THE COMMONWEALTH OF MASSACHUSETTS

OFFICE OF CONSUMER AFFAIRS AND BUSINESS REGULATION

DIVISION OF INSURANCE

Report on the Limited Scope Market Conduct Examination of

Harvard Pilgrim Health Care, Inc
HPHC Insurance Company, Inc.
Tufts Health Public Plans, Inc.
Tufts Insurance Company, Inc.
Tufts Associated Health Maintenance Organization, Inc.

Boston, Massachusetts

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

NAIC COMPANY CODES: 96911, 18975, 14131, 60117 AND 95688

EMPLOYER ID NUMBERS: 04-2452600, 04-3149694, 80-0721489, 04-3319729, AND 04-2674079

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COMMONWEALTH OF MASSACHUSETTS
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MICHAEL T. CALJOUW
COMMISSIONER

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 **Harvard Pilgrim Health Care, Inc., HPHC Insurance Company, Inc., Tufts Health Public Plans, Inc., Tufts Insurance Company, Inc., and Tufts Associated Health Maintenance Organization, Inc.** ("Companies" or "Point32Health"). The examination included but was not limited to the Companies' 2022 calendar year health insurance business in Massachusetts.

The Companies home office:

1 Wellness Way
Canton, MA 02021

The following report thereon is respectfully submitted.

ACRONYMS

Acute Treatment Services ("ATS")
Agency for Healthcare Research and Quality's ("AHRQ")
American Society of Addition Medicine ("ASAM")
Applied Behavioral Analysis ("ABA")
Behavioral Health ("BH")
Better Business Bureau ("BBB")
Centers for Medicare & Medicaid Services ("CMS")
Child and Adolescent Level of Care/Service Intensity Utilization System ("CALOCUS-CASII")
Council for Affordable Quality Healthcare ("CAQH")
Consolidated Appropriations Act ("CAA")
Consumer Assessment of Healthcare Providers and Systems ("CAHPS")
Early Childhood Service Intensity Instrument ("ECSII")
Explanation of Benefits ("EOB")
Explanation of Payment ("EOP")
Food And Drug Administration ("FDA")
Harvard Pilgrim Health Plan ("HPHC")
Healthcare Effectiveness Data and Information Set ("HEDIS")
INS Regulatory Insurance Services, Inc. ("INS")
Level of Care Utilization System ("LOCUS")
Massachusetts Attorney General's Office ("AGO")
Massachusetts Division of Insurance ("Division")
Massachusetts Executive Office of Health and Human Services ("EOHHS")
Market Conduct Annual Statement ("MCAS")
Market Regulation Handbook ("MRH" or "the Handbook")
Medical Specialty Policy Advisory Committee ("MSPAC") for Point32Health
Medical/Surgical ("M/S")
Mental Health ("MH")
NAIC Company Codes ("Cocodes")
National Association of Insurance Commissioners ("NAIC")
National Committee for Quality Assurance ("NCQA")
National Imaging Associates, Inc. ("NIA")
Non-Quantitative Treatment Limitation ("NQTL")
Obstetrics and Gynecology ("OB-GYN")
Office of Patient Protection ("OPP")
Positive Airway Pressure ("PAP") Therapy
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")
Tufts Health Plans ("THP")
United Behavioral Health ("UBH")
Utilization Management ("UM")
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 Companies 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 Companies 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 Companies 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 Companies 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 MERGERS AND ACQUISITIONS

Harvard Pilgrim Health Care and Tufts Health Plan combined to form a single health and well-being organization called Point32Health on January 1, 2021. The transition to a unified organization naturally takes time to develop. As a result, some findings within this report may have evolved and consequently been corrected during the interim period between Point32Health's initial response and now.

The report notes that Harvard Pilgrim no longer delegates the management of its behavioral health benefits to United Behavioral Health (operating under the brand name "Optum"). It previously used an outsourced or "carve-out" model where Optum/United Behavioral Health managed behavioral healthcare benefits but has since insourced its behavioral health program as of November 1, 2023. As a result, Point32Health, the parent company of Harvard Pilgrim and Tufts Health Plan, now manages both medical and behavioral health care coverage and programs, including utilization and care management.

COMPANY REFERENCES WITHIN THIS REPORT

To simplify the report, the examiners reference the three Tufts Health Plan companies as Tufts Health Plan, which includes Tufts Associations Health Maintenance Organization, Inc., Tufts Health Public Plans, Inc., and Tufts Insurance Company Inc. Similarly, the examiners may reference the two Harvard Pilgrim Companies, Harvard Pilgrim Health Care, Inc., and HPHC Insurance Company Inc. as Harvard Pilgrim Health Care. If all five companies are referenced, including Tufts Health Plan and Harvard Pilgrim Health Care, these will be referenced as either the Companies or Point32Health.

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

Market Conduct Annual Statement

Examination Conclusions: The examiners noted that there could be some errors in the MCAS filings for

two of the companies based on the 2022 data. The Companies should continue to monitor the percentage of prior authorization denials for M/S and compare it to the denial rates for behavioral health.

Corrective Actions: The Tufts Health Plans must refile their MCAS filing for 2023 and 2024 to ensure that the data for rows 162-164, for out-of-exchange prior authorizations are correct.

There was a discrepancy with lines 162-164 for HPHC Insurance Company, Inc. ("HPHC".) They are updating the information, and once completed, they will resubmit the correct MCAS data. The refiling must be completed and reported to the Division by February 12, 2026.

Subsequent Company Actions: The Companies did review the MCAS data and confirmed the accuracy of the data and found there was a discrepancy with lines 162-164 for HPHC Insurance Company, Inc. ("HPHC".) They are updating the information, and once completed, they will resubmit the correct MCAS data.

Regarding the inaccuracies revealed in the Tufts Health Plans ("THP") pharmacy data, for the 2022 and 2023 submissions, THP included all submitted prior authorizations, including requests that were dismissed or cancelled (i.e. did not result in a final approved or denied status, which may occur when the request is withdrawn or some other change occurs that no longer requires the request to undergo utilization review). Based on this recommendation, THP should have only included the final approvals and denials in the total. THP is updating the data to address this and, once complete, will resubmit the MCAS data. The Companies have corrected the data for the 2023 MCAS filing.

The Tufts Health Plans have updated their MCAS filing information, but the HPHC data has not yet been corrected.

Policy and Procedures for Compliance with MHPAEA

Examination Conclusions: The Companies submitted three documents. The first document describes the steering committee responsible for coordinating and assessing the activities related to MHPAEA preparedness, including the internal review of each business area's established policies, procedures, and demonstrated operationalization of parity readiness. The committee members include individuals from the following areas: actuary, benefit/product, credentialing, compliance, finance, government affairs, health care services, legal, network, and payment integrity. The document states that the committee meets at least quarterly.

The second document is a 7-slide PowerPoint on the Mental Health Parity Workstream. It provides a high-level strategy outlining the tasks needed to achieve compliance with MHPAEA. There are references to four critical areas of focus, including written comparative analysis, data analytics, policies and tools, and detailed rationale. It also specifies which plans are included in the MHPAEA compliance efforts. Additionally, the document explains how reviews will be conducted, including the role of "Champions" who will submit data to the MH Parity Team; the review process; VP approval; submission to compliance; and final review and approval by the Legal team.

The Companies also provided a third document outlining the compliance policy and procedures, including the individuals responsible for ensuring Company compliance with MHPAEA. The committees responsible include the steering committee (executives), stakeholder committee (VPs), parity lead team (key staff from legal, compliance, government affairs, and BH), and parity champions (business area MHP leads). The document also provides more details on the six areas of review identified, including QTL compliance, NQTL comparative analysis, and other areas that could be impacted by MHPAEA

compliance. The documentation, however, is lacking certain components one would expect for MHPAEA compliance, such as analysis of geographic restrictions, network adequacy, lifetime/annual limits, provider directory accuracy, protocols for emergencies (billing), and a review of other factors or processes that ensure benefits are comparable to M/S including provisions of "meaningful benefits" in the same benefit classification.

Corrective Action:

- The Companies must update the policy and procedures to include more details, such as an analysis of geographic restrictions, network adequacy, lifetime/annual limits, provider directory accuracy, protocols for emergencies (billing), and a review of other factors or processes that ensure benefits are comparable to M/S. This should also cover provisions of "meaningful benefits" within the same benefit classification.

The policy and procedures document should include the following MHPAEA compliance-related Massachusetts statutes and regulations:

211 CMR 154.000: Enforcement of Mental Health Parity
Mass Gen Laws Chapter 15A, Section 18 (Student Health)
Mass Gen Laws Chapter 176A, Section 8A (Mental Illness Expenses)
Mass Gen Laws Chapter 176B, Section 4A (expenses for mental illness under age 19)
Mass. Gen. Laws Chapter 176O, Section 14 (Review Panel; Patient Protection Office)

The MHPAEA compliance policy and procedures document should include the following federal references:

45 CFR 147.160 Parity in mental health and substance abuse disorder benefits
45 CFR Part 146.136 Parity in mental health and substance use disorder benefits
45 CFR Part 147.136: Internal Claims Appeals and External Review Process
45 CFR Part 156.115(a)(3) Provision of EHB

This updated information should be supplied to the Division by February 12, 2026.

Subsequent Company Action: The Companies acknowledge and appreciate the recommendation to update their parity program policy and procedures with more details to include analysis of geographic restrictions, network adequacy, lifetime/annual limits, provider directory accuracy, protocols for emergencies (billing), and a review of other factors or processes that ensure benefits are comparable to M/S including provisions of "meaningful benefits" in the same benefit classification. The Companies will ensure that the policy and procedures include MHPAEA compliance requirements applicable to Massachusetts.

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: INS reviewed the complaint summary log for MHPAEA compliance and identified complaints and grievances related to alleged 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: Point32Health responded with complaints from each Company. There was a total of 2,283 consumer complaints reported in 2022, with 233 of those categorized as mental health and substance use.

Company Name	Total Consumer Complaints	MH/SUD
Harvard Pilgrim Health Care, Inc.	501	179
HPHC Insurance Company, Inc.	133	38
Tufts Health Public Plans, Inc.	305	3
Tufts Insurance Company, Inc.	63	7
Tufts Associated Health Maintenance Organization, Inc.	146	6
	2,283	233

The complaints provided by the Companies allege:

- poor access to care provider network and availability,
- incorrect billing-wrong copay,
- claims payment process,
- problems with the website not being updated with the current plan information,
- inaccurate information provided by UBH/provider/practitioner,
- no benefits for emergency out-of-network behavioral health services without prior authorization, difficulty getting prescriptions,
- claim codes not being current,
- problems seeking reimbursement for behavioral health claims, and
- the plan's online provider directory is not up to date.

The examiners noted several complaints that raised concerns with network adequacy, specifically inaccurate directories and provider availability. They expressed concern about a few complaints where some members, due to the prior authorization requirements, are denied emergency out–of–network behavioral health benefits. The examiner's initial concern stemmed from the number of complaints about the lack of complete, accurate, and current provider directories.

Based on the review of the complaint information and the subsequent Companies explanations of processes in place, Point32Health meets state and federal statutory requirements for tracking and responding to consumer complaints.

Subsequent Company Actions: The Companies provided a thorough explanation of the efforts that have been put in place to ensure complete and accurate provider directories in compliance with 42 U.S. Code § 300gg-115, Protecting patients and improving the accuracy of provider directory information, M.G.L. c. 176O, § 28 and 211 CMR § 52.15. Although the Companies could not state with certainty why there were complaints related to insufficient provider coverage from 2022, they did demonstrate efforts that are in place to ensure directory accuracy. The Companies utilize the Council for Affordable Quality Healthcare ("CAQH") Directory Manager, which gives providers a centralized platform for reviewing, verifying, and reporting changes in directory data. The CAQH tool collects attestations and any updated demographic data submitted. Providers can also report changes through the secure provider portal or by submitting changes via email using a Provider Change Form.

Point32Health states that none of the Companies involved have ever required prior authorization for emergency services in or out-of-network. All internal documents and documents given to members confirm that no prior authorizations are required for emergency services.

The Companies stated that they do not know why there were complaints related to incorrect copay amounts for BH services in 2022 but confirmed that the cost share for each plan is set up in their system for each member or employer. Furthermore, the Companies explained that they brought the administration of all behavioral health services in-house in late 2023, and these functions are now managed directly by Point32Health. When any member or provider's complaint is received, it is investigated to understand how the claim is processed against the plan's benefits. If a system coding error is found, the errors are corrected, and the claim is re-processed.

Providers participating in Point32Health are only required to complete the credentialing process once. Credentialing is conducted at the enterprise level, meaning it applies to all entities and lines of business under the Point32Health umbrella. This centralized approach ensures consistency in credentialing standards and streamlines provider onboarding processes. Once credentialed, the provider is recognized across all applicable networks for which they are contracted.

Closed Provider Complaints/Grievances

The interrogatory requested a summary log of all closed provider complaints submitted by providers directly to the Companies 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 alleged 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: Point32Health responded with complaints by each Company. There were a total of 25 provider complaints reported in 2022.

Company Name	**Total Provider Complaints**
Harvard Pilgrim Health Care, Inc.	7
HPHC Insurance Company, Inc.	1
Tufts Health Public Plans, Inc.	4
Tufts Insurance Company, Inc.	2
Tufts Associated Health Maintenance Organization, Inc.	11
	25

The provider's complaints supplied by the Companies indicate an increase in fees, denial of claims, claims incorrectly processed as out-of-network, rejected claims after moving to private practice, unpaid claims, and issues with provider credentialing. In addition, there was one claim related to medical loss ratio reimbursement. There were two complaints related to unpaid claims, related to Applied Behavioral Analysis ("ABA"). At least one other complaint was related to an audiology claim which was denied because the provider's contract did not include the related billing code. Providers typically do not need a specific "approval" for every code they use; however, a company may require prior authorization for specific codes.

In addition, several of the providers who complained assumed that once they were credentialed with one of the Tufts Health Plan companies, they were authorized to provide services across all the Tufts Health Plan companies. organizations.

Subsequent Company Actions:
The Companies confirmed that the two ABA codes referenced in the complaints have been in effect with the Companies since 2019. Both of these codes are covered by the Companies with prior authorization.

The Companies also explained that the audiology billing code required prior authorization. The Companies' system stated denial because the provider's contract does not include these billing codes means that the provider submitting the code is a non-contracted provider for this service. If the code is billed for an HMO plan, the code will be denied because the plan does not have out-of-network benefits. If the code is billed by a non-contracted provider on a PPO plan, the claim will be paid pursuant to the member's out-of-network benefits.

Observation: It is recommended that the Companies develop a process to capture providers' complaints in a searchable manner if a process is not already in place. This could help identify potentially systemic issues or provider trends.

The Companies acknowledge and appreciate the recommendation to capture provider complaints in a searchable manner. Developing this type of process will require significant effort and financial resources. At this time, the Companies must prioritize their resources and financial commitments to providing quality, affordable health care coverage.

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 Companies 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: The examiners noted that there could be some errors in the MCAS filings for two of the companies based on the 2022 data. The Companies should continue to monitor the percentage of prior authorization denials for M/S and compare it to the denial rates for behavioral health.

Corrective Actions: The Tufts Health Plans must refile their MCAS filing for 2023 and 2024 to ensure that the data for rows 162-164, for out-of-exchange prior authorizations are correct. The refiling must be completed and reported to the Division by February 12, 2026.

There was a discrepancy with lines 162-164 for HPHC Insurance Company, Inc. ("HPHC".) They are updating the information, and once completed, they will resubmit the correct MCAS data.

Subsequent Company Actions: The Companies did review the MCAS data and confirmed the accuracy of the data and found there was a discrepancy with lines 162-164 for HPHC Insurance Company, Inc. ("HPHC".) They are updating the information, and once completed, they will resubmit the correct MCAS data.

Regarding the inaccuracies revealed in the Tufts Health Plan ("THP") pharmacy data, for the 2022 and 2023 submissions, THP included all submitted prior authorizations, including requests that were dismissed or cancelled (i.e. did not result in a final approved or denied status, which may occur when the request is withdrawn or some other change occurs that no longer requires the request to undergo utilization review). Based on this recommendation, THP should have only included the final approvals and denials in the total. THP is updating the data to address this and, once complete, will resubmit the MCAS data. The Companies

have corrected the data for the 2023 MCAS filing.

The Tufts Health Plans have updated their MCAS filing information, but the HPHC data has not yet been corrected.

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

Examination Conclusions: The Companies' responses regarding third-party entities involved in claim determinations and which types of claims they processed were sufficient.

Even though the merger between Tufts Health Plan and Harvard Pilgrim Health Care occurred on January 1, 2021, the Companies were not using the same TPAs in 2022. This could make consistency problematic, especially with two unique dental benefit providers, two different PBMs, and different behavioral health providers. Research conducted by the examiners revealed that Tufts Health Plan is now utilizing Optum Rx for pharmacy benefit services, which is consistent with the PBM utilized by Harvard Pilgrim Health. According to the research, Point32Health began using OptumRx as its PBM effective January 1, 2023.

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: The Companies submitted multiple documents for each company outlining the policies and procedures for denial processes. There were three to four documents for the Harvard Pilgrim Health Care companies, and the Tufts Health Plans each submitted three documents and an example Explanation of Benefits ("EOB"). Included in the submission were documents covering appeal overviews and provider appeal overviews. The examiners observed one document supplied in the response from HPHC Insurance Company that explains denials will include coding shown on the Explanation of Payment ("EOP") to explain why the line did not pay. The processes are the same for both in-network and out-of-network claim denials, except for certain out-of-network claims priced through a vendor. In some cases, providers are directed on their EOP to contact the vendor for pricing-related disputes.

One of the documents supplied by HPHC Insurance Company details processes that may happen if the automated system does not immediately match a prior authorization to a post-service request. The document states, "specific to post-service claims that are received for services that require prior authorization, *if a procedure code on a claim requires prior authorization and the system does not match to one automatically, the claim may pend for manual review. In the event the claim pends, and the claims processor does not find an authorization to match, the claim will manually deny with the corresponding message code that will appear on the provider's EOP."* If the provider is in-network to the plan, the claim will be denied without liability to the member. The provider has the right to dispute the denial following the processes outlined in the provider manual or on the EOP.

Subsequent Company Actions: There were some documents containing hyperlinks and phone numbers that no longer work because the Companies have transitioned to different vendors. These documents have since been updated to reflect the correct point of contact, and hyperlinks have been redirected to correct webpages.

THP confirms the same processes apply to all claims submitted to the plan, regardless of the type of service. All claims may be submitted electronically or mailed in (as paper claims) for manual processing.

The Companies explained that pended claims and automatic denials are different; a pended claim always requires a manual review, whereas an auto-adjudicated one does not require any manual intervention. Furthermore, they explained Harvard Pilgrim Health Care may pend claims when specific prior authorization criteria are not met. The Plan uses multiple matching criteria to validate the authorization, including billing versus authorized provider, date of service, certain procedure code variation, and units or days. If any of these criteria fail to align, the claim may be pended for manual review. However, in most cases, a mismatch in procedure code to those included on the prior authorization will result in auto-adjudication (pay or deny), and failure of criteria to align will result in a denial for no authorization found.

The Companies also addressed situations where claims require prior authorization but lack a matching procedure code, and the provider is out-of-network. For PPO plans with out-of-network benefits, members must obtain prior authorization but may designate the out-of-network provider to seek it on their behalf. If a member does not obtain prior approval when required, coverage will only apply to those services later determined to be medically necessary, and the member will be responsible for any applicable member cost sharing. For services received from a non-plan provider, the member will also be responsible for paying the penalty amount stated in the Schedule of Benefits. If HPHC determines at any point that the service is not medically necessary, no coverage will be provided for the services received and the member will be responsible for the entire cost of those services.

For HMO plans, benefit coverage is limited to covered services in-network except for emergent/urgent care.

Although Harvard Pilgrim Health Care commercial plans use the United Healthcare network of providers

outside of their service area, the Plan processes all claims, whether received from a Massachusetts provider or a United provider. United only supplies the Plan with pricing for the claim.

The Companies also attached the denial reason codes associated with HPHC claim denials.

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: The Companies provided all the information requested for claims paid and denied, broken out by M/S, MH, and SUD. The data reported from the Companies indicated that, in general, the percentage of denials for M/S claims was higher than MH and SUD. There were, however, three companies with high denial rates for SUD, including Harvard Pilgrim Health Care, Inc., HPHC Insurance Company, Inc., and Tufts Insurance Company, Inc.

Subsequent Company Actions:

The Companies explained that when reviewing the denial percentages, they discovered that most denials are based on reasons other than medical necessity. For Harvard Pilgrim Healthcare, they found that 18% of SUD professional claims were denied because the claim was incomplete. Another 17.5% were denied because the service sought was not a covered benefit. Only 1.07% of SUD professional claims were denied because of medical necessity.

An analysis of HPHC Insurance Company denial reasons revealed similar results. 30.9% of denied professional claims were rejected due to the claims being incomplete, while 26% were denied because of a duplicate claim or coverage issues, and only 4.13% were denied due to medical necessity. Analysis of Tufts Insurance Company found that 40.2% of SUD professional claims were denied for duplicate claims or coverage issues, while only 3.6% were denied for lack of medical necessity.

The Companies monitor and will continue to monitor SUD denial rates as compared to M/S and MH to ensure parity across all plans.

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 Companies list and performed a search on their 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 Companies 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:

Harvard Pilgrim Health Care

Harvard Pilgrim Health Care submitted four documents related to the policies and procedures used to verify provider data every ninety days for Optum (behavioral health network). The Companies also explained the process used for the M/S providers, which utilizes a Push Message ("PM") distribution to all M/S providers, encouraging responses if the provider data changes.

The Companies discussed how they ensure a cohesive transition of provider data between the Companies and Optum. According to the Company, "to enable a seamless member experience, HPHC displays the behavioral health network information in HPHC's print and electronic directories." The Companies state that they attest and update the required demographic data at least every 90 days because they use the CAQH Direct Assure online tool. Providers must sign up to use CAQH ProView, to utilize DirectAssure, and to update provider directory data. There is no cost for providers to use their services.

Similar to HPHC, Optum requires its network of behavioral health providers to update practice information whenever there are changes. It also has processes in place to ensure the accuracy of such information through periodic verification and attestation, requiring providers to verify their information. The Companies also reported that Optum conducts quarterly audits of its behavioral health provider information. There is no reference in the documentation provided by Optum that these updates occur every 90 days. However, providers are supposed to notify Optum within 10 calendar days in writing of any changes to the practice information.

The Optum manual stated providers may utilize the Provider Express secure portal to access "patient and practice-specific" information to verify member eligibility and benefits, check prior authorization requirements and submit requests, get updates on claims, reconsiderations, and appeals, and more. The manual also includes details on handling emergency admissions, allowing for notification within one (1) day. The document regularly references state-specific requirements, and Appendix A has hyperlinks to Massachusetts Regulatory Requirements, Massachusetts Government Programs Regulatory Requirements, and MME Regulatory Rider.

Tufts Health Plan

The Tufts Health Plans did provide a directory auditing policy and procedure. The document outlines processes used to ensure compliance with the Consolidated Appropriations Act 2021 Section 720 (a) (2) (C). The Company utilizes CAQH Direct Assure to keep its provider database updated, which is updated twice daily. CAQH requires providers to attest every 90 days to ensure the accuracy of the data. Providers who fail to attest within 200 days will be suppressed from the directory. The document also lists the responsibilities within the organization for ensuring provider enrollment.

Based on the information provided by the Companies, they meet federal requirements on maintaining provider data accuracy.

List of Massachusetts Plans Subject to Mental Health Parity in 2022

Examination Procedures Performed: INS reviewed the Companies' responses 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:

Harvard Pilgrim Health Care

Harvard Pilgrim Health Care plans submitted all the plans subject to MHPAEA. The lists were broken down to include the full name of the plan, the name of the plan as it appears on a consumer's health insurance plan, the name as it appears on the printed provider directory, and the name of the plan as it appears when conducting searches within the online directory.

Tufts Health Plan

The Tufts Health Plans provided a list of all the plans subject to MHPAEA in 2022, divided by individual companies, with three reports. Individual companies may have two sheets, one for Massachusetts Merged Market plans and one for Large Group Plans. The lists were broken down to include the full name of the plan, the name of the plan as it appears on a consumer's health insurance card, the name as it appears on the printed provider directory, and the name of the plan as it appears when conducting searches within the online directory.

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 their 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:

Harvard Pilgrim Health Care, Inc.

The examiners reviewed the Company's annual binder filing for the service area and conducted a web search for a provider for both a substance use disorder professional and an OB-GYN.

The examiners selected the HMO Flex Plan and searched for a mental health provider in the following city/zip: 01339
The examiners selected the same plan and searched the company website for an OBGYN, but the search did not produce an OBGYN. However, the search results on the following website did provide OBGYN results.
Website: https://hphc.providerlookuponlinesearch.com/
(If a consumer opens this website and uses the link located on the far-right side of the website to have a successful search, the consumer must know precisely the type of provider they need)

The categories for searching for behavioral health providers include:
1. Applied Behavioral Analysis
2. Behavioral Health Hospital & Facility
3. Behavioral Health Group/Community Mental Health Center
4. Marriage & Family Therapy
5. Mental Health Counselor
6. Psychiatric Nurse/Psychiatric Physician Assistant
7. Psychiatry
8. Psychology
9. Social Work
10. All Behavioral Health Provider Types

There is no option for substance use disorder or autism, although there is a drop-down option for ABA.

HPHC Insurance Company, Ins.
The examiners reviewed the Company's annual binder filing for the service area. They conducted a web search for a provider for both a substance use disorder professional and an OB-GYN.
The examiners selected the ChoiceNet HMO plan and searched for an anxiety disorder provider in the following city/zip: 01370
The examiners selected the same plan and searched on the company website for an OBGYN.
Website: https://www.harvardpilgrim.org/
The closest anxiety disorder provider is 3.63 miles from 01370, and the closest OB-GYN is 4.81 miles from 01370

Harvard Pilgrim Health Care (Both companies)
Searching for certain types of providers is not intuitive. Consumers would have to know exactly what kind of mental health provider they need, and SUD providers are not listed as a category. SUD searches return only one clinic. In addition, the provider specialties should be pre-populated so policyholders can look at all the categories. The current system requires policyholders to know precisely how the provider specialties are saved in the database (e.g., OB instead of OBGYN). The default distance within the application is only 10 miles, which may limit search results.

Tufts Associated Health Maintenance Organization, Inc.
The examiners reviewed the Company's annual binder filing for the service area. They conducted a web search for a provider for both a substance use disorder professional and an OB-GYN.
The examiners selected the Advantage HMO plan and searched for a substance use disorder provider in the following city/zip: 01370
Only one entity was displayed (Community Health Care), which was 6.41 miles from 01370.
The examiners selected the same plan and searched on the company website for an OBGYN.
The closest OB-GYN is 8.2 miles to 01370
Website: https://tuftshealthplan.com/

Tufts Health Public Plans, Inc.

The examiners reviewed the Company's annual binder filing for the service area. They conducted a web search for a provider for both a substance use disorder professional and an OB-GYN.
The examiners selected the Tufts Health Direct plan and searched for a PTSD provider in the following city/zip: 01339
The closest provider was 4.8 miles away and accepting new patients.
The examiners selected the same plan and searched on the company website for an OBGYN.
The closest OB-GYN is 12.7 miles from 01339
Website: https://tuftshealthplan.com

Tufts Insurance Company, Inc.
The examiners reviewed the Company's annual binder filing for the service area. They conducted a web search for a provider for both a substance use disorder professional and an OB-GYN.
The examiners selected the Your Choice 2-Tier plan and searched for a bipolar disorder provider in the following city/zip: 01370.
The closest Behavioral Health provider is 13.2 miles from 01370.
The examiners selected the same plan and searched on the Company website for an OBGYN.
The closest OB-GYN provider is 22.5 miles from 01370
Website: https://tuftshealthplan.com/

Tufts Health Plan (all three)
The Company still references Substance Abuse, but it also includes in the drop-down search for doctors by specialty Substance Use and Substance Use Disorder. Similarly, the drop-down when searching for a doctor by specialty lists Alcohol Abuse, but it also includes Alcohol Use Disorder and Alcoholism.

Observations: The Companies should consider updating their websites to make it easier for policyholders to find providers and facilities using pre-populated categories. The Companies should consider changing the default distance to a larger value, such as 10 miles, to return more results. When evaluating the website, the Companies may also want to consider adding tools to help consumers get back more results, such as including both hospitals and substance use treatment centers when looking for SUD treatment.

Subsequent Company Actions: The Companies stated that Point32Health's current processes have adopted the use of the terminology "Substance Use Disorder" for areas of focus and specialty, consistent with CAQH data. However, some practitioners' records continue to display the legacy term "Substance Abuse." This occurs when the information mapped in internal classification codes has not yet been fully updated. Point32Health recognizes the importance of using accurate, non-stigmatizing terminology. It is actively engaged in a data clean-up initiative to align all historical records with the updated term "Substance Use Disorder". These efforts are ongoing, and we are committed to ensuring our directory reflects language that is consistent, accurate, and respectful.

The Companies also acknowledge the recommendations for updating the website and will consider them when the websites are updated.

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 to determine whether adequate 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, and
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:

Harvard Pilgrim Health Care
M/S providers must complete a letter of intent and the credentialing database form from Healthcare Administrative Solutions, Inc. The CAQH Provider Data Portal requires a completed HCAS Provider Enrollment Form, a W9, an integrated Massachusetts application (credentialing/appointment), a reference letter, a health plan contract, an enrollment requirement document list, and separate required documents for being on a hospital roster.

As of 11/1/2023, Harvard Pilgrim began insourcing behavioral health management, including network and credentialing functions, so the documentation previously provided for United Behavioral Health ("UBH") is no longer pertinent. As a result, Harvard Pilgrim did submit a set of standards for provider admission documents, which included the criteria for M/S, MH, and SUD providers as well as facilities.

The Massachusetts addendum for credentialing states that they have a goal to process 95% of initial credentialing applications that are clean and complete for all provider types within sixty (60) days of the receipt of the application. Point32Health states that credentialing and contracting can take 1-2 months (roughly 60 days), but that time frame is extended if the application is incomplete. Harvard Pilgrim's average turnaround time for making decisions on completed credentialing applications was under thirty (30) days.

Tufts Health Plan
The Companies provided one document outlining their network admission practices. The standards appear similar for both M/S and BH providers, with similar data required for both applications. The application process is divided into subcategories of physicians, licensed non-physician providers (e.g., nurse practitioners, physician assistants, psychologists, social workers), and unlicensed personnel (e.g., home health aides, qualified autism service professionals, and paraprofessionals).

According to the documentation provided by the companies related to 2022, Tufts Health Plans does not allow any physicians and licensed non-physician providers if they have opted out of Medicare.

Subsequent Company Actions: The Tuft Health Plan explained whether they do not allow applications from physicians and licensed non-physician providers who have opted out of Medicare. The Tuft Health Plan explained that the Company no longer uses UBH as their vendor as of 2023.

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: The plans submitted two almost identical documents, with a few exceptions, most notably the names of the plans. The two documents include one for out-of-network reimbursement and one for in-network reimbursement for 2022. Both documents mention that "M/S, MH, and SUD are created using strategies and evidentiary standards used in applying the NQTL comparable and no more stringently applied to MH/SUD and M/S benefits as written and in operation." Since the Plan uses the same processes for developing its M/S and MH/SUD fee schedule rates, the Plan believes these processes are comparable for purposes of analysis under MHPAEA.

The in-network document

The supporting documentation regarding bill charges, allowed amounts, and percentages comparing the allowed amount as a percentage of the charges for both MH/SUD and M/S documents was unique between Harvard Pilgrim and the Tufts Health Plans.

There was no reference in either of the documents provided by the Companies related to rate reimbursement procedures for emergency care or non-emergency services from out-of-network providers at in-network facilities. The documentation could be in another policy or procedure; however, the concern is that balanced billing consumers are explicitly mentioned for out-of-network providers. The Companies should review compliance with the Consolidated Appropriations Act of 2021, which took effect on January 1, 2022.

The out-of-network document

The changes within this document mainly related to the companies' names; however, there were differences in the reimbursement approaches for out-of-network providers. Both groups use Zelis and mention the option of doing the 85th percentile of Fair Health.

Harvard Pilgrim has two methods for calculating out-of-area reimbursement: one using Zelis and Fair Health, and another that applies a percentage of the CMS-published rates for the same or similar services within the geographic area where the provider is located. The calculation also considers other factors, including "if the Zelis rate is lower than the 85th percentile of the Fair Health Rate, the Plan pays the Zelis rate." Further, as the document outlines, "when a rate is not published by CMS for the service and no industry standard methodology applies to the service, or the provider does not submit sufficient information on the claim to pay it under CMS published rates or an industry standard methodology, the allowed amount will be a percentage of the provider's billed charge."

"Claims received from providers not contracted directly with Tufts Health Plan are sent daily to Zelis for pricing. Currently, Zelis first reviews the claim against contractual arrangements available to Tufts Health Plan (such as contracts Tufts Health Plan has through network partners, such as Cigna or Multiplan for services received outside of Tufts Health Plan's service area). Zelis reviews the pricing of these contractual arrangements to determine whether any additional industry-standard coding edits and payment policy reductions are available. If so, the edits are applied, and the claims are returned to Tufts Health Plan.

Both Plans include Harvard Pilgrim Health Care and Tufts Health Plans

The Companies documentation states that in-network providers who provide services for both M/S and MH/SUD may receive higher reimbursement for services. Offering both M/S and SUD is considered a "plus" factor by the Companies.

Subsequent Company Actions: The Companies submitted their 2024 Comparative Analysis documentation, which outlines factors considered for reimbursement for M/S, MH, and SUD providers. Considerations for rate reimbursements include factors such as the geographic market, provider education, market conditions, benchmark reimbursement data, including CMS data, and many other criteria. The analysis documentation states that providers can request rates above the applicable fee schedule for consideration. There are many references within the document footers to applicable federal MHPAEA statutes. There are also links contained in the analysis documentation to manuals for providers where the process is explained in detail depending upon the plan. These manuals include a section for behavioral health which contains state specific references for both Massachusetts and Rhode Island. These manuals also contain a publication history of changes made to the manual to include recent state and federal statute changes.

The Companies responded that they are in compliance with the No Surprises Act and that they are in the process of updating the comparative analysis related to the development of out-of-network provider reimbursement rates.

The Companies also responded that the merger of Harvard Pilgrim Health Plan ("HPHC") and Tuft Health Plans ("THP") has allowed the Companies to integrate policies, procedures, and operations to create efficiencies and implement improvements in operations and in products offered to our members and employers. HPHC and THP integrated processes related to network access, provider contracting, credentialing, and reimbursement rate development.

Point32Health is correcting the language within Harvard Pilgrim's out-of-network reimbursement documentation in *the network provider reimbursement comparative analysis document* to reflect updates to the percentage of billed charges covered. The current policy now reimburses both MH/SUD and M/S services at a uniform rate of 50% of the provider's billed

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:

Harvard Pilgrim Health Care
The Companies submitted two documents. The first document included a list of individual providers and facilities' credentialing applications that were approved. The individual providers were broken down into two categories: M/S and BH/SUD. There was a total of 9,692 individual providers, with 7,192 (74.24%) classified as M/S and 2,496 (25.75%) as BH/SUD providers. Additionally, there were 275 facilities, of which 244 (88.72%) were M/S or other facilities, and 31 (11.27%) were MH/SUD

The second document listed MH/SUD credentialed providers and facilities for 2022. It included 1,562 applicants who were all approved, with 1,554 (99.48%) being individual MH/SUD providers and eight 8 (0.51%) being MH/SUD facilities. A note at the bottom of the report stated that "there were no denials during the look-back period."

Tufts Health Plan
The Tufts Health Plans also submitted the same first document as Harvard Pilgrim, but there was no additional UBH credentialing document.

Observations: According to the reports from the Companies, every credentialing application was approved. Examiners would typically expect to see some denials, incomplete applications, ineligible applications, credential discontinuations, withdrawn applications, provider resignations, and/or no contract received. Possibly the Companies did not submit all the received applications, but instead, only the applications that were approved

The Companies should be prepared in the future to provide a list of all requests for admission to the network, including those that were not approved or had incomplete or missing documentation.

VI. POLICY AND PROCEDURES FOR COMPLIANCE WITH MHPAEA

Examination Procedures Performed: The Companies supplied policies, procedures, and documentation to show the implementation of MHPAEA compliance. 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: The Companies submitted three documents. The first document describes the steering committee responsible for coordinating and assessing the activities related to MHPAEA preparedness, including the internal review of each business area's established policies, procedures, and demonstrated operationalization of parity readiness. The committee members include individuals from the following areas: actuary, benefit/product, credentialing, compliance, finance, government affairs, health care services, legal, network, and payment integrity. The document states that the committee meets at least quarterly.

The second document is a 7-slide PowerPoint on the Mental Health Parity Workstream. It provides a high-level strategy outlining the tasks needed to achieve compliance with MHPAEA. There are references to four critical areas of focus, including written comparative analysis, data analytics, policies and tools, and detailed rationale. It also specifies which plans are included in the MHPAEA compliance efforts. Additionally, the document explains how reviews will be conducted, including the role of "Champions" who will submit data to the MH Parity Team; the review process; VP approval; submission to compliance; and final review and approval by the Legal team.

The Companies also provided a third document outlining the compliance policy and procedures, including the individuals responsible for ensuring company compliance with MHPAEA. The committees responsible include the steering committee (executives), stakeholder committee (VPs), parity lead team (key staff from legal, compliance, government affairs, and BH), and parity champions (business area MHP leads). The document also provides more details on the six areas of review identified, including QTL compliance, NQTL comparative analysis, and other areas that could be impacted by MHPAEA

compliance. The documentation, however, is lacking key components one would expect for MHPAEA compliance, such as analysis of geographic restrictions, network adequacy, lifetime/annual limits, provider directory accuracy, protocols for emergencies (billing), and a review of other factors or processes that ensure benefits are comparable to M/S including provisions of "meaningful benefits" in the same benefit classification.

Corrective Action:

- The Companies must update the policy and procedures to include more details, such as an analysis of geographic restrictions, network adequacy, lifetime/annual limits, provider directory accuracy, protocols for emergencies (billing), and a review of other factors or processes that ensure benefits are comparable to M/S. This should also cover provisions of "meaningful benefits" within the same benefit classification.

The policy and procedures document should include the following MHPAEA compliance-related Massachusetts statutes and regulations:

211 CMR 154.000: Enforcement of Mental Health Parity
Mass Gen Laws Chapter 15A, Section 18 (Student Health)
Mass Gen Laws Chapter 176A, Section 8A (Mental Illness Expenses)
Mass Gen Laws Chapter 176B, Section 4A (expenses for mental illness under age 19)
Mass. Gen. Laws Chapter 176O, Section 14 (Review Panel; Patient Protection Office)

The MHPAEA compliance policy and procedures document should include the following federal references:

45 CFR 147.160 Parity in mental health and substance abuse disorder benefits
45 CFR Part 146.136 Parity in mental health and substance use disorder benefits
45 CFR Part 147.136: Internal Claims Appeals and External Review Process
45 CFR Part 156.115(a)(3) Provision of EHB

This updated information should be supplied to the Division by February 12, 2026.

Subsequent Company Action: The Companies acknowledge and appreciate the recommendation to update our parity program policy and procedures with more details to include analysis of geographic restrictions, network adequacy, lifetime/annual limits, provider directory accuracy, protocols for emergencies (billing), and a review of other factors or processes that ensure benefits are comparable to M/S including provisions of "meaningful benefits" in the same benefit classification. The Companies will ensure that the policy and procedures include MHPAEA compliance requirements applicable to Massachusetts.

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: All the Companies provided testing results for the individual, small group,

and top five group policies. The responses for 19 (individual policies) and 20 (small-group policies) were combined into a single document. The Companies stated that the individual and small-group policies are combined because the Massachusetts Merged Market plans are tested together. In addition, the Companies provided the top five plans in response to question 21. All the plans tested passed.

The initial document submitted was a high-level overview of the QTL testing results which should have been broken down by the six criteria for QTL predominant testing. These include inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency, and prescription drugs. The analysis should include the various types of QTL, such as numeric limits (day limits or other quantitative restrictions) on mental health/substance use disorder benefits. In addition, there should be specific plan terms and benefit classifications. To comply, the comparative analysis testing should demonstrate that the QTLs imposed on MH/SUD benefits are comparable to and no more stringent than the M/S QTLs. No information was provided regarding whether substantially all testing had been conducted before the predominant testing. No details were provided, only the plan name and a designation of 'bypassed'.

Subsequent Company Actions: The Companies provided an additional 49-page document, which contained a detailed breakdown of the QTL analysis by plan. The document demonstrates the Companies' detailed analysis of quantitative treatment limits, including substantially all testing, predominant level testing and the results. The Companies also confirmed that within the quantitative mental health parity testing process, the substantially all testing is conducted prior to the predominant level testing.

Based on the Companies documentation and supplemental documentation, the Companies meet with Massachusetts and federal requirements for quantitative treatment limit testing.

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:

Harvard Pilgrim Health Care
The Companies submitted two documents that require step-therapy or fail first requirements for certain pharmacy drugs. There are no medical/surgical or behavioral health benefits subject to these requirements. The Companies stated that the plans in Massachusetts offer either the premium formulary or the value formulary for a list of pharmacy drugs that require step-therapy or fail first requirements.

Within the first document, the premium formulary, 11 drugs require step-therapy for BH/SUD.

The second document, the value formulary, includes some of the same medications as the first document, but four were omitted. All medications are the brand-name products with most having generic or other similar medications available to treat MH conditions. None of the medications requiring step therapy were for smoking cessation, opioid addiction, or substance use.

Tufts Health Plan
The Companies submitted a single document listing medications that require step-therapy or fail first requirements on certain pharmacy drugs. Within this document, the premium formulary lists 179 drugs that require step-therapy for MH/SUD. None of the medications requiring step-therapy were for smoking cessation, opioid addiction, or substance use.

There is concern that requiring step therapy or fail-first medication for Vyvanse is a potential violation of MHPAEA because it is the only FDA-approved drug for the treatment of Binge Eating Disorders.

Subsequent Company Action: The Companies provided the link to the plans' pharmacy medical necessity guidelines and also the current list of medications that require step therapy.

The Companies explained that the generic Vyvanse (lisdexamfetamine) is used both for the treatment of ADHD as well as for the treatment of Binge Eating Disorders. As of 1/1/2023, the Plan does not require step therapy for this generic drug for any indication and only requires prior authorization. The Plans cover generic Vyvanse (lisdexamfetamine) for moderate to severe binge eating disorder in adults. They will approve coverage when a documented diagnosis of binge eating disorder is present for members 18 years and older in accordance with FDA-approved labeling. There is no re-requisite first-fail requirement.

Based on the Companies documentation submitted for step therapy, they meet Massachusetts and federal 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 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:

Harvard Pilgrim Healthcare
The information supplied by the Companies appears to be accurate, with one exception: the data provided for Harvard Pilgrim Health Care, Inc. lists 851 step therapy requests approved and 563 denied, which equals 1,414 total requests, not 1,295, a difference of 119 requests.

On average, the two Harvard Pilgrim companies had a 60-65% approval rating for medications requiring step therapy. Roughly 40% to 43% of the step-therapy claims were denied.

Tufts Health Plans
The Companies reported an 80-85% approval rate for step therapy and a 15-20% denial rate.

Subsequent Company Actions: The Companies provided charts demonstrating that starting in January 2023, the pharmacy utilization management was transitioned from OptumRx to an in-house program. The subsequent years' data indicate that the denial rates have been steadily decreasing each year. The Companies also stated that it is important to note that the low number of step therapy requests can skew the results, making the percentages appear higher. The Companies noted that several factors can lead to increased denial rates, such as providers selecting brand-name medication that requires the use of a therapeutic equivalent generic medication before the Plan will authorize coverage, or denials related to lack of clinical information from the provider.

Based on the Companies response and subsequent company actions, no further review of the step-therapy requests is required.

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:

Harvard Pilgrim Healthcare
The Companies responded with a list of third-party entities involved in benefit determinations on behalf of Harvard Pilgrim Health Care including: OncoHealth, Progeny Health, NIA, Carelon, United Behavioral Health ("UBH"), and Optum RX.

- OncoHealth provides the Plan with Utilization Management ("UM") for certain high-cost oncology medical drugs. OncoHealth provides the clinical criteria for these reviews.
- Progeny Health performs UM and concurrent review on behalf of the Plan for NICU admissions. Progeny uses InterQual Acute Pediatric Nursery criteria for these reviews.
- National Imaging Associates, Inc. ("NIA") provides UM services for selecting high-tech imaging services. Modalities included in high-tech imaging delegation are MRI/MRA, CT/CTA, PET, Nuclear Cardiology, and Echocardiography/Stress echocardiography. NIA additionally performs UM for select spine surgeries, Interventional Pain Assessment ("IPA"), select hip, knee, and shoulder surgeries, and sleep studies. NIA provides the clinical criteria for these reviews.
- Carelon Medical Benefits provides UM services for select genetic and molecular diagnostic testing. Carelon provides the clinical criteria for these reviews.

- UBH administers managed care, utilization management, claims processing, and other behavioral health programming for all behavioral health services covered by the Plan. UBH provides the clinical criteria for these reviews.
- Optum Rx administers specific components of the prescription drug program as the Pharmacy Benefit Manager for the Plan. This includes contracting with local and nationwide pharmacies, a mail-order network, claims processing, benefit administration and authorization, utilization management, and customer service support. Harvard Pilgrim provides the clinical criteria.

Tufts Health Plans
The Companies responded with a list of third-party entities involved in benefit determinations on behalf of the Tufts Health Plans, including EviCore, EyeMed, NIA, Delta Dental, and Cigna Payor Solutions.

- EviCore Healthcare is a Specialty Benefit Manager that provides UM services for Sleep Testing and Positive Airway Pressure ("PAP") Therapy. EviCore provides the clinical criteria used to review these services.
- EyeMed processes claims for routine vision services.
- NIA is a specialty benefit manager with a core function of providing UM for high-tech imaging services. Modalities for high-tech imaging include MRI/MRA, CT/CTA, PET, Nuclear Cardiology, and Echocardiography/Stress echocardiography. NIA also performs UM for select spine surgery, pain management, and hip, knee, and shoulder surgeries. NIA provides clinical criteria for reviewing these services.
- Delta Dental processes claims for pediatric dental services and provides the Plan with UM for pediatric dental services. Delta Dental provides the clinical criteria used to review these services.
- Carelon Medical Benefits is a specialty benefit manager that provides the Plan with UM services for select genetic and molecular diagnostic testing. Carelon provides the clinical criteria used to review these services.

The Companies response was sufficient.

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:

Harvard Pilgrim Healthcare
The Companies provided a list of hyperlinks containing the medical necessity guidelines for OncoHealth, NIA, United Behavioral Health, Carelon, Dental Benefit Providers, Inc., Progeny Health, and Optum Rx. (Some of the links returned error pages; see below.)

Tufts Health Plan
The Companies submitted a list of hyperlinks to the medical necessity guidelines for EviCore, NIA, Carelon, and Delta Dental. In addition, the Tufts Health Plans uses its own internally developed medical necessity guidelines, which are available on its public website.

Subsequent Company Actions:
Some of the links provided by Harvard Pilgrim Healthcare were out of date or brought back error codes. The Companies explained that this was because UBH/Optum maintained the sites, and the websites are no longer active. As of November 1, 2023, HPHC no longer outsources behavioral health, and the current list of pharmacy medical necessity guidelines can be found on the public website.

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:

Harvard Pilgrim Healthcare
The Companies provided a list of hyperlinks containing the medical necessity guidelines for OncoHealth, NIA, United Behavioral Health, Carelon, Dental Benefit Providers, Inc., Progeny Health, and Optum Rx. (Some of the links returned error pages; see below.)

The link to United Behavioral Health ("UBH") included the sources the Companies have identified and used for determining medical necessity. Sources used by UBH include the American Society of Addiction Medicine(ASAM), Level of Care Utilization System ("LOCUS"), Child and Adolescent Level of Care/Service Intensity Utilization System ("CALOCUS-CASII"), Early Childhood Service Intensity Instrument ("ECSII"), American Psychological Association, and Optum Behavioral Clinical Policies, Optum Psychological and Neuropsychological testing guidelines, Applied Behavioral Analysis ("ABA") Practice Parameters, ABA for Autism Spectrum Disorders and State/Contract Specific Clinical Criteria.

The Companies consider multiple sources when developing their medical necessity criteria for both M/S and MH/SUD services. These sources include evidence-based medical literature, evidence-based clinical decision support, CMS, the Food and Drug Administration ("FDA"), the National Committee for Quality Assurance ("NCQA"), Healthcare Effectiveness Data and Information Set ("HEDIS"), the Agency for Healthcare Research and Quality ("AHRQ"), the Consumer Assessment of Healthcare Providers and Systems ("CAHPS"), the Point32Health Medical Specialty Policy Advisory Committee ("MSPAC"), and/or review by MCMC, an independent review organization, as well as subject matter experts. Additionally, the Companies evaluate state mandates, state-specific coverage positions, costs, market and competitive analysis, and considerations related to fraud, waste, and abuse.

Tufts Health Plan
The Companies submitted a list of hyperlinks containing the medical necessity guidelines for EviCore, NIA, Carelon, and Delta Dental. In addition, the Tufts Health Plans uses their own internally developed

medical necessity guidelines, which are available on its public website.

Based on the Companies response, it is unclear if the sources used for determining medical necessity for the Tufts Health Plans are the same as those identified with Harvard Pilgrim Healthcare. Although the Companies provided a link to the publicly available medical necessity guidelines for Point 32, the list of sources used to make these determinations was not provided. The link contains a quick search option for looking up medications and pharmacy guidelines for Tufts Medicare Preferred, Tufts Health Plan Senior Care Options, and Tufts Health One Care, but not HPHC or Tufts Health Public Plans.

It is also unclear if the Companies modify any of the medical necessity criteria used by a third-party to be in line with company objectives, since no third-party sources were provided for the Tufts Health Plans.

Subsequent Company Actions: The Companies have a medical necessity guidelines website that allows members and physicians to search by policy/service type and filter by category. The Companies use medical necessity criteria from several third-party sources, including InterQual, Evolent, Carelon, and OncoHealth. These criteria are generally adopted as published. Criteria from Evolent, Carelon, and OncoHealth are accessible through these vendors' respective platforms and are rarely modified by the Companies.

The Companies stated that InterQual, which is licensed by the Companies, is integrated and implemented through embedded systems or SmartSheets. Further they explained that because of this integration, minimal adjustments may be made to clarify requirements, allow certain exceptions, or remove unnecessary elements as needed to meet the needs of our members. When modifications are made, they are documented on the Medical Necessity Guideline (MNG) as appropriate and/or reflected within the embedded platform.

The Companies provided an example of a medical necessity criteria that was modified. The example was related to endoscopic sinus surgery. The InterQual criteria does not include pediatric criteria for members under the age of 18, but the Companies have added a note to the clinical guideline coverage criteria specific to members under age 18.

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 concluded or the review is not pertinent to 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 companies have 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, and
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 Companies did not initially submit the data as requested. However, they did submit an annual report to the Division comprising a breakdown of authorizations requested for M/S and behavioral health, but not by MH or SUD. A review of the data submitted by the Companies indicates that in two companies within the group, the prior authorization requests for behavioral health services are denied at a slightly higher rate than for M/S services.

Company Subsequent Actions: The Companies stated that the two companies with slightly higher denial rates for prior authorizations for behavioral health services than M/S serviceswere utilizing a vendor (UBH/Optum). The two companies involved have not used this vendor since November 1, 2023.

Observation: The Companies must be prepared to provide the data broken out by MH and SUD as requested for future examinations and to continue to monitor trends between denials M/S, MH and SUD.

X. 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. This section should be completed on behalf of Harvard Pilgrim Health Care, Inc and HPHC Insurance Company, Inc.

Harvard Pilgrim Healthcare

Network Admission Standards

Examination Conclusions: The Companies provided copies of the Harvard Pilgrim and Optum Massachusetts 2023 Base Rate, fee-for-service, schedules. The fee schedule included the code, description, non-facility location 100% allowable, and facility location 100% allowable. They also provided a summary of their reimbursement methodology, the Optum fee schedule updates policy, and the HPHC Network Reimbursement policy.

The Companies' documentation demonstrates that their processes, evidentiary standards, and other factors are comparable for MH/SUD and M/S services and are no more restrictive for MH/SUD services as compared to M/S services. The Companies maintain a professional fee schedule for MH/SUD and M/S services in Massachusetts.

The Companies response was sufficient.

Network Adequacy

Examination Conclusions: Harvard Pilgrim Healthcare stated that their paper and electronic directories list all the network providers available to their members, including Optum's network of behavioral health providers. The Company updated the printed directory to include a toll-free number for reporting inaccuracies. They also added a disclaimer indicating that the network for behavioral health is maintained by United Behavioral Health and operated under the brand name Optum. A date was added to the electronic and print directories to specify when they were last updated. The Company said a notice was added to both versions notifying consumers that they can file complaints with the state insurance department that regulates their health plan. However, only an example of the Optum Network Manual was provided for this question. Consumers can view and filter available services based on their search preferences, including outpatient and inpatient services. The Company also provided the methodologies used to ensure data accuracy, including provider attestations every 90 days and a list of other tools, but primarily the CAQH DirectAssure tool for updating provider data.

The Optum Network Manual includes many references explaining how Optum handles consumer complaints. Although they mentioned that providers can complain without fear of retribution, they did not indicate that the Division/Department of Insurance can also accept providers' complaints.

The provider directory now directs consumers to the Point32Health.org website which allows consumers to toggle between the Harvard Pilgrim Health Care provider search and the Tufts Health Plan provider search.

The Companies provided screenshots to verify that the provider directories, both electronic and print, include the date of the directory's most recent update. Providers inform Harvard Pilgrim Health Care of their acceptance of new patients/panel status upon enrollment, when reporting a change, and when attesting to their provider information through the quarterly CAQH Direct Assure attestation process. The Companies illustrated how consumers can report inaccuracies, notify the company of errors within the provider directories by phone or email, and file complaints. Providers that have not attested to their information and/or have not responded to inquiries regarding the accuracy of their data are suppressed from the provider directory following Harvard Pilgrim Health Care's provider suppression policy. The Companies provided a screenshot showing a disclaimer in the Important Plan Details footer, which states that United Behavioral Health, operating under the brand name Optum, maintains the Behavioral Health Care Provider network.

The Companies provided screenshot images to confirm the recommendations the Attorney General requested were implemented. The Companies' website contains links for consumers to report data inaccuracies including when a consumer performs a search within the provider directory the results page includes a link, and from the Contact Us page, there is a Provider Directory Feedback link which includes a link to report data inaccuracies.

Point32Health provided its third quarter of 2023 provider directory audit. For the MA AOD Requirements, the Companies examined the 90-day mailing compliance and validated 15,086 provider records. For the Consolidated Appropriations Act, the Company reviewed and validated 12,970 provider records (for the 90-day validation) and 15,970 provider records (for the 180-day validation). There were 2,522 providers/facilities suppressed from the directory during the 3rd quarter, and an additional 1,452 that are no longer displayed in the directory.

The report lists each provider/facility, the Optum provider ID, the NPI the provider name, licensure, group ID, group name, the Clinician/Type, whether the entity responded to the 90-day mailing compliance, whether the entity had been validated in the past 90 days, and whether the provider had been validated in the past 365 days.

The Companies explained that Out of Scope – Suppressed from the Directory and Out of Scope – Not Displaying in the Directory-- have the same meaning. These results appear when the practitioner is not included in the directory because they are hospital based, and patients cannot make an appointment with them directly.

Point32Health provided its Provider Directory, which included 3,181 pages of providers. Each provider's directory included their name, whether they are accepting new patients, their address, phone number, specialty, board certification, hospital(s), additional language(s), race, gender, ethnicity, and virtual visit/telehealth. This information is available in a searchable format. The printed provider directory is produced annually.

The HPHC online provider directory already provides a search mechanism for consumers to identify providers who speak languages other than English. HPHC also collects languages spoken by staff and separately tracks if interpreters are available and in what languages are available for interpretation. Consumers can search the directory using the Provider Ethnicity, Additional Provider Languages, Additional Staff Languages, and Skilled Interpreter Languages categories to target a specific language needs or cultural preferences.

Utilization Review

Examination Conclusions: The Companies provided supporting documentation, including a table of

contents summarizing the changes implemented in 2020 to comply with the request from the AG's office related to Utilization Review and proper notices to members, as well as information about prior authorizations.

In 2021, the Optum "Management of Behavioral Health Benefits" and its corresponding addendum were modified. The clarifications incorporated into those policies and procedures to address the utilization management requirements under the AOD remained in place under these updated Optum policies and in the existing, unchanged HPHC "Behavioral Health Care Authorization and Notification Policy." In 2022, an addendum to the Optum Network Manual, consistent with policies and procedures implemented in 2020, confirmed that emergency services (including post-stabilization services) and admissions following emergency services do not require prior authorization. The comparative analysis and utilization management data verify that the processes, evidentiary standards, and other factors used to develop and apply utilization management techniques for outpatient behavioral health care are comparable, as written and as applied, in accordance with MHPAEA.

In addition, two Optum policies previously submitted to the AGO were retired (the "HPHC Authorization Emergency Admission Post Stabilization Services" policy and the "HPHC Management of Behavioral Health Benefits Addendum" policy).

The Point32Health website includes a behavioral health authorization document that states, "In the rare instance that an HMO member requires non-urgent/non-emergent services by a provider who does not participate in the Harvard Pilgrim network, Harvard Pilgrim Health Plan requires prior authorization." When the examiners reviewed the Point32Health referral/authorization quick reference guide for medical services for commercial products, they found that the Companies stated that for HMO members, any services provided by a non-participating provider require authorization.

According to the document supplied by the Companies, no prior authorization is required for emergency (crisis) mental health or SUD treatment. The documentation provides members and providers with helpful information, including how to get assistance in accessing mental health or substance use disorder benefits by calling Harvard Pilgrim's Behavioral Health Access Center at 888-777-4742. The Commonwealth also has the Massachusetts Behavioral Health Help Line, which can be reached by calling or texting 833-773-2445. While no law requires companies to provide a Behavioral Health Helpline directly, the focus is on ensuring that information about the 888 hotline and other emergency services is made available to individuals.

Point32Health does have a provider forms website, including over 30 different forms for behavioral health-specific requirements. All forms allow for editing, but some can be emailed while others must be completed and faxed.

The documentation provided by Harvard Pilgrim Healthcare includes coverage for medically necessary ATS and CSS for up to fourteen days without preauthorization, and Utilization Management procedures are not initiated until day seven of the treatment.

It was unclear whether Harvard Pilgrim requires prior authorization for SUD treatment other than ATS and CSS if the Provider is certified or licensed by the Massachusetts Department of Public Health. Additionally, it was unclear whether this obligation applies to members who do not have closed network plans, even when the treatment is obtained from an OON provider, provided that such OON provider is certified or licensed by the Massachusetts Department of Public Health.

Prior authorization documentation states that neither a referral from a PCP nor prior authorization is required for routine outpatient mental health/substance use disorder services. Further, it clarifies that

members may self-refer to in-network providers or contact the Behavioral Health Access Center for assistance. Additionally, it acknowledges that "Notification for routine, in-network outpatient mental health/substance use disorder services is not required." By recommending that members call for assistance in accessing mental health or substance use disorder benefits, it appears that there is a need to have some authorization, whether it is a formal prior authorization process, is unknown. There is no documentation about accepting out-of-network providers for SUD treatments by a professional certified or licensed by the Massachusetts Department of Public Health.

The Companies confirmed they have processes in place to comply with the NSA. Our website gives providers information on how to contact HPHC regarding the request to accept OON providers for SUD treatment in compliance with 45 CFR § 149.120 (No Surprises Act.)

The examiners noted two ABA denials for "no out-of-network benefits," which they do not believe violate MGL c. 175 §47AA, as the denials were for plan members enrolled in an HMO plan with services available within their network. The Companies verified that they had a 98% approval rate for ABA requests in 2022. Further, the examiners identified thirty (30) ABA denials with the reason of "supplemental clinical criteria." The Companies reiterated the high approval rate for ABA requests. They also noted that these were claims processed by UBH when behavioral health benefit management was outsourced by HPHC to UBH.

The examiners also identified five (5) SUD denials, of which four (4) were denied for medical necessity criteria not being met and one (1) was denied for behavioral clinical policies. The Companies stated that they no longer have access to the details for these 2022 claims but stated that SUD data from 2022 showed a 100% approval rate.

Observation: The Companies should consider adding the Massachusetts Behavioral Health Help Line as an added resource, especially since texting is a common means of communication.

Based on the data reviewed, the Companies appear to comply with the Attorney General's examination related to network adequacy.

XI. 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. This section should be completed on behalf of Tufts Health Public Plans, Inc., Tufts Associated Health Maintenance Organization, Inc., and Tufts Insurance Company, Inc.

Tufts Health Plan

Network Adequacy

Examination Conclusions: Point32Health stated that the majority of the changes occurred when they began using a third-party vendor, CAQH, which verifies provider data twice daily, and the tool is DirectAssure. The process for verifying provider data includes sending a notification to providers every 90 days. If providers do not confirm their information is accurate, they will receive email notifications (monthly) and telephone outreach (after 120 days) to update their information. If the provider still does not confirm its

provider directory information within 200 days, its information will be suppressed so that members cannot search for the provider on the provider directory. When and if the suppressed provider confirms its information, THP removes the suppression.

Point32Health claims to have implemented all the recommendations from the AGO report. The examiners could not verify whether providers with multiple locations were confirmed, but the CAQH application would most likely address any of those concerns. The examiners could not search for hospitalists, so it is also assumed that physicians or nurses that consumers cannot make an appointment are also filtered from the provider lists.

The Companies provided screenshots, which include the electronic provider directory and the print directory, demonstrating that the requested details have been implanted. In addition, the Companies provided the form used by providers to complete their initial onboarding, which includes fields such as whether the provider is accepting new patients. The data and updated changes are made to the TAHPMaster, which loads twice daily to the provider directory vendor (HealthSparq).

The Companies also demonstrated how a consumer can report inaccurate data using screenshots. There are multiple ways; one is at the bottom of the search result page, "contact us", and "inaccuracies," and the other is once the details for a provider have been opened, there is a button labeled "tell us if something needs to change."

The website was also updated to include phone numbers and a link to the DOI website for complaints regarding provider directory inaccuracies or provider network access issues.

In lieu of displaying 'unverified', Tufts Health Plan operationalized a process to suppress providers from the directory that have not verified their information.

The vendor CAQH/DirectAssure ensures that the data for practice locations is accurate.

Tufts Health Plan maintains its own Behavioral Health provider network. These providers contract directly with Tufts Health Plan and are not managed through a Behavioral Health Care Provider network vendor.

The Companies reported that the number of behavioral health providers who have not re-attested or submitted claims has significantly diminished over the past year. The Companies decided to include behavioral health providers in their monthly directory audit workflow to ensure they are monitored regardless of claims activity and attestation status throughout the year. They explained that a list of providers requiring changes because of their calling project is sent to Provider Enrollment each month to confirm and update their systems. They also provided a spreadsheet listing the changes made to the providers.

Point32Health provided its Provider Directory for Employer, Individual, or Family Plans. The directory contained the necessary information for reviewing providers: their names, addresses, phone numbers, genders, spoken languages, specialties, hospital affiliations, and board certifications.

The Companies provided a spreadsheet containing all the directory inaccuracy inquiries that were reported to the dedicated department email addresses for commercial lines of business. Tufts Health Plan now uses DirectAssure for Massachusetts providers as a single provider directory data source. If the provider does not re-attest to the accuracy of their data within 90 days, their application moves to the "expired attestation" status, indicating non-compliance with requirements. Every month, the Provider Operations department will identify any provider aged over 90 days. They will track these providers and send email/phone reminders to update their information every 30 days if they maintain an expired status.

Point32Health does not market hospitalists in its print or online provider directories because hospitalists provide care to patients while they are in the hospital, but do not see patients on an appointment basis. Only professional providers that are available for patients to make an appointment are marketed in our directories.

The THP Commercial inaccuracies reported in the document titled R36(B) were inclusive of provider directory issues identified across all provider types. This includes individual providers (M/S and MH/SUD) as well as facilities and hospitals.

Based on the data reviewed, the Companies appear to comply with the Attorney General's examination related to utilization review.

SUMMARY

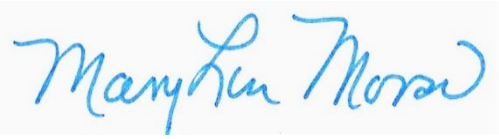
Based upon the procedures performed in this examination, INS has reviewed the Companies responses to the interrogatory which included utilization review, prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement 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 Point32 Health.

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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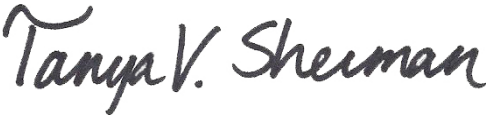
The INS Companies
Market Regulation Division
Dallas, Texas



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