THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Limited Scope Market Conduct Examination of

Fallon Community Health Plans, Inc.

Worcester, MA

For the Period January 1, 2022, through December 31, 2022

NAIC COMPANY CODE: 95541

EMPLOYER ID NUMBER: 23-7442369

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December 8, 2025

The Honorable Michael T. Caljouw
Commissioner of Insurance
Commonwealth of Massachusetts
Division of Insurance
One Federal Street, Suite 700
Boston, Massachusetts 02110-2012

Dear Commissioner Caljouw:

Pursuant to your instructions and in accordance with Massachusetts General Laws, Chapter 175, Section 4, the Massachusetts Division of Insurance ("Division") has performed a limited-scope market conduct examination ("Continuum of Regulatory Options/Interrogatory") of the market conduct affairs of **Fallon Community Health Plan, Inc.** ("Company"). The examination included but was not limited to the Company's 2022 calendar year health insurance business in Massachusetts.

The Company's home office:

One Mercantile Street, Suite 400
Worcester, MA, USA 01608

The following report thereon is respectfully submitted.

ACRONYMS

American Society of Addiction Medicine ("ASAM")
American Specialty Health ("ASH")
The Better Business Bureau ("BBB")
Behavioral Health ("BH")
Customer Care Center ("CCC")
INS Regulatory Insurance Services, Inc. ("INS")
Letter of Authorization ("LOA")
Managed Behavioral Healthcare Organization ("MBHO")
Massachusetts Attorney General's Office ("AGO")
Massachusetts Division of Insurance ("Division")
Market Conduct Annual Statement ("MCAS")
Market Regulation Handbook ("MRH" or "the Handbook")
Medical/Surgical ("M/S")
Mental Health ("MH")
National Association of Insurance Commissioners ("NAIC")
National Committee for Quality Assurance ("NCQA")
National Credentialing Committee ("NCC")
Network Quality and Performance ("NQ&P")
Non-Quantitative Treatment Limitation ("NQTL")
Obstetrics and Gynecology ("OB-GYN")
Office of Patient Protection ("OPP")
Out of Network ("OON")
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA")
Pharmacy Benefit Managers ("PBMs")
Quantitative Treatment Limitation ("QTL")
Substance Use Disorder ("SUD")
System for Electronic Rate Form Filing ("SERFF")
Third-Party Administrators ("TPAs")
United States of America ("USA")

BACKGROUND

On or about July 2023, the Massachusetts Division of Insurance ("Division") commenced a behavioral health parity compliance market conduct examination, 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. Following the legislative mandate, the limited scope examination focused primarily but not exclusively on compliance with the applicable provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MPHAEA"), 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.

The examination included an Interrogatory as provided under the Continuum of Regulatory Options ("Continuum") for market conduct examinations. The Continuum focused the examination 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. In addition, the examiners reviewed the Market Conduct Annual Statement ("MCAS"), National Association of Insurance Commissioners ("NAIC") financial filings, and Massachusetts health binder filings within the System for Electronic Rate and Form Filing ("SERFF"). In addition, for those companies that received a report from the Massachusetts Attorney General's Office ("AGO") in 2020, the examiners conducted an evaluation of the Company responses.

INS Regulatory Insurance Services, Inc. ("INS"), a consultant qualified to perform market analysis and market conduct examinations under the management and general direction of the Division, conducted the limited scope examination described in the preceding paragraphs.

SCOPE OF EXAMINATION

The examination was initiated with an interrogatory, one of the options outlined in the Continuum of Options section of the NAIC Market Regulation Handbook ("MRH" or "the Handbook"). The interrogatory focused on MHPAEA compliance in key areas, including utilization review, step therapy, network admission standards, network adequacy, denials of payment and coverage, quantitative treatment limitations, and the policies and procedures used to monitor compliance within the Company and with third-party administrators and vendors. Additionally, the interrogatory inquired about the methods employed to ensure the accuracy of the 2022 Health MCAS filed by the Company. The examiners used sources, including the Company responses, the MCAS filing, and existing reports within the Division, to assess the accuracy and completeness of Company-reported data.

EXAMINATION APPROACH

The examination employed the guidance and standards in the 2022 Handbook, the examination standards of the Division, the Commonwealth of Massachusetts' insurance laws, regulations, bulletins, and applicable federal laws and regulations. Examiners performed all procedures under the supervision of the Division's market conduct examination staff.

The Handbook provides guidance on optional processes and procedures for use during the examination and includes an approach designed to detect potential areas of non-compliance. The methodology outlined in the Handbook identifies key practices and controls used to operate the business and to meet essential business objectives, including measures designed to ensure compliance with applicable MHPAEA state and federal laws and regulations.

All unacceptable or non-compliant practices may not have been discovered or noted in this report. Failure to identify improper or non-compliant business practices does not constitute acceptance of such practices. The Company shall report to the Division on any such corrective actions taken.

Interested parties can review all Massachusetts laws, regulations, and bulletins cited in this report on the Division's website at http://www.mass.gov/doi.

EXECUTIVE SUMMARY

This summary provides a high-level overview of the examination results, while the remainder of the text

summarizes all observations, conclusions, recommendations, and corrective actions required as a result of the examination.

Required Company Corrective Action

There were no corrective actions for the Company during this examination.

I. COMPLAINTS/GRIEVANCES

Closed Consumer Complaints

The interrogatory requested a summary log of all closed consumer complaints submitted by consumers directly to the Company from January 1, 2022, through December 31, 2022. This log included any closed complaints submitted to the Division, the Massachusetts Office of the Attorney General ("AGO"), the Better Business Bureau ("BBB"), MyPatientsRights.org, and the Office of Patient Protection ("OPP").

Examination Procedures Performed: Typically, INS reviews the complaint summary log for MHPAEA compliance and identified complaints and grievances related to potential network adequacy insufficiencies. INS also inquires whether there were processes and procedures in place with third-party administrators to ensure all complaints were correctly reported. Further, INS:

a) reviews the Company's complaints and grievance registers to identify if there was a lack of in-network providers,
b) reviews the Company's complaint and grievance register to identify if there were sufficient in-network providers for M/S, MH, and SUD,
c) reviews the Company's complaint/grievance registers to detect any identifiable trends for out-of-network denials,
d) reviews the Company's complaint/grievance registers to identify any trends related to consumers having to pay out-of-network rates due to a lack of in-network providers,
e) inquires if there were policies and procedures in place for any third-party administrators (especially those handling MH/SUD) to report complaints/grievances to the Company, and
f) reviews to determine the final number of complaints and identify those that were of potential concern.

Examination Conclusions: A total of 337 were provided, including 84 grievances, 249 Level 1 Appeals, and four (4) Level 2 Appeals. The grievances cited issues such as accessibility impacted by the provider, claims, benefits lacking, copay/cost-share issues, quality of service, quality of care, provider billing, premiums, and network concerns. Among these, three (3) grievances were related to mental health/substance abuse, two (2) alleged benefits lacking-behavioral health issues, and one (1) alleged quality of care at the facility. There were two hundred forty-nine (249) Level 1 Appeals reported. Of these, 191 were post-benefits, 47 were pre-adverse, 8 were post-adverse, and 3 were pre-benefit. The most common service levels include: 85 for deductibles, 67 for specialty physician services, 26 for pharmacy, and 17 for copayments. Dispositions consisted of 136 upheld previous decisions, 110 overturned decisions, and 3 previous partially upheld decisions. One appeal related to substance abuse; the previous decision was upheld, and no action was taken. Four (4) Level 2 Appeals reported. Of those, two (2) were post-benefit and two (2) were pre-adverse. The service types include pharmacy (2) and deductible (2). The dispositions include previous decision overturned (2) and previous decision upheld (2).
The Company provided 337 complaints, none of which were of potential concern.

Closed Provider Complaints/Grievances

The interrogatory requested a summary log of all closed provider complaints submitted by providers directly to the Company from January 1, 2022, through December 31, 2022. This log included any closed complaints submitted to the Division, the AGO, the BBB, MyPatientsRights.org, and the OPP.

Examination Procedures Performed: Typically, INS reviews the summary log for MHPAEA compliance and identified any complaints/grievances related to potential network adequacy insufficiencies. Additionally, INS inquires whether there were processes and procedures in place with third-party administrators to ensure all complaints were correctly reported. Further, INS:

a) reviews the Company's complaint/grievance registers to identify whether there were sufficient in-network providers.
b) reviews the Company's complaint/grievance registers to identify whether there was a lack of in-network providers for M/S, MH, and SUD.
c) reviews the Company's complaint/grievance registers to identify whether there were trends for out-of-network denials.
d) reviews the Company's complaint/grievance registers to identify trends related to consumers having to pay out-of-network rates due to a lack of in-network providers.
e) inquires if there were policies and procedures in place for any third-party administrators (especially those handling MH/SUD) to report complaints/grievances to the Company, and
f) reviews to determine the final number of complaints and identify those of potential concern.

Examination Conclusions: A total of 2,014 provider files were reported. Many of these were provider appeals related to service denials, such as drug tests, outpatient office visits, and behavioral changes, such as smoking. The majority of the appeal dispositions include a denial letter not authorized (59), provider appeal approved-PAC review (18), a letter claim provided according to contract (13), a letter exceeding appeal review time (12), and not an appeal (9). The majority of denied appeals occurred in 2022. There were 23 denials for one particular nurse practitioner, including nine (9) for 80307 presumptive rapid drug test chemical analyzer denied via contract, five (5) for G0480 definitive drug test that uses advanced methods to identify individual drugs and their concentrations which tests for 1-7 drug classes denied via contract, six (6) 99214 office/outpatient visit for established patient denied via contract, and three (3) for G0481 definitive drug test identifying 8-14 drug classes denied via contract. The Company provided 2,014 provider appeals, including 124 MH/SUD appeals. Of these, 43 were reported as pre-authorization notification denials and 25 as prior authorization denials. Among the 124 MH/SUD appeals, 12 had a disposition of prior approval denied because the appeal letter was submitted beyond the allotted time.

The Company further clarified, through supplemental information, that the processes and procedures for MH and SUD are no more stringent than for M/S. While they are not identical, as different organizations manage them, the basic processes are similar and based on comparable rationales. Both processes allow an opportunity for providers to challenge a plan decision made on a claim on various grounds. On the Carelon side, the Provider Dispute Resolution (PDR) process applies to commercial claims. Both processes allow for a provider appeal to be logged, reviewed, and resolved, with additional payment to the provider if the resolution is in the provider's favor. The grounds for appeal differ from one process to the other, as the types of services involved differ, but they are similar in concept

The Company also provided examples of why the process is less stringent in some respects for MH/SUD providers than it is for M/S. Examples included a longer timeline for provider disputes for MH/SUD and an additional second level of review.

Moreover, the Company also stated that the MH/SUD provider network is strong and that the Company

submits its geo-access maps annually, confirming network adequacy and compliance with state regulations.

II. MARKET CONDUCT ANNUAL STATEMENT

Companies with $50,000 or more in yearly premium sales in certain lines of business must file the MCAS report annually. The companies were asked to verify the accuracy of their MCAS data or, if they had not filed MCAS, to supply the information contained in the MCAS to the examiners. The examiners verified with the Company that they attested to the accuracy of the data.

Examination Procedures Performed: INS reviewed the MCAS fields related to prior authorizations (pharmacy and excluding pharmacy), and external review data for both in-exchange and out-of-exchange. Further, INS:

a) developed statewide averages for each field for both in-exchange and out-of-exchange,
b) reviewed all prior authorization denials for non-pharmacy and pharmacy and compared the state data to the statewide medians and averages,
c) reviewed the percentage of MH/SUD prior authorization denials to see if they were higher than M/S prior authorization denials,
d) reviewed the consumer-requested external reviews (excluding pharmacy) that were overturned, and,
e) verified that addenda were filed about the accuracy of the MCAS data.

Examination Conclusions: The Company initially believed that its MCAS data for 2022 was accurate, but in the course of pulling data for this examination, the Company discovered several discrepancies with the NAIC MCAS data, and as a result, believes that some of the parameters used for the NAIC MCAS filing were incorrect.

The Company's prior authorization data pulled by its behavioral health vendor for its NAIC MCAS filing was limited to fully insured commercial members outside the Exchange (members inside the Exchange were excluded). As a result, the data submitted for the NAIC MCAS filing and the data submitted for this filing are not directly comparable.

Subsequent Company Actions: The Company confirmed that the MCAS data inaccuracy identified for 2022 was not present in 2023 or 2024 data.

III. DENIAL OF PAYMENT AND COVERAGE

Third-Party Administrator Claims Processing

The Company supplied the names of the internal and external third-party administrators ("TPAs") involved in claims processing. For this review, the request focused on any TPAs directly involved in claims processing, including those administrators who accept, deny, or otherwise adjudicate the claims. For example, the request might include pharmacy benefit managers ("PBMs"), administrators that process M/S and MH/SUD claims, and administrators that may process international claims. The list of requested TPAs should include those processing M/S claims, as well as those involved in MH/SUD claims processing. The examiners reviewed the response to identify which providers are used and for what purpose.

Examination Procedures Performed: INS reviewed the third-party entities involved with claims

processing. Further, INS identified whether:

a) M/S claims are processed through a different vendor than those processing claims for MH/SUD,
b) a vendor (within the Company group or an outside vendor) is used for pharmacy claims, and
c) whether a PBM is utilized.

Examination Conclusions: The Company provided a list of six Third Party Administrators (TPA). The Company initially provided the names of the third-party entities utilized; however, they did not indicate whether the third party was affiliated with the Company and did not provide much detail regarding the services that the third party provides to the Company. The vendors include American Specialty Health ("ASH") (chiropractic), Dental Benefit Providers (dental), Carelon Behavioral Health Strategies, LLC (behavioral health), EyeMed Vision Care, LLC (vision), Magellan Rx Management LLC (medical pharmacy benefit/post-service claim editing and rebating) and OptumRx, Inc. (PBM).

Examination Conclusions: The Company has since provided services provided by the third-party administrators. None of the third-party administrators are affiliated with the Company.

Observation: In future requests, the Company should make sure to include ClaimsXten to the list of entities that assist in the claims adjudication process as the software reviews submitted medical claims for coding accuracy, correct modifier usage, and ensures billing consistency. (In the interest of accuracy, the Company should explain that mental health claims are exempt from ClaimsXten auditing.)

Fallon also stated that they will include ClaimsXten on the list of entities that assist in the claims adjudication process in future requests.

Policies and Procedures Related to Claim Denials

Examination Procedures Performed: INS reviewed the third-party policies and procedures for claim denials. Further, INS also identified whether:

a) the Company has adequate processes and procedures for claims processing,
b) if the Company writes in multiple jurisdictions, the policies and procedures for claims denials must include information about state-specific requirements,
c) the state-specific addendums have been reviewed to determine if all addendums are up to date with any recent bulletins, statutes, regulations, or related recent amendments or revisions, and
d) the information provided was adequate to determine if the individual at the Company making the denial decision is experienced in the area they are reviewing. Ideally, the individual should be board-certified in the area being reviewed (e.g., psychologist/board-certified, behavior analyst-doctoral, and/or a psychologist with clinical experience).

Examination Conclusions: The Company provided policies and procedures for each of their third-party administrators and for Fallon Health. Fallon provided six (6) policies/procedures documents. Along with the procedures, the Company provided a spreadsheet listing 112 processes/procedures, the category, next review date, and the date modified.

The Carelon document mentioned benefit limitations for behavioral health.

Subsequent Company Actions: The Company confirmed that there are no benefit limits for behavioral health and that the documentation provided by Carelon related to benefit limitations is because they do not

control plan design and some plans may have benefit limits set by a client (insurer) or a client's customer (such as an employer group.)

Fallon clarified that when a vendor is onboarded, they review the vendor's policies and procedures to ensure compliance with state requirements, including denials. Fallon communicates changes to regulations or laws to the vendors, and the vendors must integrate changes into existing policies and procedures or add to state-specific policies and procedures.

The Company confirmed that peer advisors/peer reviewers for SUD are psychiatrists or doctoral level psychologists who determine medical necessity opinions/determinations or appeal consideration and provided a list of other qualifications.

M/S, MH and SUD Claims Received, Paid, Denied (in part or in whole)

Examination Procedures Performed: The Company provided the claims received, paid, denied in part, and denied in whole, separated by M/S, MH, and SUD. The examiner totaled the data and created statewide averages and medians to determine if companies were outliers. Further, INS identified whether:

a) the claims paid were less than statewide averages and medians,
b) the percentage of total denials was over the statewide averages and medians,
c) the denials for M/S claims were higher than statewide averages and medians,
d) the denials for M/H claims were higher than statewide averages and medians,
e) the denials for SUD claims were higher than statewide averages and medians, and
f) the denials of MH and SUD claims were higher than M/S claim denials.

Examination Conclusions: The Company responded with all the denial information. The Company's total percentage of denials for MH of was higher than the statewide average. Their total percentage of denials for M/S of was also higher than the statewide average. The total percentage of denials for substance use was in line with the statewide average. The M/S percentage of denials (in part and whole) was slightly higher than M/H and SUD.

The Company provided additional information regarding the mental health and substance use claims denied in whole. The top five reasons for M/H claims denials include: 1) duplicate claim line, 2) submit to behavioral health vendor [claim was submitted directly to Fallon Health but should have been submitted to Carelon], 3) incorrect number of units billed, 4) excluded service/provider liable, and 5) no authorization or PCP referral.

The top five denial reasons for SUD claims include: 1) duplicate claim line, 2) other insurance primary, 3) not a covered benefit, 4) no authorization or PCP referral, and 5) non-participating provider/no authorization [for HMO plans, services with a non-participating provider are generally not covered unless they have been prior authorized]

IV. NETWORK ADEQUACY

The Company was asked to supply processes and procedures to demonstrate their compliance with the state and federal requirements for network adequacy. The Company was also asked to provide a listing of their MHPAEA plans. The examiners selected a plan from the Company's list and performed a search on the Company's website, searching for an Obstetrics and Gynecology ("OB-GYN") provider and a MH or SUD provider.

Policies and Procedures Compliance with Federal Requirements on Provider Data Accuracy

Examination Procedures Performed: INS reviewed the Company's policies and procedures to determine if the Company complied with federal requirements on provider data accuracy. The purpose of the INS review was:

a) to ensure the Company had documented policies and procedures,
b) to ensure compliance with the No Surprises Act (42 USCS § 300gg-115) for all provider types and
c) to confirm that the accuracy of provider data is reviewed every 90 days.

Examination Conclusions: Fallon Health also provided its CAQH Overview Process. The purpose of this process is to keep provider directories current and accurate based on provider attestations to the Fallon Health dataset. The Company determined that CAQH would be utilized for provider directory data and started automating the data received from CAQH; a project that is still ongoing and due to be implemented at the end of 2023. Once CAQH automation is live, the CAQH data that providers attest to regarding their FH directory data every 90 days regarding the Fallon Health dataset will be loaded into FH's core directory data system updated weekly in the provider directories. This process includes automated updates and exceptions that need manual review and updating.

EyeMed provided their policy, titled *Provider Directory Validation and Accuracy*. This document included state-specific requirements, but Massachusetts was not listed. In Section 5.4 Provider Directory Accuracy Audits, the Company reported that "Routine monitoring and auditing of the provider directory is conducted to help support EyeMed's efforts in assuring the accuracy and quality of the provider data as well as timeliness in data revision processes."

Carelon provided its policy and procedure document titled, *Provider Database and Provider Directory*. In the document Carelon explains that network staff updates the practitioner and facility/organizational provider database within 14 calendar days of receiving new information from a practitioner or facility/organizational provider. Carelon removes practitioners and providers from the directory or directories within 30 calendar days. Carelon and its vendor audit the accuracy of directory information at least quarterly.

CareCentrix provided its policy and procedure titled, *Process for Updating Provider Demographic Changes*. They explain that network providers must timely notify CareCentrix of any changes to their demographic information or changes to the information submitted in their credentialing application. The Company reminds providers of their obligation to timely notify them of such changes via a quarterly provider newsflash. The policy did not indicate how often the Company verifies provider data. They also provided Provider Newsflashes for changes to provider demographic information in the following periods: January 2022, April 2022, July 2022, and October 2022.

American Specialty Health (ASH) provided their procedure that explains that on a quarterly basis, not to exceed more than three months from the prior validation, ASH practitioners are given notice to validate their demographic information that is provided to ASH.

Subsequent Company Actions: The Company confirmed that their vendors EyeMed, ASH, Carelon and CareCentrix have procedures to comply with federal standards to verify provider data at least every ninety days. Fallon, and Carelon utilize CAQH for verifying and maintaining provider data accuracy.

List of Massachusetts Plans Subject to Mental Health Parity in 2022

Examination Procedures Performed: INS reviewed the Company's response to verify that the list of plans subject to the mental health parity requirement in 2022 was provided to the Division. Further, INS reviewed the Company's response to verify:

a) the Company responded to the question, and
b) the list provided matches the 2022 SERFF Filing Binder (if applicable).

Examination Conclusions: The only Fallon Health product active for the entire year in 2022 which was subject to commercial mental health parity requirements was their Community Care HMO product. Community Care is sold in several different plan design variations on Massachusetts's state Exchange, the Health Connector. It is not actively marketed off the Exchange (no plan design variations exist other than those sold on the Exchange). It is sold only in the individual and small group markets (under Massachusetts state law, all plan design variations are available to both individual and small group customers), not in the large group market. All Community Care members have access to the same provider network.

Based on the review of the plans supplied by the Company, the response is sufficient and accurate.

Basic Web Searches

Examination Procedures Performed:
The examiners selected a plan from the Company's list and performed a search on the Company website, searching for an OB-GYN provider and a MH or SUD provider. Further, INS:

a) conducted a basic search without a login to find an OB-GYN within the plans service area,
b) conducted a basic search without a login to find an MH/SUD provider,
c) confirmed that the name of the plan displayed on the website was consistent with the Company name provided, and
d) reported challenges encountered in the search to the Company.

Examination Conclusions: The examiners selected the Fallon Health for Massachusetts, Community Care plan and searched for an addiction medicine specialist provider in the following city/zip: 01608. There was one provider available in the area and accepting new patients. The examiners assumed this is because the member or prospective member would need to search using the Carelon Behavioral Health website. However, when the examiners clicked on the link to search the Carelon Behavioral Health website for an SUD or addiction medicine specialist, the Fallon website page directed the user to enter the first three letters for the state of Massachusetts, then enter Fallon, but the Carelon site instructions instruct members to enter the first three letters of the plan name. It is confusing for consumers because it is unclear if they are supposed to enter Fallon or Community Health.

The examiners selected the same plan and searched on the company website for an OBGYN. There were 26 OBGYN's found within 10 miles of the following zip code: 01608.

Website for All Providers: Find a doctor https://fchp.org/FindPhysician/
Website for Behavioral Health Providers: Find a Provider | Carelon Behavioral Health
Website for Other Providers: Find a doctor or other health care provider

The examiners recommended that the company consider simplifying their webpage so that all available plan options are in one drop-down, instead of having hyperlinks for some plans at the top of the page and

a drop-down in the Advanced Search options section for other plans.

The examiners also found that the Carelon website requires members to type in the first three letters of their plan. However, the information on the Fallon website states that a search on the Carelon site should be completed using the state first (Massachusetts) and then selecting the plan (Fallon).

Subsequent Company Actions: The Company has simplified its instructions to search for providers in its Community Care product. The instruction now states, "If you are looking for a provider in Community Care, NaviCare or a Fallon Medicare Plus plan, please use either the Quick Search or Advanced Search below."

The link to the Carelon website has also been changed. Clicking the *Behavioral health provider* link will bring the user directly to the Fallon Health web page at Carelon, eliminating the need for members to enter the first three letters of their plan, thereby eliminating any confusion.

V. NETWORK ADMISSION STANDARDS

The Company supplied the network admission standards, reimbursement rates and policies, and the number of network admissions during the examination period of review.

Network Admission Standards Policies/Procedures Data Submitted

Examination Procedures Performed: INS reviewed the network admission standards, reimbursement rates and policies, and the number of network admissions during the examination period of review to determine if ample processes and procedures were in place. Further, INS considered:

a) if any additional barriers exist that make it harder for MH/SUD providers to become a member of the network,
b) if the Company is using a TPA or another vendor for MH/SUD. If the Company have processes in place for the vendor to follow rather than relying solely on the vendor to determine what network admission standards will apply,
c) if there are differences between MH/SUD and M/S admission processes, evaluate the differences to ensure they do not result in more stringent or have extra requirements for MH/SUD applicants. (For example, what are the liability insurance requirements for M/S versus MH/SUD?)

Examination Conclusions: Carelon Behavioral Health provided their network management policy and procedures document. The purpose of the procedure is to maintain a comprehensive network; the Company will recruit providers (practitioners and facility programs) as needed, who are accessible and available to all Carelon Behavioral Health members.

Fallon Health provided their *Availability of Services Process* document. Within this document, the Company provided its standards for availability to providers. The process defines the steps for responding to written inquiries from providers seeking participation in any of Fallon Health's products. They also provided their Expansion process, which explains the steps for determining the Company's need for the expansion and development of new provider markets.

OptumRx provided its Credentialing Checklist.

EyeMed provided its *Network Management* policy. The purpose is to establish their network management

guidelines, including but not limited to the evaluation of geographic areas for network saturation, provider requests for participation in a geographic area, management of the PLUS provider tiered network, measures taken to recruit providers in new areas and areas needing additional providers, and the process for addressing areas with noted adequacy deficiencies.

Dental Benefit Providers provided their Credentialing/Re-Credentialing policy. The document describes the process for credentialing and re-credentialing dental providers to ensure that providers meet or exceed the required qualifications, criteria, and standards.

CareCentrix provided their Credentialing policies. The types of providers to be credentialed and re-credentialed include, but are not limited to, the following: Organizational Providers, Sleep Study Facilities, Skilled Nursing Facilities, and Home Health Care.

CareCentrix provided its *Initial Application and Attestation procedures*. The purpose of this policy is to ensure systematic review of health care providers requesting participation in the CareCentrix Network. CareCentrix provided its *Assessment of Organizational Providers*. The purpose of this policy is to identify who assesses providers within the CareCentrix Network and how the assessment process is conducted

Based on the review of the network admission standards, the Company's network admission standards meet Massachusetts statutory and regulatory requirements.

Reimbursement Rate Policies

Examination Procedures Performed: INS reviewed the reimbursement rate policies and procedures. Further, INS reviewed the reimbursement rate policies to:

a) ensure the rate policies were complete and detailed,
b) verify whether a third-party or internal entity handles the reimbursement rate policies, and
c) verify the reimbursement procedures/methods are not more stringent for MH/SUD than for M/S providers. (Additional software, etc.)

Examination Conclusions: Carelon provided its procedure titled, *Initial Contracting with Providers*. The purpose of the procedure is to establish a standard for issuing agreements to providers selected to join a Carelon Behavioral Health, Inc. network or networks administered by Carelon Behavioral Health. The procedures explain that under special circumstances, the contracting director/manager may issue a Letter of Authorization ("LOA") (in states where the LOA is recognized as a contract). The LOA is utilized in situations where negotiations about contract language and/or reimbursement rates are expected to be lengthy, and the provider has refused to sign an Out-of-Network ("OON") agreement. For some Carelon Behavioral Health clients, contract and rate agreements are managed by the client. In these situations, the client provides the contract and rate documentation to Carelon Behavioral Health. These contract documents must be submitted as part of the final, complete credentialing packet prior to review by the National Credentialing Committee ("NCC"). The rate agreements were not submitted.

CareCentrix: Provider reimbursement rates are based on the market rates for the specific service or item and are mutually agreed upon with each provider and memorialized in the provider's contract with CareCentrix.

Dental Benefit Providers provided a UnitedHealthcare policy titled, Provider Submissions and Reimbursement- Dental Claims. UnitedHealthcare pays contracted providers for covered dental services according to the payment methodologies outlined in the provider's contract and non-contracted providers

as established by the Centers for Medicare & Medicaid Services, as applicable.

EyeMed provided its *Network Management* policy. Members receive a certificate rider, ID cards, postcards, or emails directing them to the EyeMed website and the Customer Care Center ("CCC") for provider and benefit information. When providers are unavailable within a reasonable time or distance, members are informed through the provider directory or when contacting the CCC. Members without access to an in-network provider within a reasonable distance or those who are unable to schedule an appointment within two (2) weeks are eligible to submit an out-of- network claim form to receive the in-network level of benefit.

Fallon Health provided their *Provider Reimbursement NQTL- Commercial*. This document details the rating for both inpatient and outpatient base rates for M/S and MH/SUD. In patient MH/SUD base rates start at 100% of Medicare payment rates with per diem, case rates and percentage of charge calculations. Outpatient MH/SUD rates are established at 110% of base rates for "Metropolitan Boston" and "the rest of Massachusetts." Fallon, through Beacon (or any other Managed Behavioral Healthcare Organization ("MBHO")), will use the same Behavioral Health Base Rates for all Massachusetts providers in its network.

OptumRx provided their claims processing procedures.

The Company's third-party administrators provided their processes/procedures for provider reimbursement.

The Carelon document contains policies and procedures for the initial contracting with providers. The document does not include details on how the rates for MH/SUD are calculated, what base rates are used and any additional criteria considered in determining rate reimbursements, however, that documentation was provided in the response to the AG's report rather than as part of the responses to this examination.

Number of Network Admissions During the Period (M/S, MH and SUD)

Examination Procedures Performed: INS reviewed the network admissions for the examination period. Further, INS reviewed the data to ensure:

a) the information was separated into M/S and MH/SUD,
b) the information included facilities for M/S and MH/SUD,
c) the reasons for denial were included, and
d) the percentage of denials for MH/SUD was similar to those for M/S.

Examination Conclusions: The Company provided the information from their third-party administrators. Carelon, which provides services related to the management of Fallon Health's behavioral health benefit, did not provide a spreadsheet of individuals and/or facilities approved or denied in 2022. They explained that the network in Massachusetts is an open network; therefore, all requests for network participation are approved as long as the provider meets all credentialing requirements.

Fallon Health provided a spreadsheet that included 14 approvals (13 for individuals and one (1) for a facility) and 110 declinations (107 for individuals and three (3) for facilities). They did not specify the reasons for the declinations but explained that the majority are denied due to the provider not being located in the service area for Community Care (which as a limited network product has a limited geographic footprint).

Optum RX provided a spreadsheet that included approvals and denials in the 2022 data year. They did include reasons for the denials. There were no facilities included in this spreadsheet, only individuals.

EyeMed provided a spreadsheet of 509 individuals approved in the 2022 data year. There were no facilities listed and no denials reported.

Corrective Action: The Company must be able to provide the list from Carelon for all individuals and facilities approved for admission into the network in future examinations.

Subsequent Company Actions: The Company did commit to providing this data in the future.

VI. POLICY AND PROCEDURES FOR COMPLIANCE WITH MHPAEA

Examination Procedures Performed: The Company supplied policies, procedures, and documentation to show the implementation of MHPAEA compliance. Further, INS reviewed the data to:

a) ensure the Company has policies and procedures for ensuring compliance with MHPAEA,
b) ensure the Company monitors/audits vendors for compliance and,
c) ensure the Company has an organized compliance plan for MHPAEA oversight.

Examination Conclusions: The Company provided their *Parity Oversight and Monitoring Procedures*. The procedure included benefit classification and coverage, parity compliance monitoring overview, financial requirements and quantitative treatment limitations, non-quantitative treatment limitations, parity compliance, ongoing monitoring of NQTL operations measures, and parity compliance monitoring for vendors. The purpose of this document is to define mental health parity requirements and expectations to ensure compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA). The procedure also incorporates the following Massachusetts state laws that regulate compliance with MHPAEA: M.G.L. Chapter 176G, Section 8 (Commercial), Chapter 224 of the Acts of 2012, Section 254 (Commercial), 211 CMR 154 (Commercial), Chapter 224 of the Acts of 2021, Chapter 177 of the Acts of 2022, Section 265 (MassHealth), 130 CMR 450.123 (MassHealth), MassHealth Accountable Care Partnerships Plan Contract, Sections 6.3.A.1 – 6.3.A.2, and MassHealth Senior Care Organization Contract, Sections 2.1.B – 2.1.C.

The Company also provided the *Parity Compliance Program Procedures* document. The purpose of this policy is to set out Fallon's parity compliance program and describe the processes by which this program ensures comparable coverage for benefits to treat mental health and substance use disorders. The policy outlines the workgroups of individuals in Fallon's workforce that are responsible for assessing parity compliance on an ongoing basis.

Based on the review, the Company meets the Massachusetts statutory and regulatory requirements regarding compliance with MHPAEA.

VII. QUANTITATIVE TREATMENT LIMITATIONS

The Company must demonstrate that QTL testing was conducted with indicators for pass/fail.

Examination Procedures Performed: The examiners reviewed the data to determine if the QTL testing was complete. Further, INS reviewed the data to:

a) ensure the Company provided testing results (pass/fail),
b) verify if the Company reported fail in any one or multiple categories,
c) verify if the QTL analysis included the substantially all testing,
d) verify if the QTL analysis includes predominant testing, and
e) verify if the Company demonstrated that the substantially all testing (2/3 threshold) was completed before the predominant testing.

Examination Conclusions: The Company provided a spreadsheet with testing results for all 2023 plans sold in the individual market. Fallon Health currently offers only one commercial HMO product, called Community Care. All plans listed on the provided spreadsheet are variations of the Community Care plan design. Community Care is sold only in the individual and small group markets, not in the large group market. Under Massachusetts state law, all plan design variations are available to both individual and small group customers.

The Company provided its QTL testing results broken down by their substantially all test for inpatient and outpatient non-office visits and predominance test for inpatient and outpatient non-office visits. The Company provided these results for their Community Care plan and included results for the following design variations: Platinum, High Gold, Low Gold, High Silver, High Silver II, Low Silver, Bronze 1, Catastrophic, CC Plan Type 1, CC Plan Type 2, and CC Plan Type 3. The test results were all reported as passed.

Based on the review, the Company meets the Massachusetts statutory and regulatory requirements regarding compliance with QTL testing.

VIII. STEP THERAPY

The Company submitted the step-therapy requirements, the number of step-therapy requests, and the number approved, denied in part, or denied in whole.

List of M/S, MH/SUD and Pharmacy Benefits Requiring Step-Therapy

Examination Procedures Performed: The examiners reviewed the data to determine if the step-therapy or fail first requirements distinguished between M/S, MH/SUD, and pharmacy. Further, INS reviewed the data to:

a) ensure the Company provided step-therapy documentation,
b) verify the Company provided step-therapy for both M/S and MH/SUD,
c) identify if any MH/SUD medications should not require step-therapy (e.g., smoking cessation) and,
d) determine if all medications within a particular class of MH/SUD medications, including generic versions, require step therapy.

Examination Conclusions: The Company stated that all items requiring step therapy are pharmacy items, although some are covered under the pharmacy benefit and others under the medical benefit.

The spreadsheet listed 34 drugs classified as medical benefits of which 33 were for M/S and one (1) was for MH/SUD. The sheet also included 174 drugs classified as pharmacy benefits, with 155 for M/S and 19 for MH/SUD.

The Company provided a combined step therapy drug list that included a total of 208 drugs, 174 pharmacy benefits, and 34 medical benefits. Of those, 188 were M/S and 20 were MH/SUD.

Based on the review of the M/S, MH/SUD, and pharmacy benefits requiring step-therapy, the Company meets the Massachusetts statutory and regulatory requirements.

Number of Step-Therapy Requests, Approved, Denied (in part or in whole)

Examination Procedures Performed: The examiners reviewed the data to determine the number of approved, partially denied, or fully denied step-therapy requests that were completed during the examination period. Further, INS reviewed the data to:

a) determine statewide averages and medians for approvals, partial denials, and whole denials,
b) determine if the Company had higher averages and medians than the statewide averages, and,
c) identify if the number/percentages of denials and partial denials are higher for MH and SUD as compared to M/S.

Examination Conclusions: The Company reported 1,008 step-therapy request determinations made in 2022, with 27.78% of these denied in whole. The Company was slightly below statewide averages for the percentage of total requests denied in whole. The original data submitted did not include a breakdown by M/S, MH, and SUD.

Subsequent Company Response: The Company provided a breakdown of the data by category and additional details on the results. Of the 724 approved requests reported in the original submission, 596 were M/S, and 128 were MH/SUD. Of the 280 denied requests reported in the original submission, 240 were M/S and 40 were MH/SUD. All four (4) of the partially approved requests reported in the original submission were M/S.

The data used to respond to this question in the original submission was drawn from two different source: OptumRx (pharmacy benefit drugs) and Magellan (medical benefit drugs). Two hundred and sixty-two (262) of the denied requests were handled by OptumRx. The OptumRx data included the following breakdowns: M/S 223 (medical necessity: 156; non-FDA: 44; plan exclusion: 18; non-formulary: 5), MH/SUD 39 (medical necessity: 31; non-FDA: 7; non-formulary: 1). All four of the partial approvals were handled by Optum Rx and were M/S (medical necessity 3, plan exclusion 1). Eighteen (18) of the denied requests were handled by Magellan. The Magellan data included the following breakdowns: 17 M/S (medical criteria not met (9), lack of admin information or benefits (6), maximum dose exceeded (1), no eligible benefits (1), and one (1) MH/SUD lack of administrative information or benefits.

IX. UTILIZATION REVIEW

The Company was requested to provide the TPAs for MH/SUD, the medical necessity guidelines criteria, and the sources for those guidelines. In addition, the Company was requested to provide the M/S, M/H, and SUD requests separated by approved, denied in part, and denied in whole, further classified by prior authorization, concurrent review, and retrospective review.

Third-Party Administrators and Medical Necessity Claim Determinations

Examination Procedures Performed: The examiners reviewed the list of third-party administrators provided by the Company. Further, INS reviewed the data to verify if:

a) the list included all TPAs and the role they play in determining medical necessity (type of claims, etc.),
b) the address was provided for the TPA vendor, and,
c) whether the TPA is affiliated with the Company or group.

Examination Conclusions: The Company did provide to the list of entities conducting medical necessity guidelines criteria for both M/S and MH/SUD

Based on the review of the third-party administrators and medical necessity claim determinations, the Company provided a sufficient response.

Medical Necessity Guidelines

Examination Procedures Performed: The examiners reviewed the utilization review medical necessity guidelines. Further, INS reviewed the data to:

a) verify that the M/S medical necessity guideline criteria were supplied,
b) verify that the MH/SUD medical necessity guideline criteria were supplied, and
c) review the medical necessity guidelines to determine if medical necessity criteria for MH/SUD are comparable to, or less strict than, those for medical/surgical care.

Examination Conclusions: The Company did provide the links to the medical necessity guidelines for all of the third-party administrators. The links supplied include Fallon Health, Care Centrix, Carelon, EviCore, Magellan and OptumRx. The documents included M/S, MH and SUD guidelines.

Based on the review of the third-party administrators' medical necessity guidelines, the Company provided a sufficient response.

Sources for Medical Necessity Guidelines

Examination Procedures Performed: The examiners reviewed the sources used for determining medical necessity guidelines. Further, INS reviewed the data to:

a) verify the list of sources used by the Company in the development of the criteria for M/S was provided,
b) verify the list of sources used by the Company in the development of criteria for MH/SUD was provided,
c) verify that the sources for M/S medical necessity criteria are consistent with scientifically based guidelines of national medical or healthcare coverage organizations or governmental agencies,
d) verify that the sources for MH/SUD medical necessity criteria are consistent with scientifically based guidelines of national medical or healthcare coverage organizations or governmental agencies, and
e) determine if the Company modified the medical necessity criteria used by a third party to be in line with Company objectives.

Examination Conclusions: The medical necessity guidelines provided by the Company include details of the sources used for making determinations.

Fallon Health: Sources used in developing criteria include CMS, MassHealth, peer reviewed literature, national society position papers, and other payors' policies (used as benchmarks in the interests of consistency and lower administrative burden for providers). Fallon Health uses proprietary criteria for adult and pediatric acute level of care reviews, molecular diagnostics (genetic testing), and spinal

procedures We do not typically modify proprietary criteria. Fallon provided their Medical Necessity Criteria and Clinical Coverage Guidelines NQTL. The guidelines are separated by inpatient, outpatient, emergency, and pharmacy benefits for medical/surgical and MH/SUD.

CareCentrix: When performing utilization management for Fallon members, CareCentrix utilizes clinical guidelines approved by Fallon. Such guidelines were not provided by a third-party source.

Carelon: Externally Developed Criteria: Medical Necessity Criteria developed and maintained by an entity (i.e., Professional association, client, state, etc.) outside of Carelon Behavioral Health. Carelon will revise internally owned National or Custom MNC. Carelon does not modify any externally owned criteria. Carelon may communicate recommendations to the owners of externally developed criteria. The policy does not state that Carelon can modify any of the criteria provided by a third-party source.

eviCore: eviCore does not use third party entities.

Magellan: The Company provided their Medical Necessity Criteria Development and Review procedure. This procedure is applicable to annual reviews or ad hoc reviews of medical necessity criteria for drugs in scope for Magellan Rx Management Specialty Pharmacy Utilization Management (UM).
OptumRx: All criteria is developed with and approved by Fallon and represents a mixture of material developed by OptumRx and material obtained from third-party sources.

Based on the review of the medical necessity guidelines, the Company's medical necessity guidelines meet the Massachusetts statutory and regulatory requirements.

Prior Authorization, Concurrent Review, and Retrospective Review

Note: Not all health insurance companies are required to perform concurrent and retrospective reviews in every instance. For example, a concurrent review typically focuses on treatments that are currently in progress. If a patient's treatment has been concluded or if the review is not pertinent to the ongoing care, a concurrent review may not be necessary. However, it should be noted that Massachusetts regulations do include requirements for concurrent review, primarily within the workers' compensation system and for health insurance carriers, to ensure the appropriateness and medical necessity of ongoing treatment, as outlined in Massachusetts General Laws, Chapter 176O, Section 12. Similarly, retrospective reviews may not be necessary in situations where the Company has made an effort to verify concurrent reviews by analyzing documentation and coding before claims are submitted, thereby ensuring accuracy.

Examination Procedures Performed: The examiners reviewed the approved, partially denied, and whole denials for prior authorization, concurrent reviews, and retrospective reviews, divided into M/S, MH, and SUD. Further, INS reviewed the data to:

a) develop averages and medians for M/S, MH, and SUD prior authorization, concurrent reviews, and retrospective reviews,
b) verify the Company supplied the prior authorization data for M/S, MH, and SUD,
c) verify the prior authorization approvals, denials, and partial denials are in line with statewide averages,
d) review the prior authorizations and determine if the percentage of denials (partial and whole) is higher for MH or SUD than M/S,
e) review the prior authorizations and determine if the percentage of denials (partial and whole) is higher for both MH and SUD combined than it is for M/S,
f) verify that the Company supplied the concurrent review data for M/S, MH, and SUD,
g) verify the concurrent review approvals, denials and partial denials are in line with statewide averages,

h) evaluate the concurrent review numbers provided by the Company and determine if the percentage of denials (partial and whole) is higher for MH or SUD than M/S,
i) assess the concurrent review data and determine if the percentage of denials (partial and whole) is higher for both MH and SUD combined than it is for M/S,
j) verify that the Company supplied the retrospective review data for M/S, MH, and SUD,
k) verify that the retrospective review approvals, denials, and partial denials are in line with statewide averages,
l) assess the retrospective review data and determine if the percentage of denials (partial and whole) is higher for MH or SUD than M/S,
m) assess the retrospective review data and determine if the percentage of denials (partial and whole) is higher for both MH and SUD combined than it is for M/S.

Examination Conclusions:
The Company provided the requested data, which showed that 100% of their SUD and MH (retrospective and concurrent reviews) were approved, while 96.95% of the MH prior authorizations were approved. Additionally, over 90% of the Company's M/S prior authorizations and concurrent and retrospective reviews were approved.

Massachusetts Attorney General Status Update Regarding the 2020 Examination

The examiners requested documentation and explanations to verify that the Companies complied with the AGO's 2020 examination. The documentation submitted to the Attorney General in response to the report was reviewed for accuracy and completeness. The examiners also requested additional information as part of the review. The recommendations from the AGO's report included details in the areas of network adequacy and utilization review.

Network Admission Standards

Please provide the last annual report submitted to the AGO on or before April 1, 2023, regarding:

- All substantive changes to the methodologies used to determine Base Rates,
- The MH/SUD and M/S Base Rate fee-for-service schedules,
- And documents sufficient to identify the factors and processes used by Fallon to determine its annual Base Rates.

Examination Conclusion: The Company provided two spreadsheets with 2023 rate reimbursements for both medical and behavioral health. The document for behavioral health entitled *01012023 Beacon-Base Rates fee schedule-FlexCare Grouper Template_Fallon_20230201.xls* lists the various procedure codes with modifiers and rates effective data from until a termination date of 12/31/2029.

The examiners reviewed the rate reimbursements and compared medical and behavioral health rates for common procedure codes for behavioral health, including 90837, which is a 60-minute psychotherapy session, and 90791 an initial psychiatric evaluation without accompanying medical services. The rates were similar and, in many cases, the exact same rate for services performed by a clinical psychologist.

Network Adequacy

Please provide a summary of the modifications made and implemented by the Company to comply with the recommendations from the 2020 Attorney's General findings, including:

- Adding the ability for consumers to view outpatient services,
- Ensure accuracy of provider information in provider directories and company website searching,
- Remove locations for providers where they do not provide health services, and
- Update provider information to distinguish that not all providers accept all plans.

Examination Conclusions: The Company did not provide a response to question 33. The examiners were able to conduct searches on the Company website and found that outpatient services are in the drop-down for searching for a provider on the website. The website search tool also allows members and the public to select their plan before searching. The Company is using CAQH for updating its provider data.

In addition, please provide documentation showing the recommendations from the 2020 Attorney General's findings to the provider directory which have been implemented, including:

- Disclose the date on which the electronic Directory was last updated and the date of printing of any paper Directory,

- State the circumstances under which a Health Care Professional will be designated in the Provider Directories as "accepting new patients,"
- Disclose how consumers should report Provider Directory inaccuracies, including a customer service telephone number and an electronic link that members may use to notify Fallon and Beacon via e-mail of inaccurate Provider Directory information,
- Provide notice to consumers that they may file complaints relating to Provider Directory inaccuracies or Provider network access issues to DOI, including the contact information and method for filing such a complaint with DOI,
- Disclose when information in an electronic Provider Directory has been designated "unverified,"
- Explain that such "unverified" information may not be current but updated information has not yet been obtained,
- Disclose how consumers should report Provider Directory inaccuracies, including a customer service telephone number and an electronic link that members may use to notify Fallon and Beacon via e-mail of inaccurate Provider Directory information,
- Allow members to search for and identify each Health Care Professional in their networks individually (regardless of whether they see patients as solo practitioners or as part of a group practice); where applicable, identify each Health Care Professional in a listing that is separate from a listing for that Health Care Professional's group practice,
- For each Health Care Professional, list their Practice Location as indicated and supplied by the Health Care Professional (or, as applicable, the Designated Contact for such Health Care Professional), and
- Not list that Health Care Professional as practicing at other physical addresses of a group practice that have not been reported by the Health Care Professional.

Examination Conclusion: The Company provided examples and screenshots to substantiate all the Attorney General's requests related to the provider directory. The examples included both evidence for the electronic provider directory and the printable provider directory.

Please provide the provider directory's most current MH/SUD Care Provider audit.

Examination Conclusion: The Company provided the most current MH/SUD provider directory audit. The report includes percentage correct, percentage of deficiencies, total corrections and total deficiencies. The sources evaluated include CAQH overall, Connects, Flexcare, and Carelon. The report was from the third quarter of 2023.

Subsequent Company Actions: The Company provided more recent examples of provider directory audits that demonstrate improved accuracy. The Company conducts monthly audits.

Please provide an example of the most current printed provider directory (PDF) that includes the following fields:

For each Health Care Professional

1. Name
2. Gender (to the extent provided by the Health Care Professional)
3. Practice Location(s)
4. Provider type
5. Specialty, if applicable
6. Whether they are accepting new patients
7. Group practice affiliation(s)
8. Facility affiliations, if applicable

9. Languages spoken other than English, if applicable
10. Services provided
11. Population served
12. Telephone contact information, and
13. Relevant board certification(s).

For hospitals

1. Hospital name
2. Hospital type
3. Participating in hospital location
4. Relevant accreditations, and
5. Telephone contact information.

For Facilities other than hospitals

1. Facility Name
2. Facility type
3. Participating Facility location(s), and
4. Telephone contact information.

Examination Conclusion: The Company provided screenshot images for both the facility and health practitioners from their electronic provider directory online. The images included all the required criteria, however, these were for the online directory and not for the PDF of the printed provider directories. Federal requirements 45 CFR § 156.230 - Network adequacy standards (b) (1) requires a provider directory to be available "online in accordance with guidance from HHS *and to potential enrollees in hard copy upon request*."

Subsequent Company Actions: The Company provided an example of the printed provider directory which included providers and facilities. The details from the printed provider directories for individuals include all of the required fields listed above including basic demographics, languages, specialties, and whether the provider is accepting new patients. The example page from the printed provider directory for facilities include the required demographic data and also whether the facility has a Joint Commission Accreditation.

Please confirm that the criteria listed in question 36 are also available in the electronic directories in a searchable format or can filter the search results.

Examination Conclusion: The Company provided screenshot images for both the facility and health practitioners from their electronic provider directory online. The images included all the required criteria.

Utilization Review

Please provide a summary of the modifications made and implemented by the Company to comply with the recommendations from the 2020 Attorney General's findings, including that the Company shall disclose their Utilization Management policies and procedures, including requirements relating to prior authorization and notice, in Member documents, provider manuals, internal policies, and on websites. Please provide examples of the following disclosures:

- Shall maintain and have the ability to produce data sufficient to monitor compliance with MHPAEA and its regulations, including, without limitation, denials and modifications of initial requests for authorization; outcomes resulting from concurrent review (i.e., utilization review of ongoing services), including denials and modifications of request for continued

treatment; days and/or visits authorized at each review; and frequency of concurrent reviews conducted,

- Notification that Members do not ever need prior authorization to be admitted as an inpatient to a Facility from a licensed emergency department to receive Behavioral Health Care,
- Notification that Routine Behavioral Health Care Services do not require prior authorization,
- Identification of prior authorization processes and requirements applicable to all Behavioral Health outpatient services that are not Routine Behavioral Health Care Services,
- For Fallon plans and Members covered by Chapter 258, notification that Members' coverage for SUD is subject to the provisions of Chapter 258, that initial authorization for SUD treatment is not required; and that Acute Treatment Services and Clinical Stabilization Services treatment will be covered for up to a total of fourteen days without authorization or medical necessity review,
- Inpatient Services: shall not require Members to obtain prior authorization to be admitted to a Facility to receive mental health inpatient treatment after treatment in an emergency department, even if temporarily placed in an interim M/S bed regardless of whether the Member has been stabilized,
- Outpatient Services: shall not require Members or Providers to obtain prior authorization to initiate or continue Routine Behavioral Health Care Services. Accordingly, Fallon and Beacon shall discontinue the existing practice of requiring prior authorization for a Fallon Member's further treatment with a Health Care Professional after eight Initial Encounters for Routine Behavioral Health Care Services,
- Outpatient Services: shall ensure that the processes, strategies, evidentiary standards, or any other factors Fallon and Beacon consider in developing, implementing, and applying Utilization Management techniques concerning outpatient Behavioral Health Care, including whether and to what extent such techniques will be used, shall be comparable to, and applied no more stringently than, those applied with respect to MIS outpatient services. Further, Fallon and Beacon shall document-the processes, evidentiary standards and other factors used to develop and apply Utilization Management techniques for outpatient Behavioral Health Care and how such processes, evidentiary standards, and other factors were applied comparably with respect to Utilization Management techniques used for outpatient M/S care,
- No longer requiring members to obtain authorization for the continuation of certain routine Outpatient Behavioral Health Services beyond eight office visits while authorization requirements were not applied comparably for M/S office visits, and
- No longer requiring Members who had been stabilized after emergency treatment to obtain prior authorization before being admitted for certain inpatient mental health care. Authorization requirements were not applied in a comparable way for Members admitted to the hospital from the emergency room for M/S inpatient care.

Examination Conclusion: The Company provided their MHP data template submitted to the Massachusetts Division of Insurance, as well as documentation stating the company's commitment to monitoring and complying with MHPAEA, such as QTL and NQTL analysis.

The Company also submitted updated processes and procedures indicating implementation for mental health and substance use services after treatment in an emergency department that will not require prior authorization. Further the examiners found a prior authorization form online that lists potential services requiring prior authorization and routine mental health or substance use counseling was not on that list. The Company also removed the requirement to get prior authorizations for continued routine outpatient behavioral health services beyond eight office visits.

SUMMARY

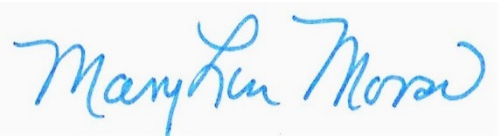
Based upon the procedures performed in this examination, INS has reviewed the Company's responses to the interrogatory which included utilization review, prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement rates, network adequacy, complaint/grievance data, information verifying compliance with MHPAEA, and denials of payment and coverage, as set forth in the 2022 Handbook, the examination standards of the Division, and the Commonwealth of Massachusetts insurance laws, regulations, and bulletins.

ACKNOWLEDGEMENT

This acknowledgment is to certify that the undersigned is duly qualified and, in conjunction with INS, applied certain agreed-upon procedures to the Company's corporate records for the Division to perform a comprehensive market conduct examination of the Company.

The undersigned's participation in this comprehensive market conduct examination as the Examiner-In-Charge encompassed responsibility for the coordination and direction of the examination performed, which was in accordance with, and substantially complied with, those standards established by the NAIC and the Handbook. In addition, this participation consisted of involvement in the planning (development, supervision, and review of agreed-upon procedures), communication, and status reporting throughout the examination, administration, and preparation of the examination report.

The Division acknowledges the cooperation and assistance extended to all examiners by the officers and employees of the Company during the comprehensive market conduct examination.



Commonwealth of Massachusetts
Division of Insurance
Boston, Massachusetts

The INS Companies
Market Regulation Division
Dallas, Texas

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