Empire BlueCross BlueShield
An Anthem Company

Covered services assessment
nonquantitative treatment limit description

The federal Mental Health Parity and Addiction Equity Act requires health insurers that cover mental health and substance abuse services to cover those services in a way that is not less favorable than how medical/surgical services are covered. In general, mental health and substance abuse services (together, "Behavioral Health Services") and medical services must be provided on a comparable basis. There are various rules that apply to how health insurers confirm they provide benefits for Behavioral Health Services in a way that is comparable to how they cover medical/surgical care.

Empire has evaluated its processes utilizing the Department of Labor's self-compliance tool for the Mental Health Parity and Addiction Equity Act. Below, we discuss the factors used by Empire to apply nonquantitative treatment limits to covered medical and behavioral health services. As demonstrated below, the same factors are applied to nonquantitative treatment limits for both medical and behavioral health services.

Definitions

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 not including 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).

Nonquantitative treatment limitations (NQTLs) means limits that are not numerical limits but which otherwise limit the scope or duration of benefits for treatment under a plan or coverage, such as, preauthorization. In contrast, quantitative treatment limits are based on things like number of visits, days of coverage and dollar limits. A permanent exclusion of all benefits for a particular condition or disorder is not a treatment limitation for purposes of this definition.

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). Empire provides benefits for mental health (MH) or substance use disorder (SUD) benefits in every classification in which medical/surgical benefits are provided. In determining the classification in which a benefit belongs, Empire applies the same standards to medical/surgical benefits as to MH/SUD benefits.

Following are Q&A's to provide additional information about how Empire confirms behavioral health services are covered on no less favorable terms than those that apply to medical/surgical services.

Are services subject to a medical necessity standard?
Yes. Empire's fully insured plans require that services, whether medical/surgical or behavioral health in nature, be medically necessary. "Medically Necessary" services are procedures, treatments, supplies, devices, equipment, facilities or drugs (all services) that a medical practitioner, exercising prudent clinical judgment, would provide to a covered individual for the purpose of preventing, evaluating, diagnosing or treating an illness, injury or disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the covered individual's illness, injury or disease; and
- Not primarily for the convenience of the covered individual, physician or other health care provider; and
- Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that covered individual's illness, injury or disease.

Our medical necessity policy can be found here.

Are there exclusions for experimental, investigational and unproven services?
Yes, Empire's fully insured policy excludes services, whether medical/surgical or behavioral health, that are investigational. "Investigational" means that the procedure, treatment, supply, device, equipment, facility or drug (all services) does not meet the Company Technology Evaluation Criteria because it does not meet one or more of the following criteria:

- Have final approval from the appropriate government regulatory body; or
- Have the credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community which permits reasonable conclusions concerning the effect of the procedure, treatment, supply, device, equipment, facility or drug (all services) on health outcomes; or
- Be proven materially to improve the net health outcome; or
- Be as beneficial as any established alternative; or
- Show improvement outside the investigational settings.

In addition to the above criteria, the Medical Policy & Technology Assessment Committee (MPTAC) will consider recommendations of national physician specialty societies, nationally recognized professional healthcare organizations and public health agencies, and in its sole discretion, may consider other relevant factors, including information from the practicing community.

What criteria must health professionals meet to be admitted to a network?
Providers and facilities, whether medical/surgical or behavioral health, must satisfy our credentialing criteria to be admitted to our networks. Those factors include whether (1) the provider submitted a complete and accurate

application, (2) the provider is licensed in the state with an unencumbered license; (3) the provider has education and training from an accredited educational organization and, depending on the specialty, have the appropriate board certification; (4) the provider is not currently federal sanctioned, debarred or excluded from participation in Medicare, Medicaid or the Federal Employee Health Benefit Program; and (5) if the provider can prescribe controlled substances, does the provider have a current, valid, unencumbered DEA/CDS registration in the state. In the case of a facility, the facility must (1) submit a complete and accurate application; (2) be licensed in the state with an unencumbered license; (3) have a valid and current Medicare certification; (4) not currently federally sanctioned, debarred or excluded from participation in Medicare, Medicaid or the Federal Employee Health Benefit Program; (5) have liability insurance acceptable to Empire; and (6) if not appropriately accredited, submit a copy of its CMS, state site or designated independent external entity survey for review.

What is the basis for non-network provider reimbursement?
In New York, Empire applies the following reimbursement methods to covered non-network medical and behavioral health provider services:

- Hospital Based Physicians and other professional providers: a percentage of the National Medicare fee schedule unless another schedule is chosen by a large employer group.
- Hospital emergency and emergency room physicians: the *greater of* the negotiated amount for participating providers; *or* the maximum amount we will pay for the covered services; *or* the amount that would be paid under Medicare, less member cost sharing, subject to the state statutory external dispute process.
- Ambulatory surgery centers, dialysis centers, hospitals, home health care providers, hospice, skilled nursing facilities and mental health/substance abuse facilities: average participating provider rates for the county in which the service was rendered.
- Ambulance: FAIR Health database rate at the 80th percentile.

Are there exclusions for failure to complete a course of treatment?
No. Our fully insured plans do not have exclusions for failure to complete a medical or behavioral health course of treatment for medical or behavioral health services.

Formulary design for prescription drugs
IngenioRx, which is an affiliate of Empire, is the pharmacy benefit manager. All drugs, whether for behavioral health conditions or non-behavioral health conditions, are reviewed through the same Pharmacy and Therapeutics Committee (P&T) process. All single source brand drugs are reviewed clinically by the P&T to determine whether the drug being reviewed has a favorable, comparable, insufficient evidence or unfavorable treatment profile. The factors considered in developing the formulary include Food and Drug Administration (FDA) approved uses; information from FDA approved package inserts; critically and/or scientifically credible findings, usually from reputable peer-reviewed literature; information in major or peer-reviewed medical publications; recommendations of recognized expert organizations, including specialty clinical societies and academic medical centers; clinical practice guidelines; practice pattern and utilization data; effectiveness data, when available; safety data; and the clinical attributes of a drug, which are characteristics of a drug product that differentiate it from alternative products (e.g., frequency of dosing, ease of use, etc.). Then the P&T approves clinical edits based on clinical evidence. When making a determination as to what clinical edits, such as prior authorization, step therapy, quantity limitations, dose optimization and duplicate therapy, should apply, the P&T review looks at the information described above as well. The P&T charter and bylaws prohibit it from considering rebates or potential rebates, drug cost, economic cost or

benefit, benefit types, or any other consideration that is not relevant to the clinical aspects when deciding what clinical edits to apply.

Once the P&T makes a clinical determination (i.e., favorable, comparable, insufficient evidence or unfavorable)le and approves applicable clinical edits for a new drug or a new use of an existing drug, the Value Assessment Subcommittee determines what tier the drug should go into. It does this by reviewing the treatment profile assigned by the P&T and the member impact of the prospective tiering and clinical edits assigned to the drug as well. It may also take into consideration other factors such as clinical comments from the P&T Committee, financial information, provider impact or abrasion, market considerations, and generic availability.

The P&T's voting members are not employees of IngenioRx, Empire or Empire's parent company Anthem, Inc. Voting members are practicing physicians and most are from leading academic medical centers from across the country. All major specialties are represented, including psychiatry. The P&T psychiatrist is the chair of a behavioral health subcommittee, which includes five additional psychiatrists and a behavioral health pharmacist. The P&T committee members are credentialed and required to be in good standing. We take measures to minimize potential sources of bias or conflict of interest.

Is prior authorization required for inpatient services?
Yes, our fully insured plans require that all inpatient services, except emergency care, (as well as other listed services) be preauthorized. This applies to all medical and behavioral health inpatient services.

Is prior authorization required for outpatient services?
Preauthorization (pre-approval) is required for some outpatient services (as well as other listed services). The factors that Empire considers when deciding to apply preauthorization to a medical or behavioral health service are:

a. A medical policy or clinical guideline exists for the service
b. Appropriateness of care
    i. Is the service medically necessary?
    ii. Is the service being provided at the most clinically appropriate level of care for the member's condition (e.g., can the surgery be done at an ASC instead of on an outpatient hospital basis)?
c. Member safety
d. Member and provider impact/abrasion
e. Return on Investment ("ROI") of 3-1 and a minimum cost of $25,000 at the billing code level
f. State laws, regulations or other regulatory requirements

Doctors in the plan are responsible for obtaining the approval. Otherwise, members need to ask the doctor if they are required to get pre-approval before receiving the services.

Visit this **website to see the preauthorization list** for our plans.
Select New York

1. Select Medical Policy, Clinical UM Guidelines and Pre-Cert Requirements on the left side of the screen.
2. Select the precertification requirements for Local Plan Members on the main portion of the page.

Is a concurrent review conducted for inpatient or outpatient services?
If we approve a length of stay in an inpatient facility or a course of treatment for an outpatient service for a medical or behavioral health condition, for example five days in a skilled nursing center or residential program, we do not perform another review to decide whether to shorten the number of days already approved. But if a member's provider determines that additional days of service are needed toward the end of the preapproved stay, we will work with the facility upon request to determine if *more* days are medically necessary.

When is a retrospective review done for inpatient or outpatient services?
If a medical policy or clinical guideline exists, we will review those services when we receive a claim, unless the service was pre-approved as part of the preauthorization process. This is the same for both medical/surgical and behavioral health services.

Do you have fail first requirements (also known as step therapy protocols)?
If medical studies show that a treatment's effectiveness was evaluated only after the patient tried and failed more conservative treatment first (physical therapy, prescription drugs, compression stockings, etc.), then we typically require a similar attempt at conservative treatment before we approve a more intensive level of service (surgery).

For prescription drugs, step therapy is a clinical edit and is applied as described in the pharmacy question and answer.

How does Empire detect fraud, waste and abuse?
Empire maintains a robust program to detect fraud, waste and abuse that applies uniformly to medical/surgical services as well as behavioral health services. There are state and federal laws that address fraud in health care and the National Healthcare Anti-Fraud Association estimates that financial losses due to health care fraud are in the tens of billions of dollars each year. Empire detects fraud, waste and abuse by:

a. Applying the screening requirements of the federal Office of Inspector General and General Services Administration to identify individuals or entities excluded, sanctioned, disqualified or otherwise ineligible from working in a federal health care program or contracting with the federal government
b. Responding to requests by federal and state regulators, law enforcement or other governmental entities that are investigating fraud, waste and abuse and are seeking information from Empire.
c. Identifying a potential fraud, waste or abuse activity by an associate, provider, policyholder or member.
d. Performing internal data analysis of claims.

Once an issue is identified, it is investigated, which may include record reviews or interview. If it is determined that fraud, waste or abuse occurred, Empire may take one or more of the following actions: educate whoever did the activity; demand repayment; refer the matter to the appropriate state or federal law enforcement agency; and/or file a lawsuit on Empire's own behalf.