical/surgical benefits.* If a plan (or health insurance coverage) does not include an aggregate lifetime or annual dollar limit on any medical/surgical benefits or includes an aggregate lifetime or annual dollar limit that applies to less than one-third of all medical/surgical benefits, it may not impose an aggregate lifetime or annual dollar limit, respectively, on mental health or substance use disorder benefits.

(3) *Plan with a limit on at least two-thirds of all medical/surgical benefits.* If a plan (or health insurance coverage) includes an aggregate lifetime or annual dollar limit on at least two-thirds of all medical/surgical benefits, it must either -

(i) Apply the aggregate lifetime or annual dollar limit both to the medical/surgical benefits to which the limit would otherwise apply and to mental health or substance use disorder benefits in a manner that does not distinguish between the medical/surgical benefits and mental health or substance use disorder benefits; or

(ii) Not include an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is less than the aggregate lifetime or annual

dollar limit, respectively, on medical/surgical benefits. (For cumulative limits other than aggregate lifetime or annual dollar limits, see paragraph (c)(3)(v) of this section prohibiting separately accumulating cumulative financial requirements or cumulative quantitative treatment limitations.)

(4) *Determining one-third and two-thirds of all medical/surgical benefits.* For purposes of this paragraph (b), the determination of whether the portion of medical/surgical benefits subject to an aggregate lifetime or annual dollar limit represents one-third or two-thirds of all medical/surgical benefits is based on the dollar amount of all plan payments for medical/surgical benefits expected to be paid under the plan for the plan year (or for the portion of the plan year after a change in plan benefits that affects the applicability of the aggregate lifetime or annual dollar limits). Any reasonable method may be used to determine whether the dollar amount expected to be paid under the plan will constitute one-third or two-thirds of the dollar amount of all plan payments for medical/surgical benefits.

(5) *Plan not described in paragraph (b)(2) or (b)(3) of this section* -

(i) *In general.* A group health plan (or health insurance coverage) that is not described in paragraph (b)(2) or (b)(3) of this section with respect to aggregate lifetime or annual dollar limits on medical/surgical benefits, must either -

(A) Impose no aggregate lifetime or annual dollar limit, as appropriate, on mental health or substance use disorder benefits; or

(B) Impose an aggregate lifetime or annual dollar limit on mental health or substance use disorder benefits that is no less than an average limit calculated for medical/surgical benefits in the following manner. The average limit is calculated by taking into account the weighted average of the aggregate lifetime or annual dollar limits, as appropriate, that are applicable to the categories of medical/surgical benefits. Limits based on delivery systems, such as inpatient/outpatient treatment or normal treatment of common, low-cost conditions (such as treatment of normal births), do not constitute categories for purposes of this paragraph (b)(5)(i)(B). In addition, for purposes of determining weighted averages, any benefits that are not within a category that is subject to a separately-designated dollar limit under the plan are taken into account as a single separate category by using an estimate of the upper limit on the dollar amount that a plan may reasonably be expected to incur with respect to such benefits, taking into account any other applicable restrictions under the plan.