# Mental health parity compliance in Anthem health plans

The federal Mental Health Parity and Addiction Equity Act of 2008 requires that health insurers provide benefits for mental health and substance use disorders (together called “behavioral health services”) at levels comparable to benefits they provide for medical or surgical services. Specifically, financial requirements and treatment limitations for mental health/substance use disorder services can’t be more restrictive than those for medical/surgical services.

Here, we explain how Anthem ensures that it covers services in compliance with this law.

**How does Anthem Blue Cross create medical policy?**

Anthem evaluates a request to create a new medical policy or clinical utilization management (UM) guideline through a process that tracks and documents needed approvals from impacted areas and considers their operational and financial impact. If we determine that medical necessity criteria are appropriate, we submit the information to the Medical Policy & Technology Assessment Committee (MPTAC) for approval. MPTAC is a multidisciplinary group that includes doctors from various medical specialties (including mental health/substance use disorder), clinical practice environments and geographic areas.

Anthem reviews existing medical policies and clinical UM guidelines every year to determine if new peer-reviewed medical studies or other authoritative published sources could impact the policy/guideline’s determination of medical necessity or investigational status. Anthem may also solicit feedback from relevant specialists when appropriate.

Anthem also uses Milliman Care Guidelines (MCG) for both medical and behavioral health reviews, unless there is a state law that dictates another type of guideline be used (e.g., ASAM or LOCUS/CALOCUS). MPTAC handles the review of third party guidelines and considers any potential customization.

You can review a full description of how MPTAC creates and approves policies here. Anthem applies these policies in the same manner for medical/surgical and mental health/substance use disorder services.
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**Does Anthem limit services based on medical necessity?**

Yes. Anthem’s fully insured plans typically require that covered services be medically necessary, whether they’re medical/surgical or mental health/substance use disorder services. This requirement is part of our medical policy development. "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 to prevent, evaluate, diagnose or treat 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 for the diagnosis or treatment of that covered individual's illness, injury or disease.

You can review our medical necessity policy here.

**Does Anthem exclude experimental, investigational and unproven services?**

Yes, Anthem's fully insured policy excludes investigational services, whether medical/surgical or mental health/substance use disorder. "Investigational" means that the procedure, treatment, supply, device, equipment, facility or drug (all services) doesn't meet the Company Technology Evaluation Criteria because it doesn't 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 that permits reasonable conclusions concerning the effect of the procedure, treatment, supply, device, equipment, facility or drug (all services) on health outcomes; or
- Proven materially to improve the net health outcome; or
- Is as beneficial as any established alternative; or
- Show improvement outside the investigational settings.

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

You can review the Anthem medical policy here .

**What criteria do health professionals need to meet to be admitted to an Anthem network?**

Providers and facilities, whether medical/surgical or mental health/substance use disorder, must satisfy our credentialing criteria (independent practitioner status and professional competency) to be admitted to our networks.

For health professionals, these criteria include:

- Submission of a complete and accurate application.
- Unencumbered licensure in the state.
- Education and training from an accredited educational organization and, depending on the specialty, appropriate board certification.
- Not currently being federally sanctioned, debarred or excluded from participation in Medicare, Medicaid or the Federal Employee Health Benefit Program.
- If the provider can prescribe controlled substances, a current, valid, unencumbered DEA/CDS registration in the state.

For facilities, the criteria are:

- Submission of a complete and accurate application.
- Unencumbered licensure in the state.
- Valid and current Medicare certification.
- Not currently federally sanctioned, debarred or excluded from participation in Medicare, Medicaid or the Federal Employee Health Benefit Program.
- Liability insurance acceptable to Anthem.

- If not appropriately accredited, submission of a copy of its Centers for Medicare & Medicaid Services (CMS), state site or designated independent external entity survey for review.

**How does Anthem determine how to reimburse providers outside its network?**

In general, the rates we use to price or pay for services rendered by providers that do not participate in our networks are based on rates that are accepted by providers that do participate in Anthem networks. In some cases, we may negotiate with the non-network provider on a price. For claims incurred outside of Anthem's 14 states, we may also rely on the pricing sent to us by the local Blue Cross or Blue Shield plan. Finally, some states have laws that may dictate the amount we pay.

**Do Anthem plans have exclusions for failure to complete a course of treatment?**

No. Our fully insured plans don't have exclusions for failure to complete a course of treatment for medical or mental health/substance use disorder services.

**How does Anthem choose which prescription drugs to cover (formulary design)?**

CarelonRx, an Anthem affiliate, is the pharmacy benefit manager. All drugs, whether for mental health/substance use disorder conditions or medical/surgical services, are reviewed by our Pharmacy and Therapeutics Committee (P&T) process.

The P&T Committee clinically reviews all single-source brand-name drugs and assigns each a treatment profile of favorable, comparable, insufficient evidence or unfavorable based on the following criteria:

- 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
- The drug's clinical attributes, which are characteristics of a drug product that differentiate it from alternative products (e.g., frequency of dosing, ease of use, etc.)

The P&T Committee also approves clinical edits to certain drugs based on clinical evidence. These edits may include prior authorization, step therapy, and quantity limitations. The P&T Committee 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 which clinical edits to apply.

Once the P&T makes a clinical determination (i.e., favorable, comparable, insufficient evidence or unfavorable) and approves applicable clinical edits for a new drug or a new use of an existing drug, the Value Assessment

Committee (VAC) determines what tier the drug should go on. It reviews the treatment profile assigned by the P&T as well as the member impact of the prospective tier and clinical edits assigned to the drug. It may also consider other factors, such as clinical comments from the P&T Committee, financial information, provider impact or abrasion, market considerations and the availability of generic drugs.

The P&T's voting members are not employees of CarelonRx, Anthem or Anthem's parent company Elevance Health, Inc. Voting members are practicing physicians and most are from leading academic medical centers 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.

**Do Anthem plans require pre-approval for inpatient services?**

Yes, our fully insured plans require that all inpatient services, except emergency care (as well as other listed services) have prior authorization (also called preauthorization or pre-approval). This applies to all medical and mental health/substance use disorder inpatient services.

**Do Anthem plans require pre-approval for outpatient services?**

Anthem requires prior authorization (also called preauthorization or pre-approval) for some outpatient services (as well as other listed services). Anthem considers the following factors when deciding to apply prior authorization to a service:

- Applicable Medical Policy or Adoption of a Clinical Utilization Management Guideline over the particular service;
    - Appropriateness of care;
    - Member Safety;
    - Member/Provider Abrasion;
    - High Cost of Services;
- Competitor Policies (inpatient only);
- State laws, regulations, or other federal/state mandates (e.g., Medicaid contract requirements).

Doctors in the plan are responsible for obtaining prior authorization if it's required. Members should ask the doctor if they're required to get prior authorization before receiving the services.

**Does Anthem conduct concurrent reviews 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, we don't 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 or course of treatment, if requested we'll work with the facility or provider to determine if *more* days are medically necessary. Concurrent reviews are initiated by the provider for both medical/surgical and mental health/substance use disorder services.

**When does Anthem do a retrospective review for inpatient or outpatient services?**

If there's a medical policy or clinical guideline for a service, we review the service when we receive a claim, unless the service was pre-approved. This is the same for both medical/surgical and mental health/substance use disorder services.

**Does Anthem 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 (e.g., 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 (such as surgery).

For prescription drugs, step therapy is a clinical edit and is applied as described in the "How does Anthem choose which prescription drugs to cover (formulary design)?" question on page 4.

**How does Anthem detect fraud, waste and abuse?**

Anthem maintains a robust program to detect fraud, waste and abuse that applies uniformly to medical/surgical as well as mental health/substance use disorder 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.

Anthem detects fraud, waste and abuse by:

1. 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.
2. 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 Anthem.
3. Identifying a potential fraud, waste or abuse activity by an associate, provider, policyholder or member.
4. Performing internal data analysis of claims.

Once we identify a possible fraud, waste or abuse issue, we investigate it, which may include record reviews or interview. If the collected evidence shows inappropriate coding and/or medical record documentation, we may take one or more of the following actions:

- Educate
- Demand repayment
- Refer the matter to the appropriate state or federal law enforcement agency
- File a lawsuit on Anthem's behalf.