Massachusetts Division of Insurance
Mental Health Parity Summary Report
For the Period of
Calendar Year 2023

Acknowledgements

The enclosed report was prepared by the Massachusetts Division of Insurance ("Division"). It is being furnished to the Clerk of the Massachusetts Senate, the Clerk of the Massachusetts House of Representatives, the Joint Committee on Mental Health, Substance Use and Recovery, and the Joint Committee on Health Care Financing in accordance with M.G.L. c. 26, section 8M.

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Mental Health Parity Reports

This report represents the initial report of the Division of Insurance to present information regarding carriers' compliance with state and federal Mental Health Parity rules. According to section 8M(d) of M.G.L. 26, the report is to include the following:

> "(i) the methodology the commissioner is using to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act;
> (ii) the methodology the commissioner is using to check for compliance with section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and section 4M of chapter 176G;
> (iii) the report of each market conduct examination conducted or completed during the immediately preceding calendar year regarding access to behavioral health services or compliance with parity in mental health and substance use disorder benefits under state and federal laws and any actions taken as a result of such market conduct examinations;
> (iv) a breakdown of treatment authorization data for each carrier for mental health treatment services, substance use disorder treatment services and medical and surgical treatment services for the immediately preceding calendar year indicating for each treatment service: (A) the number of inpatient days, outpatient services and total services requested; (B) the number and per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day requests modified resulting in a lower amount of inpatient days authorized than requested and the reason for the modification, inpatient day requests denied and the reason for the denial, inpatient day requests where an internal appeal was filed and approved, inpatient day requests where an internal appeal was filed and denied, inpatient day requests where an external appeal was filed and upheld and inpatient day requests where an external appeal was filed and overturned; and (C) the number and per cent of outpatient service requests authorized, outpatient service requests modified, outpatient service requests modified resulting in a lower amount of outpatient service authorized than requested and the reason for the modification, outpatient service requests denied and the reason for the denial, outpatient service requests where an internal appeal was filed and approved, outpatient service requests where an internal appeal was filed and denied, outpatient service requests where an external appeal was filed and upheld and outpatient service requests where an external appeal was filed and overturned;
> (v) the number of consumer complaints received by the division of insurance under subsection (f) of section 8K in the immediately preceding calendar year and a summary of all such complaints resolved by the division during that time period, including: (A) the number of complaints resolved in favor of the consumer; (B) the number of complaints resolved in favor of the carrier; and (C) any enforcement actions taken in response to such complaints; and
> (vi) information about any educational or corrective actions the commissioner has taken to ensure carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and said section 47B of said chapter 175, said section 8A of said chapter 176A, said section 4A of said chapter 176B and said section 4M of said chapter 176G.
>
> The summary report shall be written in nontechnical, readily understandable language and made available to the public by posting the report on the division's website."

1. Methodology to Check for Compliance with the Federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

One of the central features of MHPAEA is the requirement that carriers that are subject to MHPAEA cannot impose annual or lifetime dollar limits on mental health and substance use benefits that are less favorable than any such limits imposed on medical/surgical benefits.

Additionally, while financial treatment limits are permitted, the law requires that any financial treatment limits are no more restrictive for mental health/substance use services in the following categories: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency, and prescription drugs. The Division reviews health carriers' evidences of coverage and schedules of benefit to ensure compliance with this requirement.

Prior to the enactment of Chapter 177 of the Acts of 2022, the Division of Insurance issued Bulletin 2013-06, dated May 31, 2013, requiring that commercial health insurers and health maintenance organizations, as well as Blue Cross and Blue Shield of Massachusetts, Inc. issuing or renewing insured products in Massachusetts (collectively, "Carriers") submit certain information to the Division annually by July 1 to demonstrate compliance with a broad array of mental health parity requirements, including MHPAEA and Massachusetts state mental health parity laws and regulations. This information is generally comprised of the following:

- Signed Certification of Compliance;
- Completed Federal Self-Compliance Tool, including copies of NQTL analyses;
- Confirmation of coverage of the following behavioral health services for children and adolescents required pursuant to Chapter 110 of the Acts of 2017:
    - Intensive care coordination for a child with serious emotional disturbances;
    - Mobile crisis intervention;
    - Family support and training;
    - In-home therapy;
    - Therapeutic mentoring services; and
    - In-home behavioral services (collective referred to as "Behavioral Health for Children and Adolescents" or "BHCA"); and
- Additional Massachusetts-specific information, including Prior Authorization Data, as outlined in Bulletin 2013-06 and subsequent annual request memoranda to Carriers.

The Division's instructions to Carriers for the 2022 Mental Health Parity Report, issued on May 5, 2023, consisted of all the aforementioned items, but replaced the previous requests outlined in Bulletin 2013-06 with new requests targeting compliance with M.G.L. c. 8M, as enacted by Chapter 177 o the Acts of 2022.

None of the Carriers that submitted a 2022 Mental Health Parity Annual Report to the Division identified any areas of deficiency or any corrective actions arising from the certification process, and according to the Division's review each carrier appeared to be in compliance with this section of the law.

Summary of Reports Pursuant to M.G.L. c. 26, Section 8M(a)(i)-(iv)

The Division received reports from 21 carriers in response to the Division's Filing Guidance 2023-E – Annual Mental Health Parity Compliance Certifications. Carriers were required to submit responses for the following categories.

(i) the specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations and a description of all mental health and substance use disorder benefits and medical and surgical benefits to which each term applies in each respective benefits classification; provided, however, that the nonquantitative treatment limitations shall include the processes, strategies, evidentiary standards or other factors used to develop and apply the carrier's reimbursement rates for mental health and substance use disorder benefits and medical and surgical benefits in each respective benefits classification;

(ii) the factors used to determine that the nonquantitative treatment limitations will apply to mental health and substance use disorder benefits and medical and surgical benefits;

(iii) the evidentiary standards used for the factors identified in clause (ii), when applicable, and any other source or evidence relied upon to design and apply the nonquantitative treatment limitations to mental health and substance use disorder benefits and medical and surgical benefits; provided, however, that every factor shall be defined;

(iv) a comparative analysis demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to mental health and substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to medical and surgical benefits in the benefits classification;

(v) the specific findings and conclusions reached by the carrier with respect to health insurance coverage, including any results of the analysis described in clause (iv) that indicate whether the carrier is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including, but not limited to, 45 CFR Part 146.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3).

Carrier Responses

A summary of each carrier's specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations and a description of all mental health and substance use disorder benefits and medical and surgical benefits to which each term applies in each respective benefits classification is provided in Appendix C below.

None of the Carriers that submitted a 2022 Mental Health Parity Annual Report to the Division identified any areas of deficiency or any corrective actions arising from the certification process.

A summary of each carrier's factors and evidentiary standards used to determine that the nonquantitative treatment limitations will apply to mental health and substance use disorder benefits and medical and surgical benefits is provided in Appendix D. The following are the categories included in each carrier's comparative analysis.

4 Ever Life Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization Review
Concurrent Review
Retrospective Review
Emergency Services
Pharmacy Services
Prescription Drug Formulary Design
Case Management
New Technologies
Provider Credentialing and Contracting
Completing Course of Treatment Review
Provider Reimbursement

Aetna Health, Inc. (a Pennsylvania Corporation)

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization

Concurrent Review
Retrospective Review
Sequenced Treatment
Network Provider Reimbursement
Facility Provider Reimbursement
Non-participating Provider Reimbursement
Non-participating Facility Reimbursement
Provider Admission Standards/Credentialing
Pharmacy/Step Therapy

Aetna Health Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization
Concurrent Review
Retrospective Review
Sequenced Treatment
Network Provider Reimbursement
Facility Provider Reimbursement
Non-participating Provider Reimbursement
Non-participating Facility Reimbursement
Provider Admission Standards/Credentialing
Pharmacy/Step Therapy

Aetna Life Insurance Company
Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

- Prior Authorization
- Concurrent Review
- Retrospective Review
- Sequenced Treatment
- Network Provider Reimbursement
- Facility Provider Reimbursement
- Non-participating Provider Reimbursement
- Non-participating Facility Reimbursement
- Provider Admission Standards/Credentialing
- Pharmacy/Step Therapy

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

- Prior Authorization and Retrospective Authorization
  - Inpatient Care
  - Ambulance Services
  - Assisted Reproductive Technologies
  - Gene Therapy/Orphan Drugs
  - Short-Term Rehabilitation Services (Homecare, OT, PT)
  - Neuropsychological and Psychological Testing
  - Outpatient Non-Surgical Procedures and Outpatient Surgical Procedures
  - Radiation Therapy, Radiology Imaging and Sleep Management Services
  - Genetic Testing
  - Urine Drug Testing
  - Applied Behavior Analysis (ABA)
  - Intermediate Levels of Care and Intensive Community-Based Treatment
  - Ketamine/Esketamine
  - Transcranial Magnetic Stimulation (TMS)
  - Out-of-Network Care
- Concurrent Review
- Pharmacy
- Provider Admission
- Reimbursement Rates
- Geographic Restrictions

Blue Cross and Blue Shield of Massachusetts, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

- Prior Authorization and Retrospective Authorization
  - Inpatient Care
  - Ambulance Services
  - Assisted Reproductive Technologies
  - Gene Therapy/Orphan Drugs
  - Short-Term Rehabilitation Services (Homecare, OT, PT)
  - Neuropsychological and Psychological Testing
  - Outpatient Non-Surgical Procedures and Outpatient Surgical Procedures
  - Radiation Therapy, Radiology Imaging and Sleep Management Services
  - Genetic Testing
  - Urine Drug Testing
  - Applied Behavior Analysis (ABA)
  - Intermediate Levels of Care and Intensive Community-Based Treatment
  - Ketamine/Esketamine
  - Transcranial Magnetic Stimulation (TMS)
  - Out-of-Network Care
- Concurrent Review
- Pharmacy
  - Provider Admission
  - Reimbursement Rates
  - Geographic Restrictions

Boston Medical Center Health Plan, Inc. (d/b/a WellSense Health Plan)

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

- Prior Authorization
- Concurrent Review
- Retrospective Review
- Fail First Policy
- Reimbursement
- Provider Credentialing
- Provider Type Exclusions
- Certification Requirement
- Geographic Restrictions
- UCR Rate Determination

Cigna Health and Life Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization – In-Network, Inpatient
Prior Authorization – Out-of-Network, Inpatient
Prior Authorization – In-Network, Outpatient
Prior Authorization – Out-of-Network, Outpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – Out-of-Network, Inpatient
Concurrent Review – Out-of-Network, Outpatient
Retrospective Review – In-Network, Inpatient
Retrospective Review – Out-of-Network, Inpatient
Retrospective Review – In-Network, Outpatient
Retrospective Review – Out-of-Network, Outpatient
Network Admissions / Credentialing / Reimbursement
Pharmacy / Step Therapy

ConnectiCare of Massachusetts, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization – In-Network, Inpatient
Prior Authorization – Out-of-Network, Inpatient
Prior Authorization – In-Network, Outpatient
Prior Authorization – Out-of-Network, Outpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – Out-of-Network, Inpatient
Concurrent Review – Out-of-Network, Outpatient
Retrospective Review – In-Network, Inpatient
Retrospective Review – Out-of-Network, Inpatient
Retrospective Review – In-Network, Outpatient
Retrospective Review – Out-of-Network, Outpatient
Medical Necessity
Experimental/Investigational/Unproven Services
Network Management – Network Adequacy
Reimbursement – Emergency Care
Reimbursement – Inpatient and Outpatient
Pharmacy / Step Therapy
Geographic Restrictions

Fallon Community Health Plan, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization & Concurrent Review
Retrospective Review
Pharmacy-Quantity Limitations
Provider Reimbursement
Pharmacy/Step Therapy
Pharmacy/Formulary Tiers
Fraud, Waste and Abuse Management
Outlier Claims Review
Coding Edits
DRG Claims
Provider Contracting
Medical Necessity

Harvard Pilgrim Health Care, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Provider Admission – In-Network Inpatient & Outpatient
Utilization Review – Inpatient & Outpatient
Pharmacy / Formulary Design
Provider Reimbursement – In-Network
Provider Reimbursement – Out-of-Network

Health New England, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization
Concurrent Review
Retrospective Review
Fail First/Step Therapy
Provider Credentialing
Board Certification Requirement
Facility-type Exclusions
Unlicensed Provider Requirement
Provider-type Exclusions
Provider Reimbursement
Geographic Restrictions
Medical Necessity Criteria

HPHC Insurance Company, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Provider Admission – In-Network Inpatient & Outpatient
Utilization Review – Inpatient & Outpatient
Pharmacy / Formulary Design
Provider Reimbursement – In-Network
Provider Reimbursement – Out-of-Network

Mass General Brigham Health Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization – In-Network, Inpatient
Prior Authorization – Out-of-Network, Inpatient
Prior Authorization – In-Network, Outpatient
Prior Authorization – Out-of-Network, Outpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – Out-of-Network, Inpatient
Concurrent Review – Out-of-Network, Outpatient
Retrospective Review – In-Network, Inpatient
Retrospective Review – Out-of-Network, Inpatient
Retrospective Review – In-Network, Outpatient
Retrospective Review – Out-of-Network, Outpatient
Pharmacy/Fail First/Step Therapy
Credentialing
Provider Reimbursement – In-Network / Facility
Provider Reimbursement – In-Network / Professional Services
Provider Reimbursement – Emergency Care
Provider Reimbursement – Inpatient/Outpatient
Geographic Restrictions

Mass General Brigham Health Plan, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization – In-Network, Inpatient
Prior Authorization – Out-of-Network, Inpatient
Prior Authorization – In-Network, Outpatient
Prior Authorization – Out-of-Network, Outpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – Out-of-Network, Inpatient
Concurrent Review – Out-of-Network, Outpatient
Retrospective Review – In-Network, Inpatient
Retrospective Review – Out-of-Network, Inpatient
Retrospective Review – In-Network, Outpatient
Retrospective Review – Out-of-Network, Outpatient
Pharmacy/Fail First/Step Therapy
Credentialing
Provider Reimbursement – In-Network / Facility
Provider Reimbursement – In-Network / Professional Services
Provider Reimbursement – Emergency Care
Provider Reimbursement – Inpatient/Outpatient
Geographic Restrictions

Tufts Associated Health Maintenance Organization, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Utilization Review – Inpatient
Utilization Review – Outpatient
Pharmacy / Formulary Design
Provider Admission
Provider Reimbursement
In-Network Reimbursement

Tufts Health Public Plans, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Utilization Review – Inpatient
Utilization Review – Outpatient
Pharmacy / Formulary Design
Provider Admission
Provider Reimbursement
In-Network Reimbursement

Tufts Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Utilization Review – Inpatient
Utilization Review – Outpatient
Pharmacy / Formulary Design
Provider Admission
Provider Reimbursement
In-Network Reimbursement

United States Fire Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Medical Management Standards
Concurrent Review
Retrospective Review
Ongoing Case Management
Provider Credentialing
Network Reimbursement
Network Adequacy
Out-of-Network Reimbursement
Exclusions
Experimental/Investigational Determinations
Facility Restrictions
Provider Restrictions
Coverage Scope Limitations
Formulary Adequacy
Formulary Structure
Approval of Prescription Coverage
Step Therapy
Pharmacy Limitations

UnitedHealthcare Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization – In-Network, Inpatient
Prior Authorization – Out-of-Network, Inpatient
Prior Authorization – In-Network, Outpatient
Prior Authorization – Out-of-Network, Outpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – Out-of-Network, Inpatient
Concurrent Review – Out-of-Network, Outpatient
Retrospective Review – In-Network, Inpatient
Retrospective Review – Out-of-Network, Inpatient
Retrospective Review – In-Network, Outpatient
Retrospective Review – Out-of-Network, Outpatient
Geographic Restrictions
In-Network Reimbursement / Professional Services
In-Network Reimbursement / Facility-Based
Out-of-Network Reimbursement / Professional Services and Facility-Based
Out-of-Network Reimbursement / Emergency Services
Pharmacy Benefit Programs Drug List
Prescription Drug Prior Authorization / Step Therapy
Network Management
Credentialing

Wellfleet Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Medical Necessity Criteria Development
Prior Authorization
Concurrent Review
Retrospective Review
Quantity Limits
Step Therapy
Experimental and Investigational Determinations
Provider Access / Credentialing and Reimbursement
Formulary Design
Prior Authorization – Prescription Drug Benefit
Quantity Limits – Prescription Drug Benefit
Out-of-Network Reimbursement

2. Methodology to Check for Compliance with section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and section 4M of chapter 176G

Section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and section 4M of chapter 176G requires health insurance carriers to cover mental health benefits on a nondiscriminatory basis "for the diagnosis and treatment of the following biologically-based mental disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, referred to in this section as the DSM: (1) schizophrenia; (2) schizoaffective disorder; (3) major depressive disorder; (4) bipolar disorder; (5) paranoia and other psychotic disorders; (6) obsessive-compulsive disorder; (7) panic disorder; (8) delirium and dementia; (9) affective disorders; (10) eating disorders; (11) post traumatic stress disorder; (12) substance abuse disorders; and (13) autism."

The Division reviewed carriers' evidences of coverage to ensure that all required mental health benefits are included. The Division reviews carriers' evidences of coverage to ensure that there are no exclusions that may provide limitations of the required mental health benefits that result in these benefits being less favorable than medical/surgical benefits. The Division reviews carriers' schedules of benefit which describe any cost-sharing features part of each plan in order to identify whether any cost-sharing is less favorable for mental health/substance use services than for medical/surgical services.

Appendix C includes a detailed summary of the review of the comparison of the behavioral health and non-behavioral health benefits of the insurance carriers' plans. None of the carriers' plans were found to be noncompliant regarding the benefits between behavioral health and non-behavioral health plans.

3. Market Conduct Examinations

There were not any market conduct examinations completed in calendar year 2023.

On August 10, 2023, the Massachusetts Division of Insurance ("Division") commenced behavioral health parity market conduct examinations of twenty-one (21) health insurance carriers pursuant to section 8K of Chapter 26 of the Massachusetts General Laws as amended by Chapter 177 of the Acts of 2022 (An Act Addressing Barriers to Care for Mental Health), section 4 of Chapter 175, section 10 of Chapter 176G and all other applicable statutes. The primary objective of the examinations is to determine the carriers'' compliance with behavioral health parity requirements under the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MPHEA"), as amended, any federal guidance or regulations relevant to the act, including 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a) (3), and applicable state mental health parity laws, including, but not limited to, section 47B of Chapter 175, section 8A of Chapter 176A, section 4A of Chapter 176B and sections 4, 4B and 4M of Chapter 176G. To assist in conducting the examinations, the Division retained INS Regulatory Insurance Services, Inc., a consultant qualified to perform market analysis and market conduct examinations, to act as its examiners.

The Division's behavioral health parity market conduct examinations are ongoing as of the date of this Report. As the examinations are in progress, the information that can be disclosed is limited, as open examinations are protected under the Commonwealth's confidentiality and privacy statutes.

For purposes of the current examinations, the Division has adopted a targeted examination process to enhance understanding of the industry's current compliance efforts regarding behavioral health and addiction parity, as mandated by federal and state legislation. The examinations adhere to the procedures and directives outlined in relevant federal and state law, and the examination procedures employ a tailored methodology using standards specified in the National Association of Insurance Commissioner's Market Regulation Handbook ("Handbook"). The Handbook, a comprehensive guide to market regulation, provides a framework for conducting thorough and effective examinations. The approach includes issuing examination notices to each carrier that explain the purpose and scope of the examination.

On August 10, 2023, the Division sent examination notices to each subject carrier. After receiving carrier acknowledgments of the examination notice, the Division's examiners initiated the examination process by submitting interrogatories and data requests to the airlines for their review and response. Interrogatories and data requests are acceptable review methods in the Continuum of Regulatory Options ("Continuum") for Market Conduct Examinations as provided in the Handbook. This option was utilized to minimize the examination costs regarding expenses and carrier staff time. During the response period, the Division's examiners and Market Conduct Director further discussed the examination process and carrier responses with most carriers at various points through online virtual meetings and conference calls. In addition, throughout the response period, all carrier questions and concerns were tracked and included with an appropriate regulatory response or comment on a Frequently Asked Questions weekly report. This resource was available by email to all carriers under examination.

The examiners' interrogatories and data requests were designed to focus on high-level aggregate data requests for areas such as utilization review, including prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement rates, network adequacy, geographic restrictions, complaint/grievance data, information verifying compliance with MPHEA and denials of payment and coverage. Additionally, the Division's examiners sought information on corrective actions implemented due to previous examinations or reviews by other regulators or law enforcement agencies.

The Division's examiners are compiling and reviewing the carriers' submitted information. Upon completion of the review, the Division will share the exam results with each carrier. The carriers can review the exam results and offer additional input. Carriers identified with potential compliance vulnerabilities will be the focus of additional examination review. The Division will continue working with those carriers and then decide on the next steps and, if necessary, corrective action plans. The examinations and, when necessary, corrective action plans, designed to address and rectify any identified compliance issues, are a crucial part of our commitment to maintaining consumer trust and ensuring fair and equitable insurance practices.

4. Authorizations

According to M.G.L. c. 176O, carriers may establish utilization review systems that evaluate the medical necessity of a requested service. If a carrier denies or modifies a request, the carrier is required to notify the covered member about this adverse determination within 2 days and provide information about how to appeal any such adverse determination both within the member's carrier's internal appeal system and if still denied through that appeal through an external review by an independent review board coordinated through the Office of Patient Protection.

Each carrier submitted a report of services requested, authorized or denied and of appeals that were conducted that were either overturned or upheld. A report presenting information on a company-by-company level is included in Appendix D. The following chart presents a summary of all the company authorizations for calendar year 2023.

No. of Requests Made (5a)	No. of Services Requested (5b)			No. of Requests Authorized[2] (5c)	No. of Requests Modified[2] (5d)	No. of Requests Denied (5e)	No. of Internal Appeals Filed (5f)	No. of Appeals Approved (5g)	No. of Appeals Denied (5h)	No. Sent For External Appeal (5i)	No. External Appeals Overturned (5j)	No. of External Appeals Upheld (5k)
	Medical[3]											
Medical	Inpatient Days	Outpatient Visits / Services	Total # of Services	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical
959,029	448,443	38,826,788	39,275,026	896,321	6,022	55,844	4,260	2,407	1,853	71	28	43
	Behavioral Health[3]											
Behavioral Health	Inpatient Days	Outpatient Visits / Services	Total # of Services	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health
45,098	152,858	6,880,598	7,033,394	42,859	1,091	1,171	338	154	184	8	5	3

1Reported information is for all 2021 non-governmental insured coverage issued in Massachusetts for requests made and appeals heard during calendar year 2021.

[2]Requests authorized + modified + denied may not add up to total requests made because some requests may be classified as both authorized and modified, some requests may have been withdrawn, or some requests may have been pending and had not yet been classified as approved, modified or denied.

[3]Information as reported by carriers in response to Bulletin 2013-06, Item 5, was submitted as part of annual mental health parity certifications required under 211 CMR 154.00.

In 2023, for medical services, 896,321 (90.6%) of the 959,029 requests were approved for care. For behavioral health services, 42,859 (95.0%) of the 45,098 requests were approved for care. For medical services, of the 6,022 requests that were modified and the 55,844 requests that were denied, a total of 4,260 (0.7%) were appealed within the insurance carrier. For behavioral health services, of the 1,091 that were modified and the 1,171 that were denied, a total of 338 (1.4%) were appealed within the carrier.

When appealed within the carrier, 2,407 (56.5%) of 4,260 medical service denials were overturned and 154 (45.5%) of 338 behavioral service denials were overturned. When appealed with the external review, 28 (39.4) of 71medical service denials were overturned and 5 (62.5%) of 8 behavioral service denials were overturned.

5. _

6. Consumer Complaint Information

The Consumer Services Unit ("CSU") responds to inquiries and assists consumers in resolving insurance complaints or disputes against insurers, producers and other licensees. The Unit works to ensure that consumers are being treated in a fair and consistent manner by licensees and helps consumers resolve various issues including claims, billing, benefits, underwriting and misrepresentation of policies, premium refunds, and cancellation concerns.

The CSU works closely with the Bureau of Managed Care ("BMC") to review consumer complaints that are pertinent to health carriers' managed care practices. The BMC is responsible according to the provisions of section 3 of M.G.L. c. 176O and 211 CMR 52.18 to investigate any managed care practices that are not compliant with statutory and regulatory standards, including whether health plan benefits may inappropriately differ between covered benefits for behavioral health and non-behavioral health services.

The Division is also charged under section 8K(a)(i) of M.G.L. c. 26 with "evaluating and resolving all consumer complaints alleging a carrier's non-compliance with state or federal laws related to mental health and substance use disorder parity." This includes any "consumer complaints alleging a carrier's non-compliance with a state or federal law related to mental health and substance use disorder parity, including any matters referred to the commissioner by the office of patient protection under subsection (g) of section 14 of chapter 176O."[1]

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1 According to section 8K(f) of M.G.L. c. 26, "The [Commissioner of Insurance] shall evaluate and resolve a consumer complaint alleging a carrier's non-compliance with a state or federal law related to mental health and substance use disorder parity, including any matters referred to the commissioner by the office of patient protection under subsection (g) of section 14 of chapter 176*O*. A consumer complaint may be submitted orally or in writing; provided, however, that an oral complaint shall be followed by a written submission to the commissioner that shall include, but not be limited to, the complainant's name and address, the nature of the complaint and the complainant's signature authorizing the release of any information regarding the complaint to help the commissioner with the review of the complaint; and provided further, that the commissioner shall create a process for a consumer to request the appointment of an authorized representative to act on the consumer's behalf.

The commissioner shall review consumer complaints under this subsection using the legal standards pertaining to quantitative treatment limitations and nonquantitative treatment limitations under applicable state and federal mental health and substance use disorder parity laws, regulations and guidance, including, but not limited to, 45 CFR Part 146.136 and 29 CFR Part 2590.712. When reviewing the complaint, the commissioner shall consider: (i) any related right to a treatment or service under any related state or federal law or regulation; (ii) written documents submitted by the complainant; (iii) medical records and medical opinions by the complainant's treating provider that requested or provided a disputed service, which shall be obtained by the complainant's carrier or by the commissioner if the carrier fails to do so; (iv) the relevant results of any behavioral health parity compliance market conduct examination conducted and completed under clause (ii) of subsection (a); (v) any relevant information included in a carrier's annual reporting requirements under section 8M; (vi) additional information from the involved parties or outside sources that the commissioner deems necessary or relevant; and (vii) information obtained from any informal meeting held by the commissioner with the parties. The commissioner shall send final written disposition of the complaint and the reasons for the commissioner's decision to the complainant and the carrier not more than 90 days after the receipt of the written complaint. If the commissioner determines that a violation of a state or federal mental health and substance use disorder parity law occurred, the commissioner shall exercise its enforcement authority under subsections (b) and (c).

The commissioner shall respond as soon as practicable to all questions or concerns from consumers about carrier compliance with state or federal laws related to mental health and substance use disorder parity that are referred to the commissioner from the office of patient protection under subsection (g) of section 14 of chapter 176*O*."

Process

The Division issued Bulletin 2013-06 and promulgated 211 CMR 154.00 to provide information about submitting complaints regarding alleged non-compliance with state and federal laws for mental health parity. The Bulletin explained how consumers and their representatives could file a complaint or make a call to present information about any alleged complaint. All calls and complaints[2] are made with the Consumer Services Unit so that they may be properly logged for further review. In addition to complaints that may be logged with the Consumer Services Unit, the Division holds monthly meetings with the Office of Patient Protection (OPP) in order to discuss complaints that may have been made with OPP including those made associated with Mental Health Parity concerns.

In order to review all filed Mental Health Parity complaints, the Division created an inter-agency team composed of representatives from the Consumer Services Unit, Bureau of Managed Care, Legal Unit, Health Care Access Bureau and Special Investigations Unit to review all Mental Health Parity complaints filed with the Consumer Services Unit. The inter-agency team meets at least monthly or more frequently when a complaint has been specifically filed as a Mental Health Parity complaint. Since many complaints are filed without being specifically identified as a Mental Health Parity complaint, each complaint made that pertains to behavioral health services are reviewed by the inter-agency team.

Within calendar year 2023, a total of 3,249 complaints were filed with the Division's Consumer Services Unit. A total of 198 (6.1%) of the total were complaints about behavioral health. Of the total filed complaints, only one was specifically associated as a mental health parity complaint.

Consumer Service Complaints

2022 **Total Complaints - 2534**	
Mental Health - Behavioral Health	139
Resolved in Favor of Consumer	45
Resolved in Favor of Carrier	60
No DOI Jurisdiction *	34

2023 **Total Complaints - 3249**	
Mental Health - Behavioral Health	192
Resolved in Favor of Consumer	69
Resolved in Favor of Carrier	88
No DOI Jurisdiction *	43

2 Over the past few years, the Division has held discussions with consumer advocates about the complaint forms because the consumer advocates believe that certain disclosure language discourages consumers from filing behavioral health complaints. On its complaint form, the Division discloses that "[t]he complaint file is public record pursuant to Massachusetts law once the complaint file is closed and may be released upon request. The Division of Insurance will maintain the confidentiality of any personally identifiable information and personal health information to the extent required by law." As the Division has noted in discussions with consumer advocates, it does not have the authority under section 10 of M.G.L. c. 66 (the Public Records Law) and 950 CMR 32.00 (Public Records Access) to exclude complaints from disclosure; therefore, the disclosure is appropriate because it makes the complainant aware that other than "personally identified information and personal health information," the complaint may become public under the provisions of Massachusetts Public Records law. The Division and the consumer advocates have not been able to develop alternate language that may address consumer advocates' concerns about the disclosure language that may discourage the filing of behavioral health complaints.

Substance Abuse	6
Resolved in Favor of Consumer	3
Resolved in Favor of Carrier	1
No DOI Jurisdiction *	2

Substance Abuse	5
Resolved in Favor of Consumer	3
Resolved in Favor of Carrier	1
No DOI Jurisdiction *	1

Mental Health Parity	0
Resolved in Favor of Consumer	0
Resolved in Favor of Carrier	0
No DOI Jurisdiction *	0

Mental Health Parity	1
Resolved in Favor of Consumer	1
Resolved in Favor of Carrier	0
No DOI Jurisdiction *	0

The inter-agency team reviewed the 192 complaints that were not identified as Mental Health Parity complaints and only one was a Mental Health Parity complaints. The majority of complaints were associated with reimbursement for provider services or access to out-of-network care.

Of the 198 behavioral health complaints, 192 were related to general mental health complaints, 5 were related to substance use comlaints and 1 was identified as a mental health parity complaint.

Of the non-mental health parity complaints, 72 were resolved in favor of the consumer and 89 were resolved in favor of the insurance carrier. A total of 44 were identified as not under the jurisdiction of the Division because the consumer was covered by an insured health plan issued in another state and subject to the jurisdiction of that other state or was covered under a self-funded employer health benefit plan that is preempted from state regulation under federal ERISA (Employee Retirement Income Security Act) rules.

Regarding the one Mental Health Parity complaint, a Carrier had an administrative process that required upfront payment of electrolysis services when part of treatment of gender dysphoria. The Carrier argued that this was necessary since it had not been able to contract with electrolists to be part of its network. Despite this contractual issue, the Division found that this was a process that did not apply for medical services and instructed the Carrier to establish a system that would provide debit cards for gender dysphoria patients to receive electrolysis services so that they would not need to pay for services and get reimbursed.

7. Educational or Corrective Action Taken

While all of the responding carriers indicated that no corrective actions were required based on internal assessments that each carrier was in compliance with federal and state Mental Health Parity laws, the Division is looking to take a number of steps to monitor compliance going forward, as described in the next section of this report.

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NEXT STEPS

Annually, the Division performs a review of 21 carriers' evidences of coverage, schedules of benefit and related information for the individual, small group and large group markets to verify that carriers are including quantitative treatment limitations that are no more restrictive for mental health/substance use services than for medical/surgical services. Additionally, the Division collects a large number of documents as part of a bi-annual managed care accreditation process for these 21 carriers. The Division intends to expand on this bi-annual review process by delving further into these documents with a particular focus on verifying compliance with MHPAEA and state Mental Health Parity laws.

As part of this process, the Division aims to compare carriers' utilization review policies and procedures; carriers' processes to establish guidelines for Medical Necessity; and perform a review of the Carrier's network adequacy standards. One additional component of the review process going forward will focus on differences among carriers who perform mental health/substance use utilization review in-house compared to carriers who delegate those functions to an external entity.

The Division currently holds regular internal meetings to discuss consumer complaints related to possible Mental Health Parity violations. The Division intends to continue to hold these regular meetings and further plans to have training sessions with staff from the Divisions Consumer Services Unit to help staff identify potential Mental Health Parity trends and concerns.

The Division created a new process for the review of Mental Health Parity compliance as a result of the creation of M.G.L. c. 26, section 8M. Because this first year created new requirements for the carriers, the Division intends to update the instructions filing guidance and the file submission process to further clarify submission requirements and to streamline the review process going forward.

While for this report we reviewed only those materials that were required as part of the new statute. However, for future reports we may look at previously filed information from the carriers to help identify areas where improvements may be suggested.

APPENDIX A

LIST OF RESPONDING CARRIERS

4 Ever Life Insurance Company
Aetna Health, Inc. (a Pennsylvania Corporation)
Aetna Health Insurance Company
Aetna Life Insurance Company
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Blue Cross and Blue Shield of Massachusetts, Inc.
Boston Medical Center Health Plan, Inc. (d/b/a WellSense Health Plan)
Cigna Health and Life Insurance Company
ConnectiCare of Massachusetts, Inc.
Fallon Community Health Plan, Inc.
Harvard Pilgrim Health Care, Inc.
Health New England, Inc.
HPHC Insurance Company, Inc.
Mass General Brigham Health Insurance Company
Mass General Brigham Health Plan, Inc.
Tufts Associated Health Maintenance Organization, Inc.
Tufts Health Public Plans, Inc.
Tufts Insurance Company
United States Fire Insurance Company
UnitedHealthcare Insurance Company
Wellfleet Insurance Company

APPENDIX B

Filing Guidance 2024-D – Annual Mental Health Parity Compliance Certifications

I. GENERAL INSTRUCTIONS

Health Insurance Carriers (Carriers) are required to submit the information and documentation contained within this Filing Guidance via an Informational Filing within the System for Electronic Rate and Form Filings (SERFF). The SERFF submission is due **no later than July 1, 2024** and covers the reporting period of January 1, 2023 through December 31, 2023. No filing fee is required for the SERFF submission. The submission will be submitted within the "Supporting Documentations" tab within SERFF. Within this tab, carriers are asked to create separate entries for each of the different documents/templates described below.

A checklist will be distributed for carriers to use to ensure that all materials have been included and submitted in their SERFF filing. This checklist can be submitted in the Checklist entry within the Supporting Documentation tab.

Carriers are required to submit a Certification of Compliance, to be signed by the carrier's Chief Executive Officer and Chief Medical Officer. ***Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes this certification.***

Please note that for the following Section II items, it is NOT necessary to create separate entries for EACH separate NQTL category.

II. M.G.L. CHAPTER 26, SECTION 8M

Chapter 177 of the Acts of 2020 creates a new law - M.G.L. c. 26, section 8M. This section 8M requires carriers to submit to the Division the following information:

(i) the specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations and a description of all mental health and substance use disorder benefits and medical and surgical benefits to which each term applies in each respective benefits classification; provided, however, that the nonquantitative treatment limitations shall include the processes, strategies, evidentiary standards or other factors used to develop and apply the carrier's reimbursement rates for mental health and substance use disorder benefits and medical and surgical benefits in each respective benefits classification;

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

(ii) the factors used to determine that the nonquantitative treatment limitations will apply to mental health and substance use disorder benefits and medical and surgical benefits;

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

(iii) the evidentiary standards used for the factors identified in clause (ii), when applicable, and any other source or evidence relied upon to design and apply the nonquantitative treatment limitations to mental health and substance use disorder benefits and medical and surgical benefits; provided, however, that every factor shall be defined;

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

(iv) a comparative analysis demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to mental health and substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to medical and surgical benefits in the benefits classification;

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

Please note that the above comparative analysis is required for the following nonquantitative treatment limitation categories:

Prior authorization, concurrent review, retrospective review, step-therapy, network admission standards, reimbursement rates and geographic restrictions

(v) the specific findings and conclusions reached by the carrier with respect to health insurance coverage, including any results of the analysis described in clause (iv) that indicate whether the carrier is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including, but not limited to, 45 CFR Part 146.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3);

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

(vi) the number of requests for parity documents received under 29 CFR 2590.712(d)(3) or 45 CFR 146.136(d)(3) and the number of any such requests for which the plan refused, declined or was unable to provide documents;

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

(vii) the additional information, if any, that a carrier is required to provide under 42 U.S.C. 300gg-26(a)(8)(B)(ii);

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

(viii) any other data or information the commissioner deems necessary to assess a carrier's compliance with mental health parity requirements.

For this section (viii), please submit the information as follows: M.G.L. c. 26, Section 8M requires certain data to be collected on an annual basis. The Division will continue to work with carriers to ensure that carriers' IT systems will be able to produce the information starting with Calendar Year 2024, due July 1, 2025. For CY 2023, please submit data as follows:

1. Please use the Excel Template [MHP_Request Data_Template_07012024] to complete the data for calendar year 2023.

2. Please ensure that:

a. The reported information is only for requests for services for fully-insured members.
b. The reported information is only for requests for services for persons covered under insured health plans that were issued or renewed within Massachusetts.
c. The reported information does not include requests for prescription medications.

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

III. *RESPONSES TO CHAPTER 110 OF THE ACTS OF 2017*

Chapter 110 of the Acts of 2017 requires that Carriers certify whether their coverage includes the following mental health home-based and community-based services for a child. Each Carrier must include a certification using the Excel template ***[MHP Template 2023_Chapter 110].***

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

(i) Intensive care coordination for a child with a serious emotional disturbance;[3] service that facilitates care planning and coordination that provides a single point of accountability for assessment, and developing and implementing a plan of care ensuring that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family/youth-driven, and ethnically, culturally, and linguistically relevant manner, and includes, but is not limited to, the following services[4]:

- Comprehensive home-based assessment
- Care Planning Team (CPT) meetings
- Individual Care Plans (ICP)
- Risk management/safety plan(s)
- Care coordination, including:
  - Links and referrals for supports and services
  - Assistance with systems navigation
  - Collateral contacts (phone and face-to-face)
  - Direct time with providers (e.g., attendance at IEP, hospital discharge, and other meetings)
  - Aftercare planning
- Education, advocacy and support to youth and parent(s)/caregiver(s)
- Individualized and family-driven interventions and/or supports for the youth and parent/caregiver
- Regular contact with youth and parent/caregiver
- Telephone support for youth and parent/caregiver
- 24/7 crisis monitoring and assistance in accessing ESP/MCI services
- Member transportation provided by staff
- Member outreach (up to 30 minutes)
- Documentation (time spent completing required paperwork as outlined in the Performance Specifications)

Please certify whether your organization covers these services. If your organization does not cover these services as described above, please identify what services are covered and what is not covered.

(ii) Mobile crisis intervention;

3 For further reference, please see Massachusetts Behavioral Health Partnership at: https://www.mass.gov/files/documents/2016/07/nh/ps-tcm-icc-ps.pdf

4 For further reference, please see Massachusetts Behavioral Health Partnership at: https://www.masspartnership.com/pdf/TCM-ICC%20service%20definition12-23-08.pdf

"Mobile crisis intervention", a short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, 7 days a week to a child experiencing a behavioral health crisis to identify, assess, treat and stabilize a situation and reduce the immediate risk of danger to the child or others; provided, however, that the intervention shall be consistent with the child's risk management or safety plan, if any.

Please certify whether your organization covers this service. If your organization does not cover this service as defined, please identify what services are covered and what is not covered.

(iii) Family support and training;

"Family support and training", a service provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to ameliorate or resolve the child's emotional or behavioral needs and to parent; provided, however, that such service shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home or another community setting.

Please certify whether your organization covers this service. If your organization does not cover this service as defined, please identify what services are covered and what is not covered.

(iv) In-home therapy;

"In-home therapy", therapeutic clinical intervention or ongoing training and therapeutic support; provided however, that the intervention or support shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home or another community setting.

Please certify whether your organization covers this service. If your organization does not cover this service as defined, please identify what services are covered and what is not covered.

(v) Therapeutic mentoring services; and

"Therapeutic mentoring services", services provided to a child designed to support age-appropriate social functioning or to ameliorate deficits in the child's age-appropriate social functioning; provided, however, that such services may include supporting, coaching and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution and relating appropriately to other children and adolescents and to adults in recreational and social activities; and provided further, that such services shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home or another community setting.

Please certify whether your organization covers this service. If your organization does not cover this service as defined, please identify what services are covered and what is not covered.

(vi) In-home behavioral services.

"In-home behavioral services", a combination of behavior management therapy and behavior management monitoring; provided, however, that such services shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home or another community setting.

Please certify whether your organization covers this service. If your organization does not cover this service as defined, please identify what services are covered and what is not covered.

In addition, please note that the following terms are also defined in Section 23 of Chapter 110 of the Acts of 2017 and are restated below.

"Child", a person under the age of 21.

"Behavior management monitoring", monitoring of a child's behavior, the implementation of a behavior plan and reinforcing implementation of a behavior plan by the child's parent or other caregiver.

"Behavior management therapy", therapy that addresses challenging behaviors that interfere with a child's successful functioning; provided, however, that "behavior management therapy" shall include assessment, development of a behavior plan and supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy; and provided further, that "behavior management therapy" may include short-term counseling and assistance.

"Ongoing therapeutic training and support", services that support implementation of a treatment plan pursuant to therapeutic clinical intervention that shall include, but not be limited to, teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situations and assisting the family in supporting the child and addressing the child's emotional and mental health needs.

"Therapeutic clinical intervention", intervention that shall include: (i) a structured and consistent therapeutic relationship between a licensed clinician and a child and the child's family to treat the child's mental health needs, including improvement of the family's ability to provide effective support for the child and promotion of healthy functioning of the child within the family; (ii) the development of a treatment plan; and (iii) using established psychotherapeutic techniques, working with the family or a subset of the family to enhance problem solving, limit setting, communication, emotional support or other family or individual functions.

IV. FEDERAL SELF-COMPLIANCE TOOL FOR THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

Please review the Federal Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA). All carriers are required to respond to each of the 8 listed questions using the Federal Self-Compliance Tool document. In doing so, carriers are required to follow each of the analyses indicated for each question. Carriers will be required to certify that all analyses in the tool were used in determining the answer to each question.

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

Please note that any documents/templates that are referenced within this Filing Guidance Notice as needing to be completed and/or filled out will be distributed separately to each carrier.

If you have any questions, please contact Niels Puetthoff at niels.puetthoff@mass.gov.

APPENDIX C
Review of Plan Benefits

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical/Surgical Inpatient	**Medical/Surgical Outpatient**	**Mental Health/SUD Inpatient**	**Mental Health/SUD Outpatient**
4 Ever Life Insurance Company	Inpatient Care: • Acute Inpatient • Subacute Inpatient (i.e., skilled nursing care) • Inpatient Hospital Physician Consultation • Inpatient Professional Services • Inpatient Hospice	Office visits: • Preventive Wellness Exams • Outpatient PCP Office Visits • Outpatient Specialist Office Visits • Telehealth/ Telemedicine Services Med/Surg All Other Outpatient Services Include: • Outpatient Facility • Outpatient Surgery • Outpatient Professional Services • Outpatient non-office preventive services/ screenings (i.e., mammograms, colonoscopies, etc.) • Radiology • Advanced Radiology (i.e., MRI, CY, PET) • Home Health Care • Outpatient Hospice • Speech Therapy	Inpatient Care: • Acute Inpatient • Subacute Inpatient (i.e., residential treatment) • Inpatient Hospital Physician Consultation • Inpatient Professional Services	Office visits: • Individual, family and group psychotherapy • Medication Management Services • Telepsychiatry Services MH/SUD All Other Outpatient Services Include: • Partial Hospitalization • Intensive Outpatient Programs • Applied Behavioral Analysis • Repetitive Transcranial Magnetic Stimulation • Ambulatory Detoxification • Outpatient Electroconvulsive Therapy (ECT) • Psychological Testing • Ambulance
Aetna Health Inc. (PA)	-Hospice care -Hospital care -Maternity and related newborn care Skilled nursing facility (SNF)	-PCP/Physician -Preventive care services -Specialist Telemedicine -Urgent Care Walk-in clinics	- -Hospital care -Residential treatment facility (RTF)	-Physician -Specialist -Telemedicine -Urgent care -Walk-in clinics
Aetna Health Insurance Company	-Hospice care -Hospital care	-PCP/Physician -Preventive care services	- -Hospital care	-Physician -Specialist

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical/Surgical Inpatient	**Medical/Surgical Outpatient**	**Mental Health/SUD Inpatient**	**Mental Health/SUD Outpatient**
	-Maternity and related newborn care Skilled nursing facility (SNF)	-Specialist Telemedicine -Urgent Care Walk-in clinics	-Residential treatment facility (RTF)	-Telemedicine -Urgent care -Walk-in clinics
Aetna Life Insurance Company	-Hospice care -Hospital care -Maternity and related newborn care Skilled nursing facility (SNF)	-PCP/Physician -Preventive care services -Specialist Telemedicine -Urgent Care Walk-in clinics	- -Hospital care -Residential treatment facility (RTF)	-Physician -Specialist -Telemedicine -Urgent care -Walk-in clinics
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	Emergent Inpatient-Notification only • Non-Emergent Inpatient Hospital services • Long Term Acute Care (LTAC) services • Rehabilitation Facility Services • Skilled Nursing Facility (SNF) services • Ambulance Services • Gene Therapy/Orphan Drugs • Inpatient Surgeries • Organ Transplants	Ambulance Services • Assisted Reproductive Technologies (IVF) • Chiropractic Therapy • Gene Therapy/Orphan Drugs • Genetic Testing • Neuropsychological testing • Outpatient non-surgical Procedures • Outpatient Surgical Procedures • Short term rehabilitation (STR) Home Health Services/Occupational Therapy/Physical Therapy • Radiation Therapy • Radiology Imaging • Sleep Management	Emergent Inpatient-notification only • Non-Emergent Inpatient Hospital Services • Crisis Stabilization Bed (CSB) • Residential Treatment Center Services (RTC/ART) • Zulresso Infusions	• Applied Behavior Analysis • Genetic Testing • Intensive Community-Based Treatment (ICBT)-Children & Adolescent • Intermediate levels of care (ILOC) – Partial Hospital Program (PHP)/Intensive Outpatient Program (IOP)/Family Stabilization Team (FST) • Ketamine/ Esketamine • Psychological Testing • Transcranial Magnetic Stimulation (TMS) • Urine Drug Testing (UDT)

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical/Surgical Inpatient	**Medical/Surgical Outpatient**	**Mental Health/SUD Inpatient**	**Mental Health/SUD Outpatient**
		• Urine Drug Testing (UDT)		
Blue Cross and Blue Shield of Massachusetts, Inc.	Emergent Inpatient-Notification only • Non-Emergent Inpatient Hospital services • Long Term Acute Care (LTAC) services • Rehabilitation Facility Services • Skilled Nursing Facility (SNF) services • Ambulance Services • Gene Therapy/Orphan Drugs • Inpatient Surgeries • Organ Transplants	Ambulance Services • Assisted Reproductive Technologies (IVF) • Chiropractic Therapy • Gene Therapy/Orphan Drugs • Genetic Testing • Neuropsychological testing • Outpatient non-surgical Procedures • Outpatient Surgical Procedures • Short term rehabilitation (STR) Home Health Services/Occupational Therapy/Physical Therapy • Radiation Therapy • Radiology Imaging • Sleep Management • Urine Drug Testing (UDT)	Emergent Inpatient-notification only • Non-Emergent Inpatient Hospital Services • Crisis Stabilization Bed (CSB) • Residential Treatment Center Services (RTC/ART) • Zulresso Infusions	• Applied Behavior Analysis • Genetic Testing • Intensive Community-Based Treatment (ICBT)-Children & Adolescent • Intermediate levels of care (ILOC) – Partial Hospital Program (PHP)/Intensive Outpatient Program (IOP)/Family Stabilization Team (FST) • Ketamine/ Esketamine • Psychological Testing • Transcranial Magnetic Stimulation (TMS) • Urine Drug Testing (UDT)
Boston Medical Center HealthNet Plan, d/b/a WellSense Health Plan	The Plan requires prior authorization for elective admissions to acute care, post-acute care, or custodial level of care.	Prior Authorization is performed for the following: • All home health care services • Outpatient rehabilitation services (PT, OT, ST) • Select outpatient procedures • Select outpatient services	Prior authorization applies to: Community Based Acute Treatment (CBAT)/Intensive Community Based Acute Treatment (ICBAT), Inpatient Mental Health, Inpatient ECT.	Prior Authorization applies to the following Behavioral Health outpatient services/benefits: ABA, TMS, Partial Hospitalization Services; CBHI services

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical/Surgical Inpatient	**Medical/Surgical Outpatient**	**Mental Health/SUD Inpatient**	**Mental Health/SUD Outpatient**
		• Durable Medical Equipment • High Tech Radiology (non-emergent outpatient, excluding those associated with observation or emergency department visits) • Most genetic testing		
Cigna Health and Life Insurance Company	Acute Inpatient Services; Subacute Inpatient Services, i.e. Skilled Nursing Care, physical rehabilitation hospitals, etc.; Inpatient Professional Services.	Advanced imaging services (e.g., CT scans, PET scans, MRIs, diagnostic cardiology) Certain outpatient surgical procedures Certain cardiology procedures Clinical trials Procedures that may be considered cosmetic in nature Durable Medical Equipment (DME) Experimental / Investigational / Unproven (EIU) Procedures Genetic testing Home Health Care (HHC) / home infusion therapy Hormone Implant Hyperbaric Oxygen Therapy Infertility services Infused / injectable medications Medical oncology Musculoskeletal services (major joint surgery and pain management services) Negative Pressure Wound Therapy Confidential Outpatient Therapy Services (Outpatient Acute Rehabilitation, Cardiac Rehabilitation, Cognitive Rehabilitation, Speech Therapy, Hearing Therapy, Occupational Therapy, Physical Therapy, Chiropractic, Acupuncture) Outpatient	Mental Health Acute Inpatient Services; Mental Health Subacute Residential Treatment; Mental Health Inpatient Professional Services; SUD Acute Inpatient Services; SUD Acute Inpatient Detoxification; SUD Subacute Residential Treatment; SUD Inpatient Professional Services.	Partial Hospitalization Applied Behavior Analysis (ABA) Transcranial Magnetic Stimulation

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical/Surgical Inpatient	**Medical/Surgical Outpatient**	**Mental Health/SUD Inpatient**	**Mental Health/SUD Outpatient**
		radiation therapy services Sleep testing Speech Therapy Therapeutic apheresis (aka Extracorporeal photopheresis (ECP) External Counterpulsation Unlisted procedures or services		
ConnectiCare of Massachusetts, Inc.	• All POS 21 acute care hospital facility admissions • Skilled nursing facility care (SNF) • Acute inpatient rehabilitation facility (IRF) • Long term acute care hospitalizations (LTAC)	• Radiology delegated to NIA • Cardiology • Muscular skeletal surgery and interventional pain management delegated to NIA	• MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment	• Partial Hospitalization (PHP)/Day Treatment • Intensive Outpatient (IOP)
Fallon Community Health Plan, Inc.	• Acute Inpatient Hospital • Elective Procedures • Chronic or Rehabilitation Inpatient Hospital Services • Hospice (24 hour) • Skilled Nursing Facility	• Acupuncture (administered w/o PA up to certain visit number-Medicaid) • Ambulatory Surgery/Outpatient Hospital Care • Breast Pumps (hospital-grade) • Dialysis • DME (< $300 does not require PA) • EPSDT • Early Intervention • Genetic Testing • Hearing Aids 6 • Home Health Services • Hospice (less than 24 hour) • Infertility o Not a covered benefit for Medicaid • Laboratory (out-of-network only) • Medical Nutritional Therapy • Orthotics • Oxygen and Respiratory Therapy Equipment • Physician – does not require PA except for out-of-network services o Note: a visit to a physician for diagnosis and planning purposes	• Acute Inpatient Hospital • Elective Procedures • Chronic or Rehabilitation Inpatient Hospital Services • Hospice (24 hour) • Skilled Nursing Facility Prior Authorization not required for inpatient services after 11/8/2022	• Partial Hospitalization Program (Based on performance metrics, some Partial Hospital Programs have the ability to submit a notification of admission without clinical review on web-based portal) • Applied Behavioral Analysis • Psychological and Neuropsychological Testing • Transcranial Magnetic Stimulation • Family Support & Training • Intensive Care Coordination (Commercial Only) • In-Home Behavioral Services • Therapeutic Mentor (Commercial Only) • Family Stabilization Team/In-Home Therapy (Commercial Only)

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical/Surgical Inpatient	**Medical/Surgical Outpatient**	**Mental Health/SUD Inpatient**	**Mental Health/SUD Outpatient**
		are not subject to PA. However, procedures on this list performed by physicians are subject to PA. • Podiatry • Prosthetic Services and Devices • Radiology and Diagnostic Tests • Therapy (PT/OT/ST) • Tobacco Cessation Services • Non-emergency Transportation • Vision Care (medical) • Vision (non-medical) • Wigs		
Harvard Pilgrim Health Care, Inc.	Select non-emergent hospital inpatient admissions • Admissions to Skilled Nursing Facilities ("SNF") • Inpatient rehabilitation admissions	Infusion and injectable medications • High end radiology • Speech therapy • Physical therapy and occupational therapy if services are expected to exceed the member's benefit limit • Molecular testing • Durable medical equipment (DME) • Sleep testing • Outpatient day surgery • Home health services (e.g., skilled nursing, physical therapy) • Interventional pain management for back pain • In vitro fertilization (IVF) • Hospice services	Prior Authorization not required for MH/SUD inpatient services; medical necessity standards applied during concurrent review	Electroconvulsive therapy (ECT) • Partial hospital programs • Intensive outpatient programs • Psychological and neuropsychological testing • Transcranial Magnetic Stimulation (rTMS) Applied Behavioral Analysis (ABA)
Health New England, Inc.	Skilled nursing facilities and inpatient rehabilitation facilities	Number of outpatient medical/surgical services	Residential Treatment Centers	Applied Behavioral Analysis (ABA), Repetitive Transcranial Magnetic Services (rTMS), Partial Hospitalization, psychiatric and neuro-psychiatric testing, mental health day treatment and Family Stabilization Treatment.
HPHC Insurance Company, Inc.	Select non-emergent hospital inpatient admissions • Admissions to Skilled Nursing Facilities	Infusion and injectable medications • High end radiology • Speech therapy • Physical therapy and occupational	Prior Authorization not required for MH/SUD inpatient services; medical necessity standards	Electroconvulsive therapy (ECT) • Partial hospital programs

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical/Surgical Inpatient	**Medical/Surgical Outpatient**	**Mental Health/SUD Inpatient**	**Mental Health/SUD Outpatient**
	("SNF") • Inpatient rehabilitation admissions	therapy if services are expected to exceed the member's benefit limit • Molecular testing • Durable medical equipment (DME) • Sleep testing • Outpatient day surgery • Home health services (e.g., skilled nursing, physical therapy) • Interventional pain management for back pain • In vitro fertilization (IVF) • Hospice services	applied during concurrent review	• Intensive outpatient programs • Psychological and neuropsychological testing • Transcranial Magnetic Stimulation (rTMS) Applied Behavioral Analysis (ABA)
Mass General Brigham Health Insurance Company	• Acute inpatient hospital (elective admission) • Inpatient Rehabilitation • Long Term Acute Care • Skilled Nursing Facilities	• Assisted Reproductive Services/Infertility Services • Subset of ambulatory surgical day procedures • Subset of DME items • Subset of genetic testing • Bariatric surgery • Bone Growth Stimulation (ultrasound, noninvasive and invasive electric bone growth Stimulation) • Breast surgeries (Subset of procedures) • Cardiac imaging • Cardiac Outpatient Mobile Telemetry • Cochlear Implants and Hearing Aids • Cosmetic and Reconstructive procedures • Early Intensive Behavioral Intervention (EIBI) (Autism Specialty Services) • Enteral, Parenteral and Nutritional Formulas • Gender Affirming Procedures • HIV associated lipodystrophy syndrome • Hyperbaric Oxygen Chamber Treatment • Implantable Neuro-Electrodes • Home and outpatient infusion • Lens, Therapeutic • High tech	• Acute Inpatient Hospitalization: In Massachusetts prior authorization is not required for emergent admissions, but providers are required to notify OHBS of the member's admission within 72 hours or the next business day. • MH Subacute Residential Treatment (a.k.a CBAT and ICBAT): facility must notify OHBS of admission and initial treatment plan within 72 hours of admission. • Acute Residential Treatment (ART) for adults.	• Partial Hospitalization Program (PHP) • Day Treatment • Intensive Outpatient Program (IOP) • Transcranial Magnetic Stimulation (TMS) • Applied Behavior Analysis (ABA) • Psychological Testing over 5 hours • Outpatient Electroconvulsive-Therapy (ECT) • Specialing

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical/Surgical Inpatient	**Medical/Surgical Outpatient**	**Mental Health/SUD Inpatient**	**Mental Health/SUD Outpatient**
		radiology imaging • Medical Specialty Medications (a subset) • Neuropsychological Testing • Non-emergency medically necessary transportation • Orthotics & Prosthetics • Pain Management Therapy • Phototherapy and Photochemotherapy for Dermatologic Conditions • Sleep studies /sleep DME • Transplant evals/ transplant		
Mass General Brigham Health Plan, Inc.	• Acute inpatient hospital (elective admission) • Inpatient Rehabilitation • Long Term Acute Care • Skilled Nursing Facilities	• Assisted Reproductive Services/Infertility Services • Subset of ambulatory surgical day procedures • Subset of DME items • Subset of genetic testing • Bariatric surgery • Bone Growth Stimulation (ultrasound, noninvasive and invasive electric bone growth Stimulation) • Breast surgeries (Subset of procedures) • Cardiac imaging • Cardiac Outpatient Mobile Telemetry • Cochlear Implants and Hearing Aids • Cosmetic and Reconstructive procedures • Early Intensive Behavioral Intervention (EIBI) (Autism Specialty Services) • Enteral, Parenteral and Nutritional Formulas • Gender Affirming Procedures • HIV associated lipodystrophy syndrome • Hyperbaric Oxygen Chamber Treatment • Implantable Neuro-Electrodes • Home and outpatient infusion • Lens, Therapeutic • High tech radiology imaging •	• Acute Inpatient Hospitalization: In Massachusetts prior authorization is not required for emergent admissions, but providers are required to notify OHBS of the member's admission within 72 hours or the next business day. • MH Subacute Residential Treatment (a.k.a CBAT and ICBAT): facility must notify OHBS of admission and initial treatment plan within 72 hours of admission. • Acute Residential Treatment (ART) for adults.	• Partial Hospitalization Program (PHP) • Day Treatment • Intensive Outpatient Program (IOP) • Transcranial Magnetic Stimulation (TMS) • Applied Behavior Analysis (ABA) • Psychological Testing over 5 hours • Outpatient Electroconvulsive-Therapy (ECT) • Specialing

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical/Surgical Inpatient	**Medical/Surgical Outpatient**	**Mental Health/SUD Inpatient**	**Mental Health/SUD Outpatient**
		Medical Specialty Medications (a subset) • Neuropsychological Testing • Non-emergency medically necessary transportation • Orthotics & Prosthetics • Pain Management Therapy • Phototherapy and Photochemotherapy for Dermatologic Conditions • Sleep studies /sleep DME • Transplant evals/ transplant		
Tufts Associated Health Maintenance Organization, Inc.	• Acute inpatient hospital admissions (concurrent review)• Sub-acute skilled nursing facility (SNF) admissions • Acute inpatient rehabilitation admissions	• High tech imaging • Home health care • Hospice services • Hyperbaric Oxygen Therapy • Osteogenesis stimulators, non-invasive • Proton beam therapy • Elective surgery • IVF/infertility services • Devices for the management of diabetes (e.g., Continuous Glucose Monitor and Artificial Pancreas) • Sleep studies • Upper GI endoscopy • Selective diagnostic procedures including mobile cardiac outpatient telemetry, video capsule endoscopy, and upper endoscopy • Genetic testing • Gene therapy • Dental procedures • Hematopoietic Stem-Cell Transplantation (HSCT) • Oral formula • Physical therapy/occupational therapy/speech therapy	Prior Authorization is not required for inpatient mental health/substance use services. Concurrent review is applied for: • Inpatient BH hospital admissions • Admissions to BH residential treatment • Crisis stabilization	•Psychological/Neuropsychological testing • Transcranial Magnetic Stimulation (rTMS) • Applied Behavioral Analysis (ABA) skilled services • In-Home Behavioral Services (IHBS) • In-Home Therapy Services (IHT) Intensive Care Coordination (after 30 days)
Tufts Health Public Plans, Inc.	• Acute inpatient hospital admissions (concurrent review) • Sub-acute skilled nursing facility (SNF) admissions • Acute inpatient rehabilitation admissions	• High tech imaging • Home health care • Hospice services • Hyperbaric Oxygen Therapy • Osteogenesis stimulators, non-invasive • Proton beam therapy • Elective surgery • IVF/infertility services • Devices for the	Prior Authorization is not required for inpatient mental health/substance use services. Concurrent review is applied for: • Inpatient BH hospital admissions • Admissions to BH	•Psychological/Neuropsychological testing • Transcranial Magnetic Stimulation (rTMS) • Applied Behavioral Analysis (ABA) skilled services • In-Home Behavioral Services (IHBS) • In-Home Therapy

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical/Surgical Inpatient	**Medical/Surgical Outpatient**	**Mental Health/SUD Inpatient**	**Mental Health/SUD Outpatient**
		management of diabetes (e.g., Continuous Glucose Monitor and Artificial Pancreas) • Sleep studies • Upper GI endoscopy • Selective diagnostic procedures including mobile cardiac outpatient telemetry, video capsule endoscopy, and upper endoscopy • Genetic testing • Gene therapy • Dental procedures • Hematopoietic Stem-Cell Transplantation (HSCT) • Oral formula • Physical therapy/occupational therapy/speech therapy	residential treatment • Crisis stabilization	Services (IHT) • Intensive Care Coordination (after 30 days)
Tufts Insurance Company	• Acute inpatient hospital admissions (concurrent review) • Sub-acute skilled nursing facility (SNF) admissions • Acute inpatient rehabilitation admissions	• High tech imaging • Home health care • Hospice services • Hyperbaric Oxygen Therapy • Osteogenesis stimulators, non-invasive • Proton beam therapy • Elective surgery • IVF/infertility services • Devices for the management of diabetes (e.g., Continuous Glucose Monitor and Artificial Pancreas) • Sleep studies • Upper GI endoscopy • Selective diagnostic procedures including mobile cardiac outpatient telemetry, video capsule endoscopy, and upper endoscopy • Genetic testing • Gene therapy • Dental procedures • Hematopoietic Stem-Cell Transplantation (HSCT) • Oral formula • Physical therapy/occupational therapy/speech therapy	Prior Authorization is not required for inpatient mental health/substance use services. Concurrent review is applied for: • Inpatient BH hospital admissions • Admissions to BH residential treatment • Crisis stabilization	•Psychological/Neuropsychological testing • Transcranial Magnetic Stimulation (rTMS) • Applied Behavioral Analysis (ABA) skilled services • In-Home Behavioral Services (IHBS) • In-Home Therapy Services (IHT) Intensive Care Coordination (after 30 days)
UnitedHealthcare Insurance Company	• Arthroplasty• Bariatric Surgery• Breast Reconstruction (non-mastectomy) • Cardiology	• Arthroplasty • Arthroscopy • Bariatric • Bone Growth Stimulator	• MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment	• Partial Hospitalization (PHP)/Day Treatment • Intensive Outpatient (IOP)

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical/Surgical Inpatient	**Medical/Surgical Outpatient**	**Mental Health/SUD Inpatient**	**Mental Health/SUD Outpatient**
	• Cerebral Seizure Monitoring – Inpatient Video EEG • Chemotherapy Services • Clinical Trials • Congenital Heart Disease • Cosmetic and Reconstructive Procedures • End-stage renal disease (ESRD) dialysis services • Foot Surgery • Gender Dysphoria Treatment • Hysterectomy • Inpatient admissions – post-acute services • Orthognathic Surgery • Sleep Apnea Procedures and Surgeries • Spinal Surgery • Transplant • Ventricular Assist Devices	• Breast Reconstruction (non-mastectomy) • *Cancer supportive care • *Cardiology • Cardiovascular • Cartilage Implants • *Chemotherapy Services • Clinical Trials • Cochlear Implants and Other Auditory Implants • Congenital Heart Disease • *Continuous Glucose Monitoring • Cosmetic and reconstructive procedures • *Durable Medical Equipment (DME) over $1,000 • *End-stage renal disease (ESRD) dialysis services • Foot Surgery • Functional Endoscopic Sinus Surgery (FESS) • Gender Dysphoria Treatment • Genetic and molecular testing to include BRCA gene testing • *Home Health Care – Non-nutritional • Hysterectomy (abdominal and laparoscopic surgeries) • Infertility • *Injectable Medications • MR-guided focused ultrasound (MRgFUS) to treat uterine fibroid • Non-Emergency Air Transport • Orthognathic Surgery • Orthotics over $1,000 • *Pain Management and Injection • Physical Therapy/Occupational Therapy	• SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment	• Electroconvulsive Therapy (ECT) • Psychological Testing • Applied Behavior Analysis (ABA) • Transcranial Magnetic Stimulation (TMS) • Specialing

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical/Surgical Inpatient	**Medical/Surgical Outpatient**	**Mental Health/SUD Inpatient**	**Mental Health/SUD Outpatient**
		• Potentially unproven services (including experimental/investigational and/or linked services) • Prostate Procedures • Prosthetics over $1,000 • *Radiation Therapy • Radiology • Rhinoplasty • Sinuplasty • Site of Service – Office-based program • Site of Service – Outpatient hospital • Site of Service – Outpatient hospital expansion • Sleep Apnea Procedures & Surgeries • Sleep Studies • Spinal Cord Stimulators • Spinal Surgery • Stimulators – not related to spine • *Therapeutic Radiopharmaceuticals • Transplant • Vein Procedures		
United States Fire Insurance Company	• Acute Inpatient Services • Subacute Inpatient Services, i.e., Skilled Nursing Care, Physical Rehabilitation Hospitals, etc. • Inpatient Professional Services	• Physician Visit • Consultant Physician • Day Surgery Miscellaneous Expenses • Surgeon • Diagnostic X-Ray & Laboratory - CT Scan, PET Scan or MRI • Emergency Room • Urgent Care • Home Health Care • Wellness Medical Expense • Infertility • Pediatric Specialty Care • Ambulance • Telemedicine • Pharmacy	• Mental Health Acute Inpatient Services • Mental Health Subacute Residential Treatment • Mental Health Inpatient Professional Services • SUD Acute Inpatient Services • SUD Acute Inpatient Detoxification • SUD Subacute Residential Treatment • SUD Inpatient Professional Services	• Autism • Eating Disorder • Intensive Behavioral Case Management • Opioid and Pain Management • Substance Use • Coaching Support for Parents and Families
Wellfleet Insurance Company	• Inpatient Hospital for a Continuous Confinement	• Preventive Services • Chemotherapy and radiation therapy • Chiropractic care	• Inpatient Mental Health Care for a continuous	• DME • Genetic testing • Home health care • Infusion therapy

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical/Surgical Inpatient	**Medical/Surgical Outpatient**	**Mental Health/SUD Inpatient**	**Mental Health/SUD Outpatient**
	• Skilled Nursing Facility • Inpatient Habilitation Services • Inpatient Rehabilitation Services	• Diagnostic imaging/testing • Durable Medical Equipment (DME) • Genetic testing • Home health care • Infertility Treatment • Infusion therapy • Outpatient surgery & procedures • Rehabilitation & habilitation therapies • Non Emergent Air Ambulance • Prosthetic and Orthotic devices	confinement when in a Hospital • Residential Treatment • Inpatient Rehabilitation Services	• Outpatient surgery & procedures • Rehabilitation therapies

APPENDIX D
Factors Used for Comparative Analysis

Summary of Responses – M.G.L. c. 26, s. 8M(a)(ii)		
Carrier	**Factors Used**	
	Medical/Surgical	**Mental Health/Substance Use**
4 Ever Life Insurance Company	The Plan: Medical policies are available online at: https://medpolicy.ibx.com/ibc/Commercial/Pages/Policy-Bulletin-View.aspx Magellan: Magellan Care Guidelines are available online at: https://www.magellanprovider.com/media/45694/mcg.pdf	
Aetna Health, Inc. (PA)	• Cost • High cost growth • Variability in cost and practice • Patient safety • Clinical quality control • Marked variation in provider utilization patterns • Incorrect utilization • Application of Clinical Policy Bulletin requirements • Standards of industry practice	
Aetna Health Insurance Company	• Cost • High cost growth • Variability in cost and practice • Patient safety • Clinical quality control • Marked variation in provider utilization patterns • Incorrect utilization • Application of Clinical Policy Bulletin requirements • Standards of industry practice	
Aetna Life Insurance Company	• Cost • High cost growth • Variability in cost and practice • Patient safety • Clinical quality control	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(ii)		
Carrier	**Factors Used**	
	Medical/Surgical	**Mental Health/Substance Use**
	• Marked variation in provider utilization patterns • Incorrect utilization • Application of Clinical Policy Bulletin requirements • Standards of industry practice	
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	Variability in costs, length of treatment, or overall number of services for treatment type, provider type and/or geographic region; Cost of treatment/procedure; Medical cost escalation; Fraud Waste and Abuse; Return on Investment	
Blue Cross and Blue Shield of Massachusetts, Inc.	Variability in costs, length of treatment, or overall number of services for treatment type, provider type and/or geographic region; Cost of treatment/procedure; Medical cost escalation; Fraud Waste and Abuse; Return on Investment	
Boston Medical Center Health Plan, Inc. d/b/a WellSense Health Plan	Examples of factors include but are not limited to the following: o Excessive utilization; o Recent medical cost escalation; o Provider discretion in determining diagnosis; o Lack of clinical efficiency of treatment or service; o High variability in cost per episode of care; o High levels of variation in length of stay; o Lack of adherence to quality standards; o Claim types with high percentage of fraud; and o Current and projected demand for services.	
Cigna Health and Life Insurance Company	Medical Necessity Medical Cost Return on Investment	
ConnectiCare of Massachusetts, Inc.	Clinical Appropriateness Value	
Fallon Community Health Plan, Inc.	- Excessive utilization - Recent medical cost escalation - Lack of adherence to quality standards - High levels of variation in length of stay - High variability in cost per episode of care - Clinical efficacy of the proposed treatment or service - Provider discretion in determining diagnoses - Claims associated with a high percentage of fraud - Severity or chronicity of the MH/SUD condition	
Harvard Pilgrim Health Care, Inc.	The Plan uses the following factors in determining what services are subject to utilization management: • Clinical appropriateness/clinical efficacy, i.e., the application of utilization management promotes optimal clinical outcomes, whether the service or procedure works for treating a certain condition	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(ii)		
Carrier	**Factors Used**	
	Medical/Surgical	**Mental Health/Substance Use**
	• Variation: whether there is variation in utilization patterns, including underutilization or overutilization relative to clinical benchmarks • Value: Potential for meaningful results from utilization management activity relative to the administrative cost	
Health New England, Inc.	Inpatient and outpatient: Clinical Efficacy, efficacy of treatment or service, level of care Prescription Drugs: cost efficacy and safety, prevention of substance abuse, patient outcomes, minimization of errors.	
HPHC Insurance Company, Inc.	The Plan uses the following factors in determining what services are subject to utilization management: • Clinical appropriateness/clinical efficacy, i.e., the application of utilization management promotes optimal clinical outcomes, whether the service or procedure works for treating a certain condition • Variation: whether there is variation in utilization patterns, including underutilization or overutilization relative to clinical benchmarks • Value: Potential for meaningful results from utilization management activity relative to the administrative cost	
Mass General Brigham Health Insurance Company	Clinical Appropriateness o Whether the application of prior authorization promotes optimal clinical outcomes Value o The process and cost of conducting clinical review results in measurable impact and improved adherence to evidence-based practice and, more effective allocation of clinical resources	Clinical Appropriateness o Whether the application of prior authorization promotes optimal clinical outcomes Value o The cost of the service exceeds the associated costs of conducting a prior authorization review
Mass General Brigham Health Plan, Inc.	Clinical Appropriateness o Whether the application of prior authorization promotes optimal clinical outcomes Value o The process and cost of conducting clinical review results in measurable impact and improved adherence to evidence-based practice and, more effective allocation of clinical resources	Clinical Appropriateness o Whether the application of prior authorization promotes optimal clinical outcomes Value o The cost of the service exceeds the associated costs of conducting a prior authorization review
Tufts Associated Health Maintenance Organization, Inc.	The Plan uses the following factors in determining what services are subject to utilization management: • Quality	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(ii)		
Carrier	**Factors Used**	
	Medical/Surgical	**Mental Health/Substance Use**
	o Safety concerns o High risk of misuse • High cost • Potential for meaningful results from utilization management and return on investment • Potential for fraud, waste, and abuse	
Tufts Health Public Plans, Inc.	The Plan uses the following factors in determining what services are subject to utilization management: • Quality o Safety concerns o High risk of misuse • High cost • Potential for meaningful results from utilization management and return on investment • Potential for fraud, waste, and abuse	
Tufts Insurance Company	The Plan uses the following factors in determining what services are subject to utilization management: • Quality o Safety concerns o High risk of misuse • High cost • Potential for meaningful results from utilization management and return on investment • Potential for fraud, waste, and abuse	
UnitedHealthcare Insurance Company	**• Clinical Appropriateness** o Whether the application of prior authorization promotes optimal clinical outcomes **• Value** o The cost of the service exceeds the associated costs of conducting a prior authorization review	
United States Fire Insurance Company	US Fire delegates health plan administration to the following vendors: • Cigna: network maintenance, including provider credentialing and negotiating appropriate reimbursement rates; • Cigna and HealthSmart: claims administration, utilization management and case management; and	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(ii)		
Carrier	**Factors Used**	
	Medical/Surgical	**Mental Health/Substance Use**
	• Express Scripts prescription drugs, including formulary development. US Fire conducted NQTL analysis utilizing plan coverage provisions and vendor NQTLs and policies and procedures. Factors included goals and objectives of vendor materials including accessibility, appropriateness, timeliness and efficacy of care.	
Wellfleet Insurance Company	• Appropriateness of utilization of services • Value of service •Cost Benefit Analysis	

APPENDIX E

Evidentiary Standards Used for Comparative Analysis

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
4 Ever Life Insurance Company	The Plan (NCQA Accredited): In creating medical policies, evidence relied upon includes credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community, physician specialty recommendations, and the views of the physicians practicing in relevant clinical areas. The Plan also relies on InterQual Clinical Decision Support Criteria, CMS guidelines, and extensive literature searches.	Magellan (NCQA Accredited): In creating medical policies, Magellan relies on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community, physician specialty recommendations, and the views of the physicians practicing in relevant clinical areas. Magellan also relies on CMS guidelines, MCG (formerly Milliman Care Guidelines), and American Society of Addiction Medicine (ASAM) criteria for substance use disorder services. Additional external sources include InterQual Criteria (an externally validated, computer-based system).
Aetna Health, Inc.	• Medicare rates • Internal claims database analysis • Internal analysis of administrative costs • Clinical guidelines and standards of practice. (These depend on the service under consideration and would include, by way of example, the most currently available versions of CMS Coverage Determinations and Medicare Benefit Policy Manual, MCG Health guidelines, National Comprehensive Cancer Network (NCCN) guidelines, American Society of Addiction Medicine (ASAM) Criteria, CALOCUS/LOCUS guidelines, and Aetna Clinical Policy Bulletins.)	
Aetna Health Insurance Company	• Medicare rates • Internal claims database analysis • Internal analysis of administrative costs • Clinical guidelines and standards of practice. (These depend on the service under consideration and would include, by way of example, the most currently available versions of CMS Coverage Determinations and Medicare Benefit Policy Manual, MCG Health guidelines, National Comprehensive Cancer Network (NCCN) guidelines, American Society of Addiction Medicine (ASAM) Criteria, CALOCUS/LOCUS guidelines, and Aetna Clinical Policy Bulletins.)	
Aetna Life Insurance Company	• Medicare rates • Internal claims database analysis • Internal analysis of administrative costs • Clinical guidelines and standards of practice. (These depend on the service under consideration and would include, by way of example, the most currently available versions of CMS Coverage Determinations and Medicare Benefit Policy Manual, MCG Health guidelines, National Comprehensive Cancer Network (NCCN) guidelines, American Society of Addiction Medicine (ASAM) Criteria, CALOCUS/LOCUS guidelines, and Aetna Clinical Policy Bulletins.)	
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	Inpatient: -Classification system (referred to as DRGs) for inpatient discharges established under Section 1886(d) of the Social Security Act; -InterQual Criteria	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	Outpatient: -Factors vary based on the outpatient service	
Blue Cross and Blue Shield of Massachusetts, Inc.	Inpatient: -Classification system (referred to as DRGs) for inpatient discharges established under Section 1886(d) of the Social Security Act; -InterQual Criteria Outpatient: -Factors vary based on the outpatient service	
Boston Medical Center Health Plan, Inc. d/b/a WellSense Health Plan	Examples of **sources of factors** include, but are not limited to, the following: o Internal claims analysis; o Medical expert reviews; o State and federal requirements; o National accreditation standards; o Internal market and competitive analysis; o Medicare physician fee schedules; and o Evidentiary standards, including any published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits. If these factors are utilized, they must be applied comparably to MH/SUD and medical/surgical benefits.	
Cigna Health and Life Insurance Company	Medical Necessity Criteria Internally developed coverage guidelines ASAM Criteria	
ConnectiCare of Massachusetts, Inc.	**Evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor:** o Expert Medical Review o Objective, evidence-based clinical criteria, and nationally recognized guidelines o Internal claims data o UM program operating costs o UM authorization data	**Evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor:** o Clinical criteria from nationally recognized third-party sources (e.g., ASAM®, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) review o Evidence-based policies, and publications and guidelines by nationally recognized authorities, such as government sources and/or professional societies

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	The Evidentiary standard that defines and/or triggers the Value factor: o Value is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the service to prior authorization by at least 1:1 • **The sources used to define the Value factor:** o National internal claims data o National UM program operating costs o National UM authorization data	
Fallon Community Health Plan, Inc.	CMS Guidelines MassHealth Guidelines InterQual Criteria Internally developed criteria	ASAM Criteria InterQual Criteria Criteria from AMA, APA, AACAP, SMHSA
Harvard Pilgrim Health Care, Inc.	The Plan uses the following sources to define the factors identified above: • **Factor**: Clinical appropriateness/clinical efficacy o Recognized medical literature, evidence-based empirical data and published research studies o Quality and clinical efficacy data o Internal and external subject matter expert feedback o State and federal requirements o Publications by government sources and/or professional societies **• Factor: Variation** o Utilization data o Cost and trend data o Quality and clinical efficacy data o Internal and external subject matter expert feedback o Publications by government sources and/or professional societies **Factor: Value** o Utilization data o Cost and trend data o Internal and external subject matter expert feedback	
Health New England, Inc.	Review of internal sources; external sources include AMA, CMS, American Psychiatric Association, Journal of Addiction Medicine; Pharmacy: FDA labeling; medical literature; internal claims data; accreditation standards of NCQA; Clinical Care Assessment Committee.	
HPHC Insurance Company, Inc.	The Plan uses the following sources to define the factors identified above: • **Factor**: Clinical appropriateness/clinical efficacy o Recognized medical literature, evidence-based empirical data and published research studies o Quality and clinical efficacy data o Internal and external subject matter expert feedback o State and federal requirements o Publications by government sources and/or professional societies	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	• Factor: Variation o Utilization data o Cost and trend data o Quality and clinical efficacy data o Internal and external subject matter expert feedback o Publications by government sources and/or professional societies **Factor: Value** o Utilization data o Cost and trend data o Internal and external subject matter expert feedback	
Mass General Brigham Health Insurance Company	**Factor – Clinical Appropriateness** is defined as the existence of evidence-based medical necessity criteria for inpatient services in accordance with nationally recognized clinical criteria and evidence-based policies. • Evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor: o Clinical criteria from a nationally recognized third-party source, InterQual® o Medical Technology Assessment Committee (MTAC) review o Evidence-based policies, publications and guidelines by nationally recognized authorities, such as government sources and/or professional societies. These include, but are not limited to: o Published articles and reports in credible, peer-reviewed English language medical and scientific journals; o Cochrane Library; o Professional organizations' clinical practice guidelines	**Factor – Clinical Appropriateness** is defined as the existence of evidence-based medical necessity criteria for inpatient services in accordance with nationally recognized clinical criteria and evidence-based policies. • Evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor: o Clinical criteria from nationally recognized third-party sources (e.g., ASAM®, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) review o Evidence-based policies, publications and guidelines by nationally recognized authorities, such as government sources and/or professional societies. **Factor – Value** is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to prior authorization review by at least 1:1. Consideration of this factor includes a review of national inpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when prior authorization is applied. The projected benefit cost savings is reviewed relative to the operating

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	o Hayes Inc., an independent health technology assessment organization; providing assessment of the safety and efficacy of technologies **Factor – Value** is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to prior authorization review. Consideration of this factor includes a review of inpatient utilization denial rates or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when prior authorization is applied. • The Evidentiary standard that defines and/or triggers the Value factor: o The process and cost of conducting clinical review results in improved adherence to evidence-based practice and more effective allocation of clinical resources • The sources used to define the Value factor: o Internal claims data	cost of administering prior authorization to determine value. • The sources used to define the Value factor: o National internal claims data o National UM program operating costs o National UM authorization data
Mass General Brigham Health Plan, Inc.	**Factor – Clinical Appropriateness** is defined as the existence of evidence-based medical necessity criteria for inpatient services in accordance with nationally recognized clinical criteria and evidence-based policies. • Evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor:	**Factor – Clinical Appropriateness** is defined as the existence of evidence-based medical necessity criteria for inpatient services in accordance with nationally recognized clinical criteria and evidence-based policies. • Evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor: o Clinical criteria from nationally recognized third-party sources (e.g., ASAM®, LOCUS, CALOCUS-

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	o Clinical criteria from a nationally recognized third-party source, InterQual® o Medical Technology Assessment Committee (MTAC) review o Evidence-based policies, publications and guidelines by nationally recognized authorities, such as government sources and/or professional societies. These include, but are not limited to: o Published articles and reports in credible, peer-reviewed English language medical and scientific journals; o Cochrane Library; o Professional organizations' clinical practice guidelines o Hayes Inc., an independent health technology assessment organization; providing assessment of the safety and efficacy of technologies **Factor – Value** is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to prior authorization review. Consideration of this factor includes a review of inpatient utilization denial rates or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when prior authorization is applied. • The Evidentiary standard that defines and/or triggers the Value factor: o The process and cost of conducting clinical review	CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) review o Evidence-based policies, publications and guidelines by nationally recognized authorities, such as government sources and/or professional societies. **Factor – Value** is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to prior authorization review by at least 1:1. Consideration of this factor includes a review of national inpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when prior authorization is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering prior authorization to determine value. • The sources used to define the Value factor: o National internal claims data o National UM program operating costs o National UM authorization data

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	results in improved adherence to evidence-based practice and more effective allocation of clinical resources • The sources used to define the Value factor: o Internal claims data	
Tufts Associated Health Maintenance Organization	The Plan uses the following sources to define the factors: • Evidence Based Medical Literature • Evidence Based Clinical Decision Support • FDA information • Financial Analysis • National accreditation and quality standards • Legal Statutes, State and Federal Mandates • Market and competitive analysis and benchmarking •Subject matter expert and provider feedback • MSPAC committees and/or independent review organization committee	
Tufts Health Public Plans, Inc.	The Plan uses the following sources to define the factors: • Evidence Based Medical Literature • Evidence Based Clinical Decision Support • FDA information • Financial Analysis • National accreditation and quality standards • Legal Statutes, State and Federal Mandates • Market and competitive analysis and benchmarking •Subject matter expert and provider feedback • MSPAC committees and/or independent review organization committee	
Tufts Insurance Company	The Plan uses the following sources to define the factors:	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	• Evidence Based Medical Literature • Evidence Based Clinical Decision Support • FDA information • Financial Analysis • National accreditation and quality standards • Legal Statutes, State and Federal Mandates • Market and competitive analysis and benchmarking •Subject matter expert and provider feedback • MSPAC committees and/or independent review organization committee	
UnitedHealthcare Insurance Company	**Factor – Clinical Appropriateness** is defined as those inpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. The Plan's evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor: o Clinical criteria from nationally recognized third-party sources (e.g., InterQual® for M/S services, and ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review o Objective, evidence-based clinical policies and nationally recognized guidelines **Factor – Value** is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to prior authorization review by at least 1:1. Consideration of this factor includes a review of national inpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when prior authorization is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering prior authorization to determine value. Sources: National internal claims data National UM program operating costs National UM authorization data	
United States Fire Insurance Company	In addition to vendor policies and procedures, US Fire utilized objective medical information including ASAM Criteria, MCG	In addition to vendor policies and procedures, US Fire utilized objective medical information including ASAM Criteria, MCG Criteria, InterQual,

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	Criteria, InterQual, National Comprehensive Cancer Network (NCCN), Official Disability Guidelines (ODG), American Medical Association (AMA) Publication of the Current Procedural Terminology (CPT) Book, American Hospital Association (AHA) Publication of Revenue Codes, American Formulary Association (AFA) Publication of Codes, FDA Labeling and Office of Clinical Evaluation & Policy (OCEP) Review.	National Comprehensive Cancer Network (NCCN), Official Disability Guidelines (ODG), American Medical Association (AMA) Publication of the Current Procedural Terminology (CPT) Book, American Hospital Association (AHA) Publication of Revenue Codes, American Formulary Association (AFA) Publication of Codes, FDA Labeling and Office of Clinical Evaluation & Policy (OCEP) Review.
Wellfleet Insurance Company	• Internal Claims database • Expert Medical Review • Input from national vendors • AMA publication of CPT • AHA publication of revenue codes • AFA publication of codes • CMS publication of codes • Wellfleet claims data for Return on Investment	

APPENDIX F
Company-Specific Authorization Information

	MASSACHUSETTS CARRIERS 2023	No. of Requests Made (5a)	No. of Services Requested (5b)			No. of Requests Authorized[2] (5c)	No. of Requests Modified[2] (5d)	No. of Requests Denied (5e)	No. of Internal Appeals Filed (5f)	No. of Appeals Approved (5g)	No. of Appeals Denied (5h)	No. Sent For External Appeal (5i)	No. External Appeals Overturned (5j)	No. of External Appeals Upheld (5k)
			Medical[3]											
		Medical	Inpatient Days	Outpatient Visits / Services	Total # of Services	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical
1	Aetna Health Inc./ Aetna Health Insurance Company	105	72	21,201	21,273	87	4	14	1	0	1	0	0	0
2	Aetna Life Insurance Company	4,600	3,613	75,596	79,209	3,721	198	631	32	6	26	1	0	1
3	Blue Cross and Blue Shield of Massachusetts, Inc.	43,414	26,082	3,222,806	3,248,888	41,060	39	2,315	101	56	45	3	1	2
4	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	332,802	314,283	25,208,076	25,522,359	318,021	394	14,387	1,631	1,028	603	3	0	3
5	Boston Medical Center Health Plan, Inc.[2]	18,852	10,736	3,532,853	3,543,589	16,891	173	1,788	237	113	124	3	1	2
6	CIGNA Health and Life Insurance Company^	139,321	2,973	136,348	139,321	132,509	2,338	4,474	596	237	359	3	3	0
7	ConnectiCare of Massachusetts, Inc.	19	5	14	19	17	0	2	7	5	2	0	0	0
8	Fallon Community Health Plan, Inc.	2,840	3,536	14,856	18,212	2,618	27	195	108	75	33	1	1	0
9	Fallon Health & Life Assurance Company, Inc.[2]	0	0	0	0	0	0	0	0	0	0	0	0	0
10	4 Ever Life Insurance Company	10	28	7	10	7	0	3	0	0	0	0	0	0
11	Harvard Pilgrim Health Care, Inc.	215,104	15,492	4,403,943	4,419,435	205,064	0	10,040	373	223	150	10	2	8
12	HPHC Insurance Company, Inc.	10,235	1,882	381,704	383,586	9,113	0	1,122	44	25	19	0	0	0
13	Health New England, Inc.	6,327	11,976	224,248	236,224	5,543	159	625	332	245	87	6	4	2
14	Mass General Brigham Health Plan, Inc. and Mass General Brigham Health Insurance Company (collectively, Mass General Brigham Health Plan)	32,547	15,295	291,734	307,029	27,888	2,680	1,979	110	45	65	6	3	3
15	Tufts Associated Health Maintenance Organization, Inc.**	39,327	3,249	358,012	361,261	34,149	0	5,178	108	52	56	6	0	6
16	Tufts Health Public Plans, Inc.[2]	72,101	38,372	725,734	764,106	63,891	0	8,210	329	152	177	13	4	9
17	Tufts Insurance Company	7,136	492	195,690	196,182	6,173	0	963	27	22	5	1	0	1
18	UnitedHealthcare Insurance Company	33,412	276	33,136	33,412	28,913	0	3,666	220	121	99	15	9	6
19	United State Fire Insurance Company	799	5	794	799	593	10	237	4	2	2	0	0	0
20	Wellfleet Insurance Company	78	76	36	112	63	0	15	0	0	0	0	0	0
	TOTALS:	**959,029**	**448,443**	**38,826,788**	**39,275,026**	**896,321**	**6,022**	**55,844**	**4,260**	**2,407**	**1,853**	**71**	**28**	**43**

			Behavioral Health[3]											
		Behavioral Health	Inpatient Days	Outpatient Visits / Services	Total # of Services	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health
1	Aetna Health Inc. / Aetna Health Insurance Company	11	74	12,612	12,686	10	1	0	0	0	0	0	0	0
2	Aetna Life Insurance Company	252	2,017	69,111	71,128	242	4	6	0	0	0	0	0	0
3	Blue Cross and Blue Shield of Massachusetts, Inc.	2,186	15,673	590,852	606,525	2,178	5	3	4	2	2	0	0	0
4	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	14,660	98,011	3,407,114	3,505,125	14,518	18	124	30	6	24	0	0	0
5	Boston Medical Center Health Plan, Inc.	843	4,407	30,554	34,961	827	3	16	1	1	0	0	0	0
6	CIGNA Health and Life Insurance Company	1,246	660	586	1,246	1,195	0	51	19	7	12	1	0	1
7	ConnectiCare of Massachusetts, Inc.	0	0	0	0	0	0	0	0	0	0	0	0	0
8	Fallon Community Health Plan, Inc.	157	638	10,218	10,856	153	1	3	1	0	1	0	0	0
9	Fallon Health & Life Assurance Company, Inc.	0	0	0	0	0	0	0	0	0	0	0	0	0
10	4 Ever Life Insurance Company	1	6	0	1	1	0	0	0	0	0	0	0	0
11	Harvard Pilgrim Health Care, Inc.	12,259	4,513	1,380,664	1,385,177	11,371	605	326	130	55	75	3	3	0
12	HPHC Insurance Company, Inc.	1,348	1,924	207,156	209,080	1,282	18	48	17	11	6	1	0	1
13	Health New England, Inc.	971	2,957	271,691	274,648	814	63	94	27	13	14	1	0	1
14	Mass General Brigham Health Plan, Inc. and Mass General Brigham Health Insurance Company (collectively, Mass General Brigham Health Plan)	3,434	7,272	364,051	371,323	2,954	371	109	97	56	41	2	2	0
15	Tufts Associated Health Maintenance Organization, Inc.	1,844	2,498	168,143	170,641	1,738	0	106	5	1	4	0	0	0
16	Tufts Health Public Plans, Inc.	3,979	11,239	304,383	315,622	3,790	0	189	5	1	4	0	0	0
17	Tufts Insurance Company	484	662	62,274	62,936	459	0	25	2	1	1	0	0	0
18	UnitedHealthcare Insurance Company	1,006	223	783	1,006	937	0	46	0	0	0	0	0	0
19	United State Fire Insurance Company	411	62	406	411	384	2	25	0	0	0	0	0	0
20	Wellfleet Insurance Company	6	22	0	22	6	0	0	0	0	0	0	0	0
	TOTALS:	**45,098**	**152,858**	**6,880,598**	**7,033,394**	**42,859**	**1,091**	**1,171**	**338**	**154**	**184**	**8**	**5**	**3**

[1]**Reported information is for all 2023 non-governmental insured coverage issued in Massachusetts for requests made and appeals heard during calendar year 2023.**

[2]**Requests authorized + modified + denied may not add up to total requests made because some requests may be classified as both authorized and modified, some requests may have been withdrawn, or some requests may have been pending and had not yet been classified as approved, modified or denied.**

[3]**Information as reported by carriers in response to Bulletin 2013-06, Item 5, was submitted as part of annual mental health parity certifications required under 211 CMR 154.00.**

The information is aggregated based on responses from the following carriers:

Aetna Health Inc.
Aetna Health Insurance Company
Aetna Life Insurance Company
AllWays Health Partners, Inc.
Blue Cross and Blue Shield of Massachusetts, Inc.
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Boston Medical Center Health Plan, Inc.
CIGNA Health and Life Insurance Company
ConnectiCare of Massachusetts, Inc.
Fallon Community Health Plan, Inc.
Tufts Associated Health Maintenance Org., Inc.
Tufts Insurance Company
Tufts Health Public Plans, Inc.
UnitedHealthcare Insurance Company
Wellfleet Insurance Company