THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Limited Scope Market Conduct Examination of

Massachusetts General Brigham Health Plan Inc.
Massachusetts General Brigham Health Insurance Company

Boston, Massachusetts

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

NAIC COMPANY CODES: 11109 AND 16375

EMPLOYER ID NUMBERS: 04-2932021AND 83-0970929

TABLE OF CONTENTS

ACRONYMS 5
BACKGROUND 5
SCOPE OF EXAMINATION 6
EXAMINATION APPROACH 6
EXECUTIVE SUMMARY 7
Required Company Corrective Action 7
I. COMPLAINTS/GRIEVANCES 8
Closed Consumer Complaints 8
Closed Provider Complaints/Grievances 9
II. MARKET CONDUCT ANNUAL STATEMENT 9
III. DENIAL OF PAYMENT AND COVERAGE 10
Third-Party Administrator Claims Processing 10
Policies and Procedures Related to Claim Denials 11
M/S, MH and SUD Claims Received, Paid, Denied (in part or in whole) 12
IV. NETWORK ADEQUACY 13
Policies and Procedures Compliance with Federal Requirements on Provider Data Accuracy 13
List of Massachusetts Plans Subject to Mental Health Parity in 2022 14
Basic Web Searches 14
V. NETWORK ADMISSION STANDARDS 15
Network Admission Standards Policies/Procedures Data Submitted 15
Reimbursement Rate Policies 15
Number of Network Admissions During the Period (M/S, MH and SUD) 17
VI. POLICY AND PROCEDURES FOR COMPLIANCE WITH MHPAEA 17
VII. QUANTITATIVE TREATMENT LIMITATIONS 18
VIII. STEP THERAPY 18
List of M/S, MH/SUD and Pharmacy Benefits Requiring Step-Therapy 18
Number of Step-Therapy Requests, Approved, Denied (in part or in whole) 19
IX. UTILIZATION REVIEW 20
Third-Party Administrators and Medical Necessity Claim Determinations 20
Medical Necessity Guidelines 20
Sources for Medical Necessity Guidelines 21
Prior Authorization, Concurrent Review, and Retrospective Review 22
XI. Massachusetts Attorney General Status Update Regarding the 2020 Examination 23
Network Adequacy 24
Utilization Review 25

SUMMARY 26
ACKNOWLEDGEMENT 27

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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 **Massachusetts General Brigham Health Plan Inc. and Massachusetts General Brigham Health Insurance Company** ("Companies" or "Massachusetts General Brigham"). The examination included but was not limited to the company's 2022 calendar year health insurance business in Massachusetts.

The Companies home office:

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Somerville, MA USA 02145-1446

The following report thereon is respectfully submitted.

ACRONYMS

American Board of Preventive Medicine (“ABPM”)
American Board of Psychiatry and Neurology. (“ABPN”)
American Osteopathic Association (“AOA”)
American Society of Addition Medicine (“ASAM”)
Behavioral Health (“BH”)
Better Business Bureau (“BBB”)
Centers for Medicare & Medicaid Services (“CMS”)
Clinical Technology Assessment Committee (“CTAC”)
Clinical Quality and Operations Committee (“CQOC”)
Community Based Acute Treatment (“CBAT”)
Consolidated Appropriations Act (“CAA”)
Council for Affordable Quality Healthcare (“CAQH”)
Director of Behavioral Health (“DBH”)
Durable Medical Equipment (“DME”)
InterQual (“IQ”)
INS Regulatory Insurance Services, Inc. ("INS")
Intensive Community Based Acute Treatment (“ICBAT”)
Legal, Regulatory Affairs & Compliance (“LRAC”)
Massachusetts Attorney General’s Office (“AGO”)
Massachusetts Division of Insurance (“Division”)
Massachusetts General Brigham Health Plan (“MGBHP”)
Market Conduct Annual Statement (“MCAS”)
Market Regulation Handbook ("MRH” or “the Handbook")
Medical Review Institute of America (“MRIoA”)
Medical/Surgical (“M/S”)
Mental Health (“MH”)
NAIC Company Codes (“Cocodes”)
National Association of Insurance Commissioners ("NAIC")
Non-Quantitative Treatment Limitation (“NQTL”)
Obstetrics and Gynecology (“OB-GYN”)
Office of Patient Protection (“OPP”)
Optum Behavioral Health Solutions (“OBHS”)
Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (“MHPAEA”)
Pharmacy Benefit Managers (“PBMs”)
Prior Authorization (“PA”)
Program of Assertive Community Treatment (“PACT”)
Quantitative Treatment Limitation (“QTL”)
Substance Use Disorder (“SUD”)
System for Electronic Rate Form Filing (“SERFF”)
Third-Party Administrators (“TPAs”)
United Behavioral Health (“UBH”)
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.

COMPANY STRUCTURE AND RECENT NAME CHANGES

Mass General Brigham is an integrated healthcare system originally formed in 1994 as Partners HealthCare through the merger of Massachusetts General Hospital and Brigham and Women's Hospital. Neighborhood Health Plan, which began as a Medicaid-focused health plan, joined Partners HealthCare in 2012, and was later rebranded as AllWays Health Partners in 2019 to reflect this integration. As of January 1, 2023, AllWays Health Partners officially changed its name to Mass General Brigham Health Plan ("MGBHP") to further signify its deep connection to the health system. Within this report, the Company references AllWays Health and also MGBHP which includes both legal entities Massachusetts General Brigham Health Plan Inc. and Massachusetts General Brigham Health Insurance Company.

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 required company corrective actions as a result of this examination.

I. COMPLAINTS/GRIEVANCES

Closed Consumer Complaints

The interrogatory requested a summary log of all closed consumer complaints submitted directly to the Company by consumers 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: INS reviewed the complaint summary log for MHPAEA compliance and identified complaints and grievances related to potential network adequacy insufficiencies. INS also inquired whether there were processes and procedures in place with third-party administrators to ensure all complaints were correctly reported. Further, INS:

a) reviewed the Companies complaints and grievance registers to identify if there was a lack of in-network providers,
b) reviewed the Companies complaint and grievance register to identify if there were sufficient in-network providers for M/S, MH, and SUD,
c) reviewed the Companies complaint/grievance registers to detect any identifiable trends for out-of-network denials,
d) reviewed the Companies 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) inquired if there were policies and procedures in place for any third-party administrators (especially those handling MH/SUD) to report complaints/grievances to the Companies, and
f) reviewed to determine the final number of complaints and identify those that were of potential concern.

Examination Conclusions:

Massachusetts General Brigham Health Insurance Company reported eight (8) consumer complaints received from any source for 2022. Of these, five (5) complaints were related to mental health and/or substance use disorders. The complaints cite the claim payment process (2), inaccurate information given by United Behavioral Health ("UBH") (1), the attitude of UBH staff (1), and the availability of specific provider/service (1). Out of the five (5) complaints, four (4) were unsubstantiated and one (1) was substantiated. Additionally, three (3) medical complaints involved reimbursement for OON provider, billing issues, and the timeframe for claim adjustment.

Massachusetts General Brigham Health Plan Inc. reported 53 consumer complaints, 51 grievances, and seven (7) appeals. There were 13 grievances about the care that they received, and two (2) grievances and one (1) appeal related to MH/SUD disorders. These alleged coverage issues for outpatient mental health treatment services with out-of-network providers (overturned), lack of access to a therapist who is taking patients (multiple therapists cancelled appointments), and unresolved claims for treatment (no resulting enforcement action).

Subsequent Company Actions: The Companies have implemented several measures to ensure the accuracy of their provider directory. The health plan has launched a secret shopping program in which MGBHP staff contact provider groups to verify directory information and report any necessary updates. Customer Service performs daily audits of the directory to identify and correct discrepancies. In addition, MGBHP has developed a system that allows providers and facilities to directly attest to and update their demographic information through the provider portal, with verified changes flowing into the core system. The health plan also obtains individual provider data from CAQH to maintain up-to-date records. Within Provider Enrollment, a monthly quality-control review is conducted to verify transaction accuracy.

Provider Enrollment has also introduced self-service functionality on the Provider Enrollment Portal, enabling providers to submit updates directly to the health plan.

Closed Provider Complaints/Grievances

The interrogatory requested a summary log of all closed provider 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 AGO, the BBB, MyPatientsRights.org, and the OPP.

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

a) reviewed the Companies complaint/grievance registers to identify whether there were sufficient in-network providers.
b) reviewed the Companies complaint/grievance registers to identify whether there was a lack of in-network providers for M/S, MH, and SUD.
c) reviewed the Companies complaint/grievance registers to identify whether there were trends for out-of-network denials.
d) reviewed the Companies 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) inquired if there were policies and procedures in place for any third-party administrators (especially those handling MH/SUD) to report complaints/grievances to the Companies, and
f) reviewed to determine the final number of complaints and identify those of potential concern.

Examination Conclusions: Massachusetts General Brigham Health Insurance Company reported two (2) provider complaints received from any source for 2022. Both complaints relate to behavioral health and alleged problems with the claim payment process. Of these, one (1) complaint was substantiated, and one (1) was unsubstantiated.

Massachusetts General Brigham Health Plan Inc. did not provide any provider complaints from any source for 2022.

Massachusetts General Brigham Health Insurance Company reported two (2) provider complaints received in 2022. Both complaints are related to behavioral health and alleged problems with the claim payment process.

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 addendums were filed about the accuracy of the MCAS data.

Examination Conclusions: Massachusetts General Brigham Health Plan has reviewed the data submitted for Prior Authorizations (Pharmacy and Excluding Pharmacy), as well as the External Review data for both In-Exchange and Out-of-Exchange. The MCAS data submitted was accurate at the time of filing and remains accurate with the following revision. While validating the data submitted, the Company's Appeals & Grievances Team identified 4 cases that were initially reported as internal appeals that have since been reclassified as external appeals. Therefore, there are now seven (7) external adverse determinations in total and four (4) fewer internal appeals cases.

Massachusetts General Brigham Health Insurance Company has reviewed the data submitted for Prior Authorizations (Pharmacy and Excluding Pharmacy), as well as the External Review data for both in-exchange and out-of-exchange. The Company confirmed that the MCAS data obtained from the Company files for MCAS is accurate, and in 2022, they only wrote large group out-of-exchange.

The examiners did note that for Massachusetts General Brigham Health Plan 32% of the in-exchange prior authorizations Prospective Utilization Review Requests) Pharmacy Only were denied, and 39% of the Out of Exchange - Prior Authorizations (Prospective Utilization Review Requests) Pharmacy Only were denied.

Subsequent Company Actions: Massachusetts General Brigham Health Plans reviewed their 2023 and 2024 filings in the Market Conduct Annual Statement related to the number of internal and external appeals and confirmed the data is accurate.

III. DENIAL OF PAYMENT AND COVERAGE

Third-Party Administrator Claims Processing

The companies 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 Companies group or an outside vendor) is used for pharmacy claims, and
c) whether a PBM is utilized.

Examination Conclusions: The Companies provided a list of two entities that perform independent claim/benefit determinations, Optum Behavioral Health Solutions ("OBHS") manages the mental health

and substance use disorder services and CVS Caremark is the Pharmacy Benefit Manager. Neither of the entities are affiliated with the Companies.

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 Companies have adequate processes and procedures for claims processing,
b) if the Companies write 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 Companies 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:

Massachusetts General Brigham Health Plan Inc.

Optum provided their processes and procedures for Physician Authorization review and outpatient services, revised on 8/02/2022. The procedure helps determine whether an accommodating authorization exists for an out-of-network provider or an individual authorization. Optum provided their procedure for ER services, revised on 10/19/22. The procedure provides general instructions for consistent and accurate processing of ER services.

Optum provided their *All Facility Treatment* procedure, last revised on 12/15/22. The procedure provides general instructions for the consistent and accurate processing of inpatient, partial, intensive outpatient, and residential treatment claims.

Allways Health Partners provided their procedures for processing outpatient services. The procedures include reasons and steps for denying claims, such as incorrect bill type, unauthorized inpatient stays, non-covered charges, and prior authorization requirements for clinics, treatment rooms, or SDC. Allways also outlined their procedures for handling claims related to outpatient observation services, inpatient room and board, and dental services.

Allways provided four (4) versions of their Utilization Authorization & Referrals general processing.
CVS NovoLogix provided instructions for processing their claims, updated on 3/17/2022. Only Home Infusion Specialists process these claims due to the requirement for special review to ensure authorizations are correctly calculating the number of units, dosage, frequency, and unit of measurement conversions.
The Company provided their procedure on how to process "J3490 Unclassified Drug and J3590 Unclassified Biologics procedure codes" that pend for pricing, revised on 4/18/2022.

The Company also provided its Claims Adjudication procedure, effective on 11/20/2017 and revised on 10/17/2023. The procedure explained that a favorable or partially favorable determination of a provider request for review will result in an adjusted claim. Partially favorable and unfavorable determinations result in a denial letter mailed to the provider. Provider determination letters are sent out by US Mail, and they are mailed one (1) business day after the determination date.

Massachusetts General Brigham Health Ins Co

They all provided the same documentation as reported above but also provided the following:
Allways Health Partners provided their PPO Claims processing procedure on how to process PPO Legacy and PPO Plus that pend for Edit 6003(MultiPlan pricing), 6004 (MultiPlan cannot price), & 6005 (PPO Plus provider contract pending).

The Companies and their third-party administrators provided their claim handling processes and procedures. Many of the denial procedures appear to be manual. The *5_MgbHP_cbsNovologix_updated 3.17.2022.pdf* document mentions that drugs billed with injection must have a prior authorization. The examiners could not find whether all injectables require prior authorization or if there are any exceptions for injectables such as Insulin, Epinephrine (Adrenalin) used for severe allergic reactions, Glatiramer (Glatopa), a generic injectable for MS, and generic vaccines.

Subsequent Company Actions: The Companies provided additional information regarding injectables. They clarified that Novologix's prior authorization requirements are confined to injectables for more serious conditions such as HIV, MS, Neutropenia, RA, and Sickle Cell. Examples of these injectables include Enbrel, Humira, Botox, and Cosentyx. This policy does not impact emergency injectables.

MGBHP acknowledges the examiner's observation that some denial procedures and related claim handling steps are processed manually. MGBHP does not view this observation as a mental health parity concern or violation. The Companies further clarified that they have additional controls in place to ensure timely processing of provider payments while ensuring quality review with standardized procedures.

The Company agreed that long-term reliance on manual processing is not ideal from an efficiency, accuracy, or scalability standpoint, so they will be conducting a focused review and remediation plan to reduce manual reliance and enhance automated controls over time.

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

Examination Procedures Performed: The Companies 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 outside of the statewide thresholds; however, accommodations were made to exclude entities that did not meet minimum thresholds. 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: Both Companies provided the requested information.

Massachusetts General Brigham Health Ins Co: The percentage of total denials for medical-surgical was 21.73% in 2022, slightly higher than the statewide average.

Massachusetts General Brigham Health Plan Inc.: The percentage of total denials for medical-surgical was 18.58% in 2022, slightly lower than the statewide average.

Their denial percentages for mental health and substance use were lower than the statewide average for both companies.

Massachusetts General Brigham Health Ins Co: For all claims combined, the Company reported 80.34% of all claims paid, 9.57% of all claims denied in part, and 10.09% of all claims denied in whole.

Massachusetts General Brigham Health Plan Inc.: For all claims combined, the Company reported 83.04% of all claims paid, 11.06% of all claims denied in part, and 5.90% of all claims denied in whole.

The majority of the claims denied for both companies were related to medical-surgical claims.

IV. NETWORK ADEQUACY

The Companies were asked to supply processes and procedures to demonstrate their compliance with the state and federal requirements for network adequacy. The Companies were 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 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 Companies' policies and procedures to determine if the MGBHP complied with federal requirements on provider data accuracy. The purpose of the INS review was:

a) to ensure the Companies' 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: Both Companies supplied their provider directory policies. The directory includes information on primary care providers, behavioral health providers, hospitals, specialty providers, and ancillary providers. Every 90 days, all providers whose information is on file with Council for Affordable Quality Healthcare ("CAQH") DirectAssure are notified via email to review their information and re-attest its accuracy. When a provider makes a change, the Company is notified via a transaction request in the CAQH DirectAssure system. The Companies' systems are updated in real time via PEP, and the online provider directory reflects the updates within 24-48 hours of completion. Practitioners may contact the Company at any time to report changes to their information. Additional updates may also be obtained through interactions with Provider Relations or Customer Service staff. As information is received, the Company's web-based directory is updated within 30 calendar days of receiving a provider's update request. Provider Network Operations conducts a quarterly QC sample of both physician and facility records to ensure that physicians and facilities are being properly loaded. The findings of this sample are sent to the Operations Committee quarterly for approval. The Company also provided its network adequacy policies and procedures, developed in response to federal standards, which require verification of provider data at least every 90 days, effective January 1, 2022. Outreach is conducted via the Company's bi-monthly newsletter.

Optum provided their *Consolidated Appropriations Act Provider Directory and Suppression* policy to provide a process for Optum Behavioral Health to routinely verify the accuracy of each health care provider and health care facility. The policy reports that a provider is requested to verify directory data no less frequently than once every 90 days. Any provider unable to be verified within a period of 180 days is suppressed from directory display until such time as verification is completed.

The Companies' procedures and the procedure provided by Optum are sufficient.

List of Massachusetts Plans Subject to Mental Health Parity in 2022

Examination Procedures Performed: INS reviewed the Companies' 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 Companies' response to verify:

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

Examination Conclusions: Massachusetts General Brigham Health Plan Inc. and Massachusetts General Brigham Health Insurance Company submitted a listing of all the plans for 2022. Massachusetts General Brigham Health Plan Inc. reported a total of 139 plans that were a part of the following networks, 81 were part of the Complete HMO, 21 were part of the Complete PPO Plus, 16 were part of the Choice Easy Tier HMO, six (6) were part of the Choice Easy Tier PPO Plus, six (6) were part of the Select HMO, five (5) were part of the Allies HMO, and four (4) were part of the Allies Choice HMO.
Massachusetts General Brigham Health Insurance Company reported a total of 59 plans, nine (9) were part of the Choice Easy Tier PPO Plus network and the remaining 50 plans are part of the Complete PPO Plus network.

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

Basic Web Searches

Examination Procedures Performed:
The examiners selected a plan from the Companies' list and performed a search on the MGBHP's website 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 plan's 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 Companies name provided, and
d) reported challenges encountered in the search to the Companies.

Examination Conclusions: The examiners selected the Complete PPO Plus and searched for a drug/alcohol addiction provider in the following city/zip code: 01339. The examiners selected the same plan and searched on the company website for an OBGYN.

Web Site: https://mgbhealthplan.sapphirethreesixtyfive.com

Observation: It should be noted that 57 OBGYNs were listed, and 41 of those were flagged as the providers' demographic information has not been verified within the last 90 days. The Companies should

continue to update their provider data for accuracy.

V. NETWORK ADMISSION STANDARDS

The Companies 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 Companies are using a TPA or another vendor for MH/SUD. If the Companies 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: United Behavioral Health's Credentialing plan included the following minimum requirements for participation.

- Physicians (M.D.'s and D.O.'s) must graduate from allopathic or osteopathic medical school and successfully complete a psychiatric residency program or other clinical training and experience as appropriate for specialty and scope of practice, as determined by the Credentialing Committee.
    a. If the physician indicates they are board certified, UBH will Primary Source Verify board certification, but need not Primary Source Verify each level of education and training if the certifying board has already Primary Source Verified it. If the physician is not board-certified, then Primary Source Verification of the highest level of education listed on the Application is required.
- Physician Psychiatrist may be board certified by the American Board of Psychiatry and Neurology. ("ABPN"), the American Osteopathic Association ("AOA") Board of Psychiatry or the American Board of Preventive Medicine ("ABPM").
- Physician Psychiatrists without a residency in Psychiatry may be accepted if they are board certified by the American Board of Preventive Medicine ("ABPM").
- Physician Addictionologists must be certified by the ABPM or have added qualifications in Addiction Psychiatry through the APBN.

Subsequent Company Action: The Companies confirmed that the provider's network admission standards for MH/SUD are not more stringent than for M/S. Both MGBHP and Optum Behavioral Health utilize CAQH in the credentialing process.

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: UBH (Optum) provided their Massachusetts *AllWays Health Partners Commercial Provider Access Standards* dated April 2022. The purpose of this policy is to establish standards to ensure that AllWays Health Partners members have appropriate access to behavioral health providers (clinicians and facilities), including services and programs, within the service delivery system, as well as access to Applied Behavior Analysis providers. It also aims to create a mechanism for monitoring availability in accordance with these standards.

UBH (Optum) provided two (2) procedures for their Annual Update of Base Rate Fee schedules for covered health services in MA, NH, CT, and ME, dated July 2021 and July 2022. The policy includes commercial base-rate fee schedules for medically necessary covered services reimbursed for commercial plan membership on a contracted fee-for-service basis. Optum-contracted providers are assigned to a specific fee schedule based on their geography as reflected by the relationship between the Centers for Medicare & Medicaid Services ("CMS") national physician fee schedule rates for the particular year and the 114 CMS geography-specific fee schedule rates.

UBH (Optum) provided its Behavioral Health National Provider Access Standards policy dated February 2021. The purpose of this policy is to establish standards to ensure that Optum®∗ members have appropriate availability of behavioral health providers (clinicians and facilities), including services and programs, within the service delivery system, and to establish a mechanism for monitoring availability against these standards.

AllWays Health Partners provided their Medicare Fee Calculation and Source File Creation, drafted in January 2019. The Medicare RBRVS file is downloaded quarterly on a calendar-year basis. This file is used primarily for MGBHP's Commercial Product physician fee schedules.

Massachusetts General Brigham Health Plan provided provider payment guidelines for out-of-network provider services. The policy states that "Covered services are defined by the member's benefit plan. The way covered services are reimbursed is determined by the Massachusetts General Brigham Health Plan in compliance with existing federal and state regulations, including the No Surprises Act for commercial claims submitted for dates of service on or after 01/01/2022. Member liability amounts may include but are not limited to copayments, deductible(s), and/or co-insurance, and will be applied dependent upon the member's benefit plan and in compliance with existing federal regulations, including the No Surprises Act."

Observations from the Review: In establishing rates, Optum explained that it uses the prior year's fee schedules as a starting point. Optum begins its annual update based on the current payment rates on its current physician fee schedules. Optum uses annual CMS RVUs and other data to update the CPT codes and to adjust the prior year's rates. CMS's annual national RVUs published in Addendum B of the Physician Fee Schedule final rule (typically released in November each year) are used as the basis to increase or decrease Optum's current fee schedule.

Optum evaluates and updates its fee schedules annually, and any adjustments indicated by the review are made to remain competitive in the marketplace and to maintain alignment with CMS RVUs.

Based on the review of the information provided by the Companies, they are in compliance with Massachusetts statutes for reimbursement rate policies and procedures.

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: Massachusetts General Brigham Health Plan Inc. and Massachusetts General Brigham Health Insurance Company provided three lists of admissions applicants. The first was a list of 1,554 behavioral health individual practitioners (1,400 mental health and 154 substance use) and eight (8) facilities (four (4) mental health and four (4) substance use) approved in 2022. There were no denials during the look-back period.

The Companies provided a second list of 4,670 new M/S providers approved/denied during the period; 4,634 were approved, and 36 were denied due to credentialing.

They also provided a list of new facilities approved/denied during the period; 95 facilities were approved, and two (2) were denied due to credentialing.

Based on the review of the network admissions, the Companies network admissions meet Massachusetts statutory and regulatory requirements.

VI. POLICY AND PROCEDURES FOR COMPLIANCE WITH MHPAEA

Examination Procedures Performed: The Companies supplied policies, procedures, and documentation to demonstrate compliance with MHPAEA. Further, INS reviewed the data to:

a) ensure the Companies have policies and procedures for ensuring compliance with MHPAEA,
b) ensure the Companies monitor/audit vendors for compliance, and
c) ensure the Companies have an organized compliance plan for MHPAEA oversight.

Examination Conclusions: Both Companies provided their Mental Health and Substance Use Disorder Parity Compliance procedure, approved on 5/01/2023. The procedure includes references to both federal and Massachusetts regulations.

The procedure reported that annually, the Mental Health Parity ("MHP") Committee initiates a formal review of the non-quantitative treatment limitations ("NQTLs") and quantitative treatment limitations ("QTLs") used in the management of health benefits. This formal review may be delegated to the Legal, Regulatory Affairs & Compliance ("LRAC") and EPMO MHP Project Team.

Annually, the MHP Committee initiates a formal review of provider reimbursement strategies to ensure compliance with the AOD's requirements. This formal review may be delegated to the LRAC and EPMO MHP Project Team.

Quarterly, or more frequently as indicated, the MHP Committee meets in accordance with the Mental Health Parity Committee Charter. These meetings aim to review, on an ongoing and timely basis, new and proposed changes to benefits, cost-sharing requirements, and clinical/network policies and procedures for

medical/surgical and behavioral health services. Annually, Massachusetts General Brigham Health Plan submits a certification to the Division of Insurance signed by the CEO and CMO stating that Massachusetts General Brigham Health Plan has completed a comprehensive review and complies with the necessary provisions of state and federal mental health parity laws, or that it identifies areas of non-compliance and corrective actions for them.

The Director of Behavioral Health ("DBH") is the primary liaison with Optum (Massachusetts General Brigham Health Plan's managed behavioral healthcare organization). It is responsible for identifying appropriate Optum representatives for input and collecting relevant documents and data that can facilitate any parity analysis.

Based on the review of the information provided by the Companies, they have supplied policies, procedures, and documentation to show the implementation of MHPAEA compliance.

VII. QUANTITATIVE TREATMENT LIMITATIONS

The Companies 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 Companies provided testing results (pass/fail),
b) verify if the Companies 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 Companies demonstrated that the substantially all testing (2/3 threshold) was completed before the predominant testing.

Examination Conclusions: Massachusetts General Brigham Health Plan and Massachusetts General Brigham Health Insurance Company provided an excel document that included QTL testing of the following top 5 most popular group plans in Massachusetts General Brigham Health Insurance Company.

The examiners reviewed the QTL analysis documentation provided by the Companies. QTL testing requires the analysis to be broken down by the required six criteria for QTL predominant testing, including: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency, and prescription drugs. The Companies did provide the required QTL testing, and all their plans passed. They also provided information on whether substantially all testing had been conducted before the predominant testing.

Based on the information provided by the Companies, they demonstrated the QTL testing was complete.

VIII. STEP THERAPY

The Companies submitted the step-therapy requirements, the number of step-therapy requests and how many were 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 Companies provided step-therapy documentation,
b) verify the Companies 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 Companies reported that their processes and strategies for developing and applying step therapy to drugs used to treat MH/SUD conditions do not differ from those for drugs used to treat M/S conditions. The same types of sources and evidentiary standards are used when considering those factors. No more weight is given to one factor or evidentiary standard over another when applying step therapy to drugs in the Med/Surg category. The Companies provided their Tier 3, Tier 4, and Tier 6 Step drug lists.

The Companies provided an itemized list of step therapy treatments, including drug, Prior Authorization ("PA") class, request type, decision, and fail first requirements/explanations. The majority of the PA classes include 645: topical corticosteroids; 321: acne-rosacea, 136: opioids ER; 95: hypnotics; 71: overactive bladder agents; 60: ophthalmic steroids; 57: Caplyta, Fanapt, Latuda, Secuado; 50: PPI's; 49: incretin mimetics; 43: testosterone products; 40: Soolantra; and 40: glaucoma.

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 Companies 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: Massachusetts General Brigham Health Plan Inc. reported that of the 65 total step claims, 21 did not provide a response. The Company broke the numbers down by M/S, MH and SUD. Of the total prior authorizations, the approval for M/S was 36.5%, for MH it was 33% and for SUD it was 100% approval. It should be noted that the numbers are small so the percentage values may appear skewed.

Massachusetts General Brigham Health Insurance Company reported that of a total of 1,623 total step claims, 602 did not provide a response. The Company broke the numbers down by M/S, MH and SUD. Of the total prior authorizations, the approval for M/S was 31.8%, for MH it was 42.9% and for SUD it was 44% approval.

Subsequent Company Actions: The Companies explained that they recently changed their Pharmacy Benefit Manager ("PBM") from CVS to Optum Rx effective January 1, 2024. For step therapy denials, a notification will be sent to the member and provider explaining why the request was denied. The notification may result in a reconsideration/appeal request or a change in product prescribed by the provider for the member. No response would populate if a reply was not received in response to the denial and comments sent to the member and provider. Any cases lacking a response would be closed, however, the member or provider could still submit a new request as a reconsideration.

IX. UTILIZATION REVIEW

The Companies were requested to provide the TPAs for MH/SUD, the medical necessity guidelines criteria, and the sources for those guidelines. In addition, the Companies were 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 Companies. 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 Companies or group.

Examination Conclusions: The Companies provided a list of all third-party entities involved in MH/SUD or M/S benefit determinations and the claims they oversee.

- Optum Behavioral Health Solutions manages the mental health and substance use disorder services for its members. They contract and maintain a network of providers, conduct utilization reviews, and process claims.
- CVS Caremark (Including Novologix) is the Pharmacy Benefit Manager for the Company's fully insured members. They contract and maintain a network of pharmacies, conduct utilization review/step therapy review, and process claims.
- CareCentrix reviews requests for sleep studies and DME for sleep-related conditions.
- EviCore reviews requests for outpatient services for molecular and genetic testing.
- Medical Review Institute of America ("MRIoA") performs determinations/decisions for medical necessity for applicable specialty services.

The information provided by the companies was sufficient for third-party administrators.

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: Mass General Brigham Health Plan, Inc. provided links to medical necessity guidelines and criteria.

The Companies also provided the link for the Companies' internal documentation that outlines processing medical necessity which unfortunately was not working; however, the examiners were able to find the updated location on the Company website. Massachusetts General Brigham Health Plan, Inc. and Massachusetts General Brigham Health Insurance Company both also use clinical criteria from a nationally recognized third-party source, InterQual®, for evidence-based clinical decision support.

CareCentrix provided a list of applicable policies for Utilization Management.

EviCore provided links to multiple documents, one for special circumstances influencing coverage determinations, medical necessity review information requirements, and the development and application of medical necessity guidelines/criteria.

MRIoA leverages their medical necessity policies. No additional policies are being provided as a result.

Massachusetts General Brigham Health Insurance Company also utilizes Hayes Inc., an independent health technology assessment organization, provides assessment of the safety and efficacy of technologies.

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 Companies in the development of the criteria for M/S was provided,
b) verify the list of sources used by the Companies 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 Companies modified the medical necessity criteria used by a third-party to be in line with company objectives.

Examination Conclusions: The Companies provided the sources used for determining medical necessity.

The companies explained that licensees use an interpretation of the American Society of Addiction Medicine's ("ASAM") criteria for addictive, substance-related, and co-occurring conditions. The Companies provided the following ASAM criteria documents for adult and adolescent admissions.

Optum provided their Behavioral Health Hierarchy of Clinical Evidence dated June 2022. In circumstances where multiple contractual and/or regulatory requirements potentially apply, Optum will apply the requirement that is most beneficial and/or least restrictive to the member.

Optum also provided their Clinical Criteria Development/Selection and Application dated February 2022. Optum uses written criteria consistent with NCQA and URAC requirements, and applicable State and Federal regulations. These Clinical Criteria are objective and based on sound clinical evidence to make benefit determinations and inform discussions about evidence-based practices and discharge planning.

The examiners noted that Massachusetts General Brigham Health Insurance Company modifies the criteria using InterQual® Massachusetts General Brigham Health Plan custom content for outpatient services, DME, procedures, home care, and high-tech radiology. Modifying third-party medical necessity guidelines from independent medical societies that are objective and evidence-based could be a conflict of interest if the changes are designed to benefit the Company and delay or create additional burdens on providers.

For MH/SUD, the Clinical Technology Assessment Committee ("CTAC") assesses externally developed clinical criteria and develops and approves behavioral clinical policies for MH/SUD services. CTAC uses scientifically based clinical evidence and the Hierarchy of Clinical Evidence in its development, assessment, and approval processes. CTAC conducts its processes in a timely manner to ensure transparency and consistency, and to identify safe and effective services for MH/SUD members.

CTAC is comprised of, but is not limited to, behavioral health medical directors, senior leaders of clinical operations, research and development, clinical review, legal, compliance, policy, and other guests as needed. The Clinical Quality and Operations Committee ("CQOC") reviews and validates behavioral clinical policies/clinical criteria endorsed by CTAC. CQOC is comprised of, but is not limited to, Senior Behavioral Health Medical Directors, Senior Leaders of Clinical Operations, and representatives from the following areas: Clinical Quality Improvement Department, Utilization Management, Clinical Operations, Appeals, Legal, Compliance, Network Strategy, and Provider Experience. Qualifications of committee members include but are not limited to board-certified psychiatrists ("MD/DO"), Psychologists ("PhD/PsyD"), and behavioral health clinicians (graduate degrees and/or RN).

All MH/SUD behavioral clinical policies are reviewed annually or more frequently if appropriate.

Subsequent Company Actions: The Companies explained that there are a few scenarios where they would change the original InterQual ("IQ") third-party medical necessity guidelines to be company custom content. The first example of changes to InterQual criteria are when the subsets do not include additional services not included in the original guidelines. The second example of why an InterQual medical necessity guideline might be modified would be when the IQ subset is overly burdensome criteria that are not well supported by evidence. Additionally, the medical necessity criteria could be modified if the Companies have reviewed literature and determined that the service should be considered investigational or whether the evidence is sufficient to consider the service as covered. And finally, there may be reminders of coverage requirements that are specific to a plan or medical policy.

Based on the review of the sources for medical necessity guidelines, the sources used to determine medical necessity guidelines for M/S, MH, and SUD meet 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 Companies 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 Companies 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 Companies 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 Companies 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: Massachusetts General Brigham Health Insurance Company: The percentage of M/S concurrent reviews denied in whole was reported as 8.64%, slightly higher than the statewide average. The number of M/S retrospective reviews denied in whole was reported as 34.44%, notably higher than the statewide average. The percentage of SUD retrospective reviews denied in whole was reported as 1.19% slightly higher than the statewide average.

Massachusetts General Brigham Health Plan Inc.: The number of M/S retrospective reviews denied in whole was reported as 42.95%, notably higher than the statewide average.

Subsequent Company Actions: The Companies explained that they conduct retrospective review requests post-service and pre-claim submission.

XI. Massachusetts Attorney General Status Update Regarding the 2020 Examination

The examiners requested documentation and explanations to verify that the Companies complied with the Massachusetts Attorney General's 2020 examination. The documentation submitted to the Attorney General 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

The AGO's report requested a list of all substantive changes to the methodologies used to determine base rates, the behavioral health and M/S base rate fee for services schedule and documents sufficient to identify the factors and processes used by AllWays directly and through an MBHO, to determine its annual base rates.

Examination Conclusions: Massachusetts General Brigham Health Plan reviews its physician and outpatient fee schedules quarterly to ensure that they are current, comprehensive, and consistent with industry standards, to the extent supported by its systems. In most cases, changes involve adding fees for new or existing codes to supplement the fees already on the fee schedule.

Massachusetts General Brigham Health Plan updates its Commercial physician, ambulance, drug, DME, laboratory, radiology, and outpatient hospital fee schedules to incorporate new codes, effective January 1, each year. For Commercial plans, existing CPT and HCPCS codes will be updated annually, effective July 1, to incorporate RVU changes.

Massachusetts General Brigham Health Plan updates its Medicare Advantage fee schedules as directed by CMS. With a few exceptions, Massachusetts General Brigham Health Plan will continue to base fees on the Centers for Medicare & Medicaid Services ("CMS") and MassHealth fee schedules, adjusted to achieve the contracted level of reimbursement.

Optum provided their fee schedule maximums for the commercial line. The chart includes service code, service title/description, Fee: MD, Fee: PHD, Fee: MA, and Fee: RN. Optum also provided a chart illustrating the average allowed and fee schedule separated by average unit cost (4/1/2022-3/31/2023) and MA STD FS 6191 (Eff Dt 1/01/2023).

Optum provided their Annual Update of Base Rate Fee Schedules for Covered Health Services in MA, NH, CT, and ME dated July 2022. The Company uses the policy to annually review and update its base fee schedule reimbursement rates for Optum's network of contracted behavioral health providers. The updated policy includes the set rates for non-physician providers. It states, "once the base fee schedule rates for physicians set forth above are set, these are then adjusted for individual provider types/licensure levels as follows:

- 85% of the physician fee schedule payment amount (e.g., psychologists and nurse practitioners)
- 75% of the physician fee schedule payment amount (e.g., social workers, master's level mental health counselors)

Subsequent Company Actions: The Companies explained that the same standards are used by M/S that are used for MH and SUD. The base rate is founded on CMS standards and is an industry standard. These rates have not changed since 2022. The outlined methodology is comparable and no more stringent for MH/SUD as it aligns with CMS standards for both M/S and MH/SUD provider reimbursement.

Network Adequacy

The 2020 Attorney General's findings requested that the Companies:

- add the ability for consumers to view outpatient services, ensure accuracy of provider information (provider directories and the Companies' website), and remove locations for providers that do not provide health services,
- list of items related to ensuring the data accuracy of the provider directory, and
- provide the most current Behavioral Health Care Provider audit of the provider directory.

Examination Conclusions: The Companies supplied a series of screenshot images showing that consumers can find outpatient services through the provider directory and website search tool. The online directory is updated daily and displays the date of the most recent update, which is located in the footer of the web page. The printed directory is available upon request; however, there was no image provided containing a date last modified for the printed directory. The Companies stated that they were implementing the acceptance of new patients feature, and that was confirmed by the examiners on the online provider search tool.

The Companies provided documentation on how the plan can suppress a provider, allowing for comments and selection of an option for the suppression reason. The suppression reasons include unverified, inactive, or other.

The Companies also provided screenshots showing how a member can report data inaccuracies. There are two locations for consumers to choose from: one from the provider details screen and one from the contact us hyperlink at the bottom of the website page. There is also a phone number available for consumers to call with a complaint to the Division of Insurance.

Providers are only allowed to bill under the directory locations where they practice. However, if they do work for an affiliated group practice location, the system has an internal function that allows them to select a "Pay-To" option, which would allow for payment but not change the providers' primary business address.

Subsequent Company Action: The Companies provided an example of a printed provider directory that demonstrates compliance with the date-of-last-update requirement. The Companies also stated that consumers/members can obtain a printed provider directory by calling customer service.

Utilization Review

The AGO's report requested a summary of the modifications the Company made and implemented to comply with two utilization review recommendations. The first recommendation was to no longer require members to obtain authorization for continued routine outpatient behavioral health services beyond eight office visits while authorization requirements were not applied comparably for M/S office visits. The second requirement was to no longer require prior authorization for members who had been stabilized after emergency treatment before being admitted for certain inpatient mental health care, while authorization requirements were not applied comparably for Members admitted to the hospital from the emergency room for M/S inpatient care.

The Companies provided a document titled *Massachusetts General Brigham Health Plan Manual Addendum.* This document included a section titled, Authorization or Notification Information. Within this section, there was a list of the reported services that require prior authorization and services requiring notification to Optum but not requiring prior authorization. In addition, there was a list of services that do not require authorization or notification, along with special considerations for the Program of Assertive Community Treatment ("PACT") - Medicaid only benefits, psychological testing, and timelines for authorization decisions.

The following was reported for the services requiring notification to Optum but not preauthorization:

- Acute Inpatient Hospitalization: In Massachusetts, prior authorization is not required for emergent admissions, but providers are required to notify Optum of the member's admission within 72 hours of admission.
- Community Based Acute Treatment ("CBAT")/Intensive Community Based Acute Treatment ("ICBAT"): In Massachusetts, prior authorization is not required for CBAT/ICBAT, but providers are required to notify Optum of the member's admission within 72 hours of admission.
- Substance Use Disorder Acute and Residential (ASAM 4.0, 3.7, 3.5): Optum complies with all requirements outlined in Session Laws, Acts (2014), Chapter 258. NOTE: authorization requirements begin on day 15. SUD Residential Rehabilitation - no authorization is required for the first fourteen (14) days, but providers are required to notify Optum of the member's admission within 48 hours.

Based on the data reviewed, the Massachusetts General Brigham companies appear to be in compliance with the Attorney General's examination related to utilization review.

SUMMARY

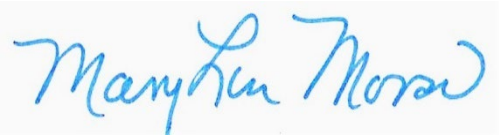
Based upon the procedures performed in this examination, INS has reviewed the Companies responses to the interrogatory which included utilization review, prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement 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 Companies' corporate records for the Division to perform a comprehensive market conduct examination of Massachusetts General Brigham.

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 Companies during the comprehensive market conduct examination.



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Commonwealth of Massachusetts
Division of Insurance
Boston, Massachusetts

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The INS Companies
Market Regulation Division
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