2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #1

No.	Company Name	1.1 - Utilization Review Person	1.2 - Utilization Review Committee	1.3.a - Mental Health Utilization Review Criteria - Developed by Whom?	1.3.b - Medical Utilization Review Criteria- Developed by Whom?	1.3.c - Review Differences
1	**Aetna Health, Inc.**	**Medical and Behavioral Health:** Chairperson of Aetna National Quality Oversight Committee	**Medical:** Aetna National Quality Advisory Committee. **Behavioral Health:** Aetna Behavioral Health Quality Advisory Committee. **Reason for different review committees:** The process is comparable, with exception of area of expertise.	Internal - Level of Care Assessment Tool; for Autism: Aetna Applied Behavioral Analysis Medical Necessity Guidelines. Substance Abuse disorders: External - Americal Society for Addiction Medicine.	MCG criteria, approved for use by Aetna National Quality Advisory Committee and Aetna National Quality Oversight Committee. Aetna also develops Clinical Policy Bulletins.	For medical and mental health services, both internal and external review criteria are used.
2	**Aetna Health Insurance Company**	**Medical and Behavioral Health:** Chairperson of Aetna National Quality Oversight Committee	**Medical:** Aetna National Quality Advisory Committee. **Behavioral Health:** Aetna Behavioral Health Quality Advisory Committee. **Reason for different review committees:** The process is comparable, with exception of area of expertise.	Internal - Level of Care Assessment Tool; for Autism: Aetna Applied Behavioral Analysis Medical Necessity Guidelines. Substance Abuse disorders: External - Americal Society for Addiction Medicine.	MCG criteria, approved for use by Aetna National Quality Advisory Committee and Aetna National Quality Oversight Committee. Aetna also develops Clinical Policy Bulletins.	For medical and mental health services, both internal and external review criteria are used.
3	**Aetna Life Insurance Company**	**Medical and Behavioral Health:** Chairperson of Aetna National Quality Oversight Committee	**Medical:** Aetna National Quality Advisory Committee. **Behavioral Health:** Aetna Behavioral Health Quality Advisory Committee. **Reason for different review committees:** The process is comparable, with exception of area of expertise.	Internal - Level of Care Assessment Tool; for Autism: Aetna Applied Behavioral Analysis Medical Necessity Guidelines. Substance Abuse disorders: External - Americal Society for Addiction Medicine.	MCG criteria, approved for use by Aetna National Quality Advisory Committee and Aetna National Quality Oversight Committee. Aetna also develops Clinical Policy Bulletins.	For medical and mental health services, both internal and external review criteria are used.
4	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical and Behavioral Health:** Associate Chief Medical Officer	**Medical and Behavioral Health:** Technical Review Committees comprised of clinicians in relevant field for both services. Have separate committees. **Reason for different review committees:** Necessary due to specialized clinical experience.	BCBSMA uses McKesson Corporation's InterQual criteria in order to maintain consistency - made up of 30 developers, 650 external consultants, 110 experts in mental health	BCBSMA uses McKesson Corporation's InterQual criteria in order to maintain consistency - made up of 30 developers, 650 external consultants, 110 experts in mental health	N/A - both developed externally using InterQual criteria.
5	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	**Medical and Behavioral Health:** Associate Chief Medical Officer	**Medical and Behavioral Health:** Technical Review Committees comprised of clinicians in relevant field for both services. Have separate committees. **Reason for different review committees:** Necessary due to specialized clinical experience.	BCBSMA uses McKesson Corporation's InterQual criteria in order to maintain consistency - made up of 30 developers, 650 external consultants, 110 experts in mental health	BCBSMA uses McKesson Corporation's InterQual criteria in order to maintain consistency - made up of 30 developers, 650 external consultants, 110 experts in mental health	N/A - both developed externally using InterQual criteria.
6	**Boston Medical Center Health Plan, Inc.**	**Medical:** Quality Improvement Committee, chaired by Director of Quality Improvement. **Behavioral Health:** Vice President of Medical Affairs and medical directors. **Reason for different persons:** Due to specialized nature of behavioral health services, they are given special consideration, requiring BMC to delegate UR to Beacon Health Strategies.	**Medical:** BMCHP uses quality committee reporting structure. **Behavioral Health:** Beacon's Level of Care Committee. **Reason for different review committees:** Due to specialized nature of behavioral health services, they are given special consideration, requiring BMC to delegate UR to Beacon Health Strategies.	Use Beacon's utilization review criteria. Process: Beacon adheres to NCQA Utilization Management standards and compares national scientific and evidence based criteria sets.	Combination of internal and external review sources. Uses McKesson InterQual criteria. Internally, Medical Policy Manager responsible for review of literature, scientific studies and other information.	The process is the same, using external sources for both, relying on experts to develop utilization review criteria. BMC also uses internally developed criteria for small number of services.

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7	**CeltiCare Health Plan of Massachsuetts, Inc.**	**Medical and Behavioral Health:** Chief Medical Officer.	**Medical and Behavioral Health:** Primary source for utilization review criteria is McKesson's InterQual criteria sets. When not availible, behavioral health and medical clinicians develop criteria based on their areas of expertise. ALL of the criteria are reviewed and approved by the CeltiCare Quality Improvement Committee.	Primary source is through external review process using McKesson's InterQual.	Primary source is through external review process using McKesson's InterQual. Anually, a small minority of policies (Partial Hospital Program and Intensive Outpatient Program) are developed by internal clinicians with review by local external experts via the QIC.	Has elected to employ utilization review criteria for mental health/substance use disorder services that were developed by professionals within own organization.
8	**CIGNA Health and Life Insurance Company**	**Medical and Behavioral Health:** Chief Medical Officer.	Medical and Behavioral Health: CIGNA Medical Technology Assessment Committee. Scope of review includes medical/surgical and mental health matters. Current chair is a psychiatrist.	Criteria developed internally with team of physicians, nurses, psychologists, social workers, and substance use disorder clinicians. Updated at least every 2 years.	Combination of internal and external review sources, including MCG to determine medical necessity.	Need to rely on MCG to determine medical necessity where CIGNA has not developed its own coverage policy.
9	**ConnectiCare of Massachusetts, Inc.**	Medical: Physician Advisory Committee chaired by CMO or the Medical Director reporting to the CMO. Behavioral Health: Optum's Behavioral Policy & Analytics Committee reviews and approves guidelines, chaired by Senior Vice President, Medical Management. Reason for different persons: ConnectiCare believes that these matters should be reviewed by subject matter experts.	Medical: Criteria reviewed by Medical Operations Staff, Medical Staff and Physician Advisory Committee. Behavioral Health: Uses Optum's mental Policy & Analytics Committee. Reason for different review committees: ConnectiCare believes that these matters should be reviewed by subject matter experts.	External review using Optum's Coverage Determination Guidelines; Level of Care Guidelines; clinical guidelines.	Developed by ConnectiCare staff or adopted from external sources and approved by ConnectiCare Physician Advisory Committee.	Optum is the subject matter expert and understands clinical needs of members.
10	**Connecticut General Life Insurance Company**	**Medical and Behavioral Health:** Chief Medical Officer	Medical and Behavioral Health: CIGNA Medical Technology Assessment Committee. Scope of review includes medical/surgical and mental health matters. Current chair is a psychiatrist.	Criteria developed internally with team of physicians, nurses, psychologists, social workers, and substance use disorder clinicians. Updated at least every 2 years.	Combination of internal and external review sources, including MCG to determine medical necessity.	Need to rely on MCG to determine medical necessity where CIGNA has not developed its own coverage policy.
11	**Fallon Community Health Plan, Inc.**	**Medical:** FCHP Chief Medical Officer. **Behavioral Health:** Beacon Vice President of Medical Affairs and Medical Directors. **Reason for different persons:** Beacon has subject matter expertise and has NCQA accreditation in behavioral health services.	**Medical:** FCHP Technical Assessment Committee. **Behavioral Health:** Beacon Level of Care Committee. **Reason for different review committees:** Beacon has subject matter expertise and FCHP relies on Beacon's specialized knowledge.	Criteria developed externally using Beacon's Level of Care Criteria.	FCHP uses InterQual Level of Care Criteria, and for some specialty areas, FCHP's interal criteria.	While FCHP maintains oversight over Beacon's utilization review criteria, Beacon has specialized breadth and depth of expertise in the area of behavioral health.
12	**Fallon Health & Life Assurance Company**	**Medical:** FCHP Chief Medical Officer. **Behavioral Health:** Beacon Vice President of Medical Affairs and Medical Directors. **Reason for different persons:** Beacon has subject matter expertise and has NCQA accreditation in behavioral health services.	**Medical:** FCHP Technical Assessment Committee. **Behavioral Health:** Beacon Level of Care Committee. **Reason for different review committees:** Beacon has subject matter expertise and FCHP relies on Beacon's specialized knowledge.	Criteria developed externally using Beacon's Level of Care Criteria.	FCHP uses InterQual Level of Care Criteria, and for some specialty areas, FCHP's interal criteria.	While FCHP maintains oversight over Beacon's utilization review criteria, Beacon has specialized breadth and depth of expertise in the area of behavioral health.

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No.	Company Name	1.1 - Utilization Review Person	1.2 - Utilization Review Committee	1.3.a - Mental Health Utilization Review Criteria - Developed by Whom?	1.3.b - Medical Utilization Review Criteria- Developed by Whom?	1.3.c - Review Differences
13	**Harvard Pilgrim Health Care, Inc.**	**Medical:** Senior Medical Director; Director for Clinical Policy and Compliance. **Behavioral Health:** Senior Vice President, Medical Management. **Reason for different persons:** Optum has subject matter expertise in behavioral health. Different people because Optum has professional expertise to handle utlization review for mental health.	**Medical:** Harvard Pilgrim has Utilization Management and Clinical Policy Committee. **Behavioral Health:** Optum has Behavioral Policy & Analytics Committee. **Reason for different review committees:** Separate committees exist due to different expertise needs. Committees sometimes work together across the two different fields.	Optum develops its utlization review criteria for use by Harvard Pilgrim. Harvard Pilgrim approves criteria by Optum for use with Harvard Pilgrim members.	Harvard Pilgrim's Utilization Management and Clinical Policy Department develops and regularly reviews clinical guidelines.	Review differences exist because Optum has the expertise to review mental health utilization review criteria.
14	**Health New England, Inc.**	**Medical and Behavioral Health:** Chief Medical Officer.	**Medical and Behavioral Health:** Medical Technology Assessment Committee, chaired by CMO, responsible for both.	Uses both internally created review criteria developed and updated with the input of local physicians through annual review by the Clinical Care Assessment Committee (CCAC) and the Behavioral Health Assessment Committee (BHAC), as well as McKesson's InterQual criteria as these clinical criteria sets are nationally recognized, clinically relevant, and reflective of best practices.	Uses both internally created review criteria developed and updated with the input of local physicians through annual review by the CCAC and the BHAC, as well as McKesson's InterQual criteria as these clinical criteria sets are nationally recognized, clinically relevant, and reflective of best practices.	HNE uses a combination of internally developed and externally licensed criteria for both mental health/substance use and medical/surgical services.
15	**HPHC Insurance Company, Inc.**	**Medical:** Senior Medical Director; Director for Clinical Policy and Compliance. **Behavioral Health:** Senior Vice President, Medical Management. **Reason for different persons:** Optum has subject matter expertise in behavioral health. Different people because Optum has professional expertise to handle utlization review for mental health.	**Medical:** Harvard Pilgrim has Utilization Management and Clinical Policy Committee. **Behavioral Health:** Optum has mental Policy & Analytics Committee. **Reason for different review committees:** Separate committees exist due to different expertise needs. Committees sometimes work together across the two different fields.	Optum develops its utlization review criteria for use by Harvard Pilgrim. Harvard Pilgrim approves criteria by Optum for use with Harvard Pilgrim members.	Harvard Pilgrim's Utilization Management and Clinical Policy Department develops and regularly reviews clinical guidelines.	Review differences exist because Optum has the expertise to review mental health utilization review criteria.
16	**Neighborhood Health Plan, Inc.**	**Medical:** Chief Medical Officer and Medical Directors **Behavioral Health:** Vice President of Medical Affairs and Medical Directors. **Reason for different persons:** Clinical Policy and Quality Committee reviews and approves both medical and behavioral health criteria. Participants include physicians on medical and behavioral health side.	**Medical:** Technical Assessment Team, comprised of CMO, Medical Directors, clinicians and other internal staff. **Behavioral Health:** Level of Care Committee, comprised of psychiatrists, doctoral and masters level behavioral health and substance abuse clinicians and licensed social workers. **Reason for different review committees:** NHP contracts with Beacon due to their knowledge and expertise in treatment of mental health and substance use disorders.	Beacon is responsible for the development, review and management of utiilization review criteria for mental health/substance use services.	NHP uses both internally created utilization review criteria, as well as McKesson's InterQual criteria.	NHP delegates mental health utilization review matters to Beacon because they are specialized in the area.

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17	**Network Health, LLC (now known as Tufts Health Public Plans, Inc.)**	**Medical and Behavioral Health:** Chief Medical Officer	**Medical and Behavioral Health:** Technical review committee that considers both new and changes to criteria. Chief Medical Officer and Medical Director for Behavioral Health are active participants in this committee.	Criteria developed mainly through McKesson's InterQual Criteria, but sometimes developed internally.	Criteria developed mainly through McKesson's InterQual Criteria, but sometimes developed internally.	The process is both done internally and externally for both medical and mental health.
18	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical and Behavioral Health:** Senior Vice President and Chief Medical Officer.	**Medical:** Medical Specialty Advisory Committee. **Behavioral Health:** Mental Health Operations and Policy Committee. **Reason for different review committees:** Different Committees due to different areas of expertise, but Medical Technology Assessment Process for both.	Criteria developed internally, as well as through McKesson's InterQual Criteria.	Criteria developed internally, as well as through McKesson's InterQual Criteria.	The process is both done internally and externally for both medical and mental health.
19	**Tufts Insurance Company**	**Medical and Behavioral Health:** Senior Vice President and Chief Medical Officer.	**Medical:** Medical Specialty Advisory Committee. **Behavioral Health:** Mental Health Operations and Policy Committee. **Reason for different review committees:** Different Committees due to different areas of expertise, but Medical Technology Assessment Process for both.	Criteria developed internally, as well as through McKesson's InterQual Criteria.	Criteria developed internally, as well as through McKesson's InterQual Criteria.	The process is both done internally and externally for both medical and mental health.
20	**UniCare Life & Health Insurance Company**	**Medical and Behavioral Health:** Anthem UM Services, Inc. (AUMSI) Quality Improvement Committee	**Medical and Behavioral Health:** The WellPoint Medical Policy and Technology Assessment Committee (MPTAC) develops medical policy and clinical UM guidelines and is responsible for determining medical necessity.	Criteria mostly developed internally, along with Milliman Care Guidelines.	Criteria mostly developed internally, along with Milliman Care Guidelines.	The process is both done internally and externally for both medical and mental health.
21	**UnitedHealthcare Insurance Company**	**Medical:** National Medical Care Management Committee. **Behavioral Health:** Behavioral Policy & Analytics Committee. **Reason for different persons:** It is deemed prudent to have appropriately trained and experience specialists in their respective fields develop the utilization review and criteria.	**Medical:** National Medical Care Management Committee. **Behavioral Health:** Behavioral Policy & Analytics Committee is responsible for review. **Reason for different review committees:** It is deemed prudent to have appropriately trained and experience specialists in their respective fields develop the utilization review and criteria.	Optum's utilization review criteria are developed by mental health/substance use professionals within UHC.	UHC's Clinical Services Medical Management uses internal and external clinical review criteria	The review utilization processes used to develop necessity criteria for medical care and mental health/substance abuse services are similar.

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No.	Company Name	1.4.a - Practicing Physician Input - Mental Health	1.4.b - Practicing Physician Input - Medical	1.4.c - Explain if different process
1	**Aetna Health, Inc.**	Behavioral Health Quality Advisory Committee, with 6-8 behavioral health practicioners (1 psychiatrist, 1 psychologist, 1 social worker, 1 master's prepared clinician, 1 BH provider representative, 1 PCP).	National Quality Advisory Committee, includes range of practicing practitioners, both PCP's and specialists.	Process is comparable, with exception of area of expertise.
2	**Aetna Health Insurance Company**	Behavioral Health Quality Advisory Committee, with 6-8 behavioral health practicioners (1 psychiatrist, 1 psychologist, 1 social worker, 1 master's prepared clinician, 1 BH provider representative, 1 PCP).	National Quality Advisory Committee, includes range of practicing practitioners, both PCP's and specialists.	Process is comparable, with exception of area of expertise.
3	**Aetna Life Insurance Company**	Behavioral Health Quality Advisory Committee, with 6-8 behavioral health practicioners (1 psychiatrist, 1 psychologist, 1 social worker, 1 master's prepared clinician, 1 BH provider representative, 1 PCP).	National Quality Advisory Committee, includes range of practicing practitioners, both PCP's and specialists.	Process is comparable, with exception of area of expertise.
4	**Blue Cross and Blue Shield of Massachusetts, Inc.**	Initial drafts of InterQual content. Then physician review. Also, Medical Policy Group meets monthly, includes physician representatives.	Initial drafts of InterQual content. Then physician review. Also, Medical Policy Group meets monthly, includes physician representatives	Same process used during physician review for both mental health and medical review.
5	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	Initial drafts of InterQual content. Then physician review. Also, Medical Policy Group meets monthly, includes physician representatives.	Initial drafts of InterQual content. Then physician review. Also, Medical Policy Group meets monthly, includes physician representatives	Same process used during physician review for both mental health and medical review.
6	**Boston Medical Center Health Plan, Inc.**	Beacon solicits input from practicing psychiatrists, psychologists, nurses, advanced practice nurses, and licensed clinicians. Level of Care Committee, Beacon Provider Advisory Council, and Expert Panel all involved in review.	The review of medical utilization review criteria includes physicians that are part of the Medical Policy Criteria Technology Assessment Committee, Quality Improvement Committee, and Quality, and Clinical Management Committee.	The processes are comparable. The external sources are nationally recognized standards.

No.	Company Name	1.4.a - Practicing Physician Input - Mental Health	1.4.b - Practicing Physician Input - Medical	1.4.c - Explain if different process
7	**CeltiCare Health Plan of Massachsuetts, Inc.**	InterQual criteria are reviewed using consulting providers. Also, the Celticare Health Quality Improvement Committee is comprised of CeltiCare Health staff and local community based providers.	InterQual criteria are reviewed using consulting providers. Also, the Celticare Health Quality Improvement Committee is comprised of CeltiCare Health staff and local community based providers.	The process for each is the same.
8	**CIGNA Health and Life Insurance Company**	CIGNA draws on feedback from network providers. Can be made via website, Coverage Policy Unit or Technical Assessment Committee.	Feedback from physicians through website, local market CIGNA Medical Executive, or Coverage Policy Unit and Technical Assessment Committee.	Similar process, but more inclusive of practicing physicians for mental health process.
9	**ConnectiCare of Massachusetts, Inc.**	Input from Optum's National Provider Advisory Council, made up of practicing physicians and mental health professionals from Optum's provider network. The Behavioral Specialty Advisory Council is made up of representatives from national behavioral health specialty societies.	UR criteria approved by ConnectiCare Physican Advisory Committee. Criteria sets reviewed annually by Medical Operations Staff and Medical Directors.	Difference due to use of Optum as mental health expert.
10	**Connecticut General Life Insurance Company**	CIGNA draws on feedback from network providers. Can be made via website, Coverage Policy Unit or Technical Assessment Committee.	Feedback from physicians through website, local market CIGNA Medical Executive, or Coverage Policy Unit and Technical Assessment Committee.	Similar process, but more inclusive of practicing physicians for mental health process.
11	**Fallon Community Health Plan, Inc.**	Beacon obtains input from practicing psychiatrists, psychologists, nurses, advanced practice nurses, and licensed clinicians. Criteria submitted to LOC Committee, and submitted to Beacon Provider Advisory Council and Expert Panel.	FCHP uses a Technical Assessment Committee that is tasked with reviewing and developing criteria. It is made up of network physicians from various specialty areas.	Both Beacon and FCHP are accredited by NCQA, which requires physician input. While different committees exist for each, the process for both to include physicians in review of criteria is similar.
12	**Fallon Health & Life Assurance Company**	Beacon obtains input from practicing psychiatrists, psychologists, nurses, advanced practice nurses, and licensed clinicians. Criteria submitted to LOC Committee, and submitted to Beacon Provider Advisory Council and Expert Panel.	FCHP uses a Technical Assessment Committee that is tasked with reviewing and developing criteria. It is made up of network physicians from various specialty areas.	Both Beacon and FCHP are accredited by NCQA, which requires physician input. While different committees exist for each, the process for both to include physicians in review of criteria is similar.

No.	Company Name	1.4.a - Practicing Physician Input - Mental Health	1.4.b - Practicing Physician Input - Medical	1.4.c - Explain if different process
13	**Harvard Pilgrim Health Care, Inc.**	In updating level of care guidelines, Optum uses its National Provider Advisory Council, made up of practicing physicians; and Behavioral Specialty Advisory Council, made up of representatives from national mental health specialty societies.	Harvard Pilgrim's Medical Directors work with community physicians to look at utilization review criteria that is being developed or reviewed. For certain criteria such as psychological testing, Harvard Pilgrim will obtain input from nonphysicians such as psychologists.	While their processes are not exactly the same, Optum's and Harvard Pilgrim both comply with the Mental Health Parity Laws by obtaining input from practicing physicians regarding their criteria.
14	**Health New England, Inc.**	Behavioral Health Advisory Committee, co-chaired by CMO and board certified psychiatrist, reviews mental health/substance use criteria. Made up of psychiatrists, psychologists, and licensed social workers.	Clinical Care Assessment Committee reviews medical criteria. Chaired by CMO, members are physicians from general surgey, internal medicine, pediatrics, family medicine. Also board certified psychiatrist.	The process is the same even though there are different committees.
15	**HPHC Insurance Company, Inc.**	In updating level of care guidelines, Optum uses its National Provider Advisory Council, made up of practicing physicians; and Behavioral Specialty Advisory Council, made up of representatives from national mental health specialty societies.	Harvard Pilgrim's Medical Directors work with community physicians to look at utilization review criteria that is being developed or reviewed. For certain criteria such as psychological testing, Harvard Pilgrim will obtain input from nonphysicians such as psychologists.	While their processes are not exactly the same, Optum's and Harvard Pilgrim both comply with the Mental Health Parity Laws by obtaining input from practicing physicians regarding their criteria.
16	**Neighborhood Health Plan, Inc.**	Solicit input for development and maintenance for behavioral health services from practicing behavioral health experts, including psychiatrists, psychologists, nurses, advanced practice nurses, and licensed clinicians.	Solicit input for development and maintenance for medical/surgical services from board certified, practicing physicians, and health professionals from specialty areas	Process is similar, as input is solicited from relevant medical professionals.

No.	Company Name	1.4.a - Practicing Physician Input - Mental Health	1.4.b - Practicing Physician Input - Medical	1.4.c - Explain if different process
17	**Network Health, LLC (now known as Tufts Health Public Plans, Inc.)**	Clinical guidelines reviewed by Technology Review Committee, Physician Advisor Council and Utilization Management Committee. Medical Directors and non-physicians including Behavioral Health UR RN management staff are involved in the final approval process during the Utilization Management Committee.	Clinical guidelines reviewed by Technology Review Committee, Physician Advisor Council and Utilization Management Committee. Medical Directors and non-physicians including Behavioral Health UR RN management staff are involved in the final approval process during the Utilization Management Committee.	The process for each is the same.
18	**Tufts Associated Health Maintenance Organization, Inc.**	Review criteria are developed using recommendations from practicing physicians and governmental agency policies. Criteria are reviewed internally by Mental Health Operations and Policy Committee.	Medical Specialty Policy Advisory Committee evaluates new and emerging technology. Members are external practicing physicians and internal managers.	Process is through internal and external stakeholders for both medical and mental health utilization review.
19	**Tufts Insurance Company**	Review criteria are developed using recommendations from practicing physicians and governmental agency policies. Criteria are reviewed internally by Mental Health Operations and Policy Committee.	Medical Specialty Policy Advisory Committee evaluates new and emerging technology. Members are external practicing physicians and internal managers.	Process is through internal and external stakeholders for both medical and mental health utilization review.
20	**UniCare Life & Health Insurance Company**	Medical Policy and Technology Assessment Committee (MPTAC) includes practicing physicians from multiple specialty fields. Voting members include external physicians from clinical and academic practices, and internal medical directors. Subcommittees may include physicians external to MPTAC who also have clinical and academic practices.	MPTAC inclues practicing physicians from multiple specialty fields. Voting members include physicians. Subcommittees include external and internal physicians who make recommendations regarding utilization review.	Process is through internal and external stakeholders for both medical and mental health utilization review.
21	**UnitedHealthcare Insurance Company**	Optum has developed Coverage Determination Guidelines. They are based on multidisciplinary input from Optum's clinical staff, network providers, national behavioral health speciality societies, and clinical subject matter experts.	Medical policies developed and maintaned in accordance with clinical evidence in published peer-reviewed medical literature.	Difference due to use of Optum as mental health expert.

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Summary of Responses to Bulletin 2013-06: Item #2

No.	Company Name	2.1 - Notification Process - Who is Responsible?	2.2 - Methods of media used for notification	2.3 - Instructions for contacting organization
1	**Aetna Health, Inc.**	**Medical and Behavioral Health:** Provider Communications; Utilization Management Clinicians and Medical Directors; Network Staff.	**Medical and Behavioral Health:** Internet posting; mailed letters; provider newsletters; provider contracts; quality management bulletins.	**Medical and Behavioral Health:** Providers can contact Aetna via mail, phone, fax, or electronically. Instructions are given via methods given in 2.2.
2	**Aetna Health Insurance Company**	**Medical and Behavioral Health:** Provider Communications; Utilization Management Clinicians and Medical Directors; Network Staff.	**Medical and Behavioral Health:** Internet posting; mailed letters; provider newsletters; provider contracts; quality management bulletins.	**Medical and Behavioral Health:** Providers can contact Aetna via mail, phone, fax, or electronically. Instructions are given via methods given in 2.2.
3	**Aetna Life Insurance Company**	**Medical and Behavioral Health:** Provider Communications; Utilization Management Clinicians and Medical Directors; Network Staff.	**Medical and Behavioral Health:** Internet posting; mailed letters; provider newsletters; provider contracts; quality management bulletins.	**Medical and Behavioral Health:** Providers can contact Aetna via mail, phone, fax, or electronically. Instructions are given via methods given in 2.2.
4	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical and Behavioral Health:** Notifies providers through secure online Provider Portal. Network Management Team responsible for all notifications.	**Medical and Behavioral Health:** Methods are Provider Portal, and news alerts sent via e-mail and regular mail.	**Medical and Behavioral Health:** Provider feedback through Electric Blue Review (EBR). Comments from providers to carrier is via dedicated e-mail address which is listed in three different locations.
5	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	**Medical and Behavioral Health:** Notifies providers through secure online Provider Portal. Network Management Team responsible for all notifications.	**Medical and Behavioral Health:** Methods are Provider Portal, and news alerts sent via e-mail and regular mail.	**Medical and Behavioral Health:** Provider feedback through Electric Blue Review (EBR). Comments from providers to carrier is via dedicated e-mail address which is listed in three different locations.
6	**Boston Medical Center Health Plan, Inc.**	**Medical:** Medical Management and Marketing Department. **Behavioral Health:** Beacon's Network Department, along with its Quality and Utilization Management department. **Reason for different persons:** MHP laws allow for separate persons, as long as process is comparable.	**Medical:** Mailed network notifications; e-mail; provider news letter. **Behavioral Health:** Online Provider Portal, also notification via mail to visit Provider Portal.	**Medical:** Notifications posted on website. Can also contact Provider Network Consultant; can also call toll free number. **Behavioral Health:** Notification via mail, e-mail, and Beacon Provider Portal.
7	**CeltiCare Health Plan of Massachsuetts, Inc.**	**Medical and Behavioral Health:** VP, Network Contracting for CeltiCare Health.	**Medical and Behavioral Health:** Mail, e-mail, website notification, provider portal information, and provider newsletters.	**Medical and Behavioral Health:** Instructions are provided in the provider manuals that any provider may contact the applicable clinical departments to voice comments, concerns or requests for policy changes. Additionally, a form is available on the CeltiCare Health website that a provider may complete and fax to the plan for consideration.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #2

No.	Company Name	2.1 - Notification Process - Who is Responsible?	2.2 - Methods of media used for notification	2.3 - Instructions for contacting organization
8	**CIGNA Health and Life Insurance Company**	Medical and Behavioral Health: Vice President of Total Health and Network is responsible. Senior Director of Provider Contracting for Specialty Services, including Behavioral Health, and the Senior Director of Provider Contracting for CIGNA HealthCare both report to the VP of Total Health and Network.	Medical: Articles in electronic quarterly newsletter, notice of updates on CIGNAforHCP.com. Copies of their coverage policies and the CIGNA Reference Guide are avilible to healthcare professionals upon request Behavioral Health: Articles in electronic quarterly newsletter, notice of updates on CIGNAforHCP.com. Copies of Medical Necessity Guidelines (includes mental health and substance abuse utilization review) and Medical Management Program are also available to health care professionals upon request.	Medical and Behavioral Health: CIGNA instructs carriers to give feedback through website, through the CIGNA Medical Executive in their market, or directly to the Coverage Policy Unit and Medical Technology Assessment Committee.
9	**ConnectiCare of Massachusetts, Inc.**	Medical: For medical providers, ConnectiCare Manager of Operations and Communications Quality (with input from the Medical Director and/or CMO) is responsible for maintenance of its website which provides policies on UR criteria. Behavioral Health: Optum's Behavioral Policy and Analytics Committee is responsible for ensuring that guidelines are readily available to providers - available on Optum website.	Medical: Medical and surgical UR criteria available via ConnectiCare website and linked within the online provider manual, also available on the website. Behavioral Health: Optum's Coverage Determination Guidelines and Level of Care Guidelines are available on provider website and paper copies are available upon request.	**Medical:** For medical UR, comments can be made through the Physician Advisory Committee or directly to the Medical Director of Chief Medical Officer. **Behavioral Health:** Feedback through Behavioral Specialty Advisory Council or by contacting an Optum Medical Director directly.
10	**Connecticut General Life Insurance Company**	Medical and Behavioral Health: Vice President of Total Health and Network is responsible. Senior Director of Provider Contracting for Specialty Services, including Behavioral Health, and the Senior Director of Provider Contracting for CIGNA HealthCare both report to the VP of Total Health and Network.	Medical: Articles in electronic quarterly newsletter, notice of updates on CIGNAforHCP.com. Copies of their coverage policies and the CIGNA Reference Guide are avilible to healthcare professionals upon request Behavioral Health: Articles in electronic quarterly newsletter, notice of updates on CIGNAforHCP.com. Copies of Medical Necessity Guidelines (includes mental health and substance abuse utilization review) and Medical Management Program are also available to health care professionals upon request.	Medical and Behavioral Health: CIGNA instructs carriers to give feedback through website, through the CIGNA Medical Executive in their market, or directly to the Coverage Policy Unit and Medical Technology Assessment Committee.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #2

No.	Company Name	2.1 - Notification Process - Who is Responsible?	2.2 - Methods of media used for notification	2.3 - Instructions for contacting organization
11	**Fallon Community Health Plan, Inc.**	**Medical:** Provider Relations section of FCHP's Network Development & Management Department is responsible for notifying providers about medical/surgical review criteria. **Behavioral Health:** The Beacon Network Department together with the Quality and Utilization Management Department oversees the communication of review criteria to providers.	**Medical:** Provider Manual; mail; newsletters. **Behavioral Health:** Provider Manual; e-mail; newsletters; annual provider postcards.	**Medical:** Bi-monthly newsletter to providers; contact Provider Community Council. **Behavioral Health:** Via Provider Portal; via mail; via e-mail; and via contacting Beacon Provider Advisory Council.
12	**Fallon Health & Life Assurance Company**	**Medical:** Provider Relations section of FCHP's Network Development & Management Department is responsible for notifying providers about medical/surgical review criteria. **Behavioral Health:** The Beacon Network Department together with the Quality and Utilization Management Department oversees the communication of review criteria to providers.	**Medical:** Provider Manual; mail; newsletters. **Behavioral Health:** Provider Manual; e-mail; newsletters; annual provider postcards.	**Medical:** Bi-monthly newsletter to providers; contact Provider Community Council. **Behavioral Health:** Via Provider Portal; via mail; via e-mail; and via contacting Beacon Provider Advisory Council.
13	**Harvard Pilgrim Health Care, Inc.**	**Medical:** Editor for Provider Communications and Education is responsible for these notifications to providers. **Behavioral Health:** Optum's Behavioral Policy & Analytics Committee is responsible for availability of clinical guidelines to provicers. **Reason for difference:** Since Optum develops mental health/substance use criteria, it is appropriate for Optum to have different people responsible for notification to providers.	**Medical:** Provided through Provider manaul; through *Network Matters* - monthly e-newsletter; through provider website www.harvardpilgrim.org/providers; through Provider Service Center. **Behavioral Health:** Provided through Level of Care Guidelines available on Optum's provider website.	**Medical:** Medical Directors have periodic provider meetings. Provider manual also has instructions on contacing Physician Call Center. **Behavioral Health:** Input directly solicited from Optum's National Provider Advisory Council and Behavioral Specialty Advisory Council.
14	**Health New England, Inc.**	**Medical and Behavioral Health:** HNE's Integrated Care Manager - Utilization Management is responsible.	**Medical and Behavioral Health:** Internally developed criteria posted on website. Also postcard sent out when criteria updated and posted on provider blog. Hardcopy available upon request.	**Medical and Behavioral Health:** Instructions on how to contact HNE are provided in the Provider Manual. Instructions are the same for both mental health/substance use providers and medical/surgical providers.

No.	Company Name	2.1 - Notification Process - Who is Responsible?	2.2 - Methods of media used for notification	2.3 - Instructions for contacting organization
15	**HPHC Insurance Company, Inc.**	**Medical:** Editor for Provider Communications and Education is responsible for these notifications to providers. **Behavioral Health:** Optum's Behavioral Policy & Analytics Committee is responsible for availability of clinical guidelines to provicers. **Reason for difference:** Since Optum develops mental health/substance use criteria, it is appropriate for Optum to have different people responsible for notification to providers.	**Medical:** Provided through Provider manaul; through *Network Matters* - monthly e-newsletter; through provider website www.harvardpilgrim.org/providers; through Provider Service Center. **Behavioral Health:** Provided through Level of Care Guidelines available on Optum's provider website.	**Medical:** Medical Directors have periodic provider meetings. Provider manual also has instructions on contacing Physician Call Center. **Behavioral Health:** Input directly solicited from Optum's National Provider Advisory Council and Behavioral Specialty Advisory Council.
16	**Neighborhood Health Plan, Inc.**	**Medical:** For the website notification: Clinical Operations with Provider Relations and Corporate Communications; for written or electronic notification: Provider Relations, and Customer Care; for telephonic notification: Clinical Operations. **Behavioral Health:** For the website notification: Clinical and Quality with Provider Relations/Network Management and Corporate Communications; for written or electronic notification: Provider Relations, and Customer Care; for telephonic notification: Clinical Operations. **Reason for difference:** NHP contracts with Beacon due to their knowledge and expertise in treatment of mental health and substance use disorders.	**Medical and Behavioral Health:** via website, telephone, and written electronic communication - Provider Manual.	**Medical and Behavioral Health:** NHP notifies providers via online Provider Portal, via fax, and via telephone.
17	**Network Health, LLC (now known as Tufts Health Public Plans, Inc.)**	**Medical and Behavioral Health:** The Network Health Marketing and Communications, Medical Management and Behavioral Health Departments are responsible for provider notifications regarding utilization review criteria	**Medical and Behavioral Health:** Network Health uses mailed letters, email blasts and provider updates/monthly newsletters for any updates in the utilization review criteria.	**Medical and Behavioral Health:** Network Health instructs providers to contact them via the Network Health website and the Provider Manual.
18	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical and Behavioral Health:** Tufts Health Plan Provider Communications and Education Department is responsible for notification.	**Medical and Behavioral Health:** Provider Update quarterly newsletter mailed to plan providers; articles posted on provider website www.tuftshealthplan.com/providers; for mental/substance use: Mental Health Newsletter to contracting mental health providers.	**Medical and Behavioral Health:** Tufts notifies providers via the plan website and the Tufts Health Plan Commercial Provider Manual.

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Summary of Responses to Bulletin 2013-06: Item #2

No.	Company Name	2.1 - Notification Process - Who is Responsible?	2.2 - Methods of media used for notification	2.3 - Instructions for contacting organization
19	**Tufts Insurance Company**	**Medical and Behavioral Health:** Tufts Health Plan Provider Communications and Education Department is responsible for notification.	**Medical and Behavioral Health:** Provider Update quarterly newsletter mailed to plan providers; articles posted on provider website www.tuftshealthplan.com/providers; for mental/substance use: Mental Health Newsletter to contracting mental health providers.	**Medical and Behavioral Health:** Tufts notifies providers via the plan website and the Tufts Health Plan Commercial Provider Manual.
20	**UniCare Life & Health Insurance Company**	**Medical and Behavioral Health:** Department of Provider Communications is responsible for notification.	**Medical and Behavioral Health:** Monthly newsletter to providers; e-mails, regular mail; provider website.	**Medical and Behavioral Health:** providers can send information requests via mail, e-mail or fax.
21	**UnitedHealthcare Insurance Company**	**Medical and Behavioral Health:** Internet based programs; letters; provider newsletters; e-mails; provider administrative guide.	**Medical and Behavioral Health:** Providers are notified on the provider portal, via phone, or in writing to Medical Directors.	**Medical and Behavioral Health:** Providers are notified on the provider portal, via phone, or in writing to Medical Directors.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #3

No.	Company Name	3.1 - Person Responsible	3.2 - Average Number and Medical Expertise	3.3 - Systems Used for Request for Services
1	**Aetna Health, Inc.**	**Medical and Behavioral Health:** Northeast Regional Medical Director	**Medical: 111**, including RN's, LPN's, LVN's, and physician medical directors. **Behavioral Health:** 69 staff members, including RN's, social workers, professional counselors, theraptists and psychiatric medical directors. **Reason for difference:** There is a higher volume of medical cases.	**Medical and Behavioral Health:** Requests through Electronic Data Interchange, secure provider website, mail, telephone, and fax.
2	**Aetna Health Insurance Company**	**Medical and Behavioral Health:** Northeast Regional Medical Director	**Medical: 111**, including RN's, LPN's, LVN's, and physician medical directors. **Behavioral Health:** 69 staff members, including RN's, social workers, professional counselors, theraptists and psychiatric medical directors. **Reason for difference:** There is a higher volume of medical cases.	**Medical and Behavioral Health:** Requests through Electronic Data Interchange, secure provider website, mail, telephone, and fax.
3	**Aetna Life Insurance Company**	**Medical and Behavioral Health:** Northeast Regional Medical Director	**Medical: 111**, including RN's, LPN's, LVN's, and physician medical directors. **Behavioral Health:** 69 staff members, including RN's, social workers, professional counselors, theraptists and psychiatric medical directors. **Reason for difference:** There is a higher volume of medical cases.	**Medical and Behavioral Health:** Requests through Electronic Data Interchange, secure provider website, mail, telephone, and fax.
4	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical:** Associate Medical Director for Medical Surgical Physician Review and the Director for Utilization Medical Surgical Utilization Management are responsible for medical/surgical services. **Behavioral Health:** Director of mental Health for administration of utilization management. Associate Medical Director for mental Health responsible for operations of mental Health Physician and Psychologist Review Unit.	**Medical:** On average 42 licensed clinicians in Medical Surgical Utilization Review Department. On average 13 persons in Medical Surgical Physician Review Unit responsible for utilization management. **Behavioral Health:** On average 25 independently licensed mental health clinicians. On average 11 members of mental Health Physician and Psychologist Review Unit responsible for utilization management operations. **Reason for difference:** Differences reflective of volume of requests.	**Medical and Behavioral Health:** Requests primarily sent via fax for both medical and mental health requests. Some requests sent via Erndeon electronic transactions for: Hospital Admission, Nutritional Counseling, Home Care, Speech Therapy, Occupational Therapy, Physical Therapy and Outpatient referrals for specialists. Type of communication is at discretion of provider.
5	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	**Medical:** Associate Medical Director for Medical Surgical Physician Review and the Director for Utilization Medical Surgical Utilization Management are responsible for medical/surgical services. **Behavioral Health:** Director of mental Health for administration of utilization management. Associate Medical Director for mental Health responsible for operations of mental Health Physician and Psychologist Review Unit.	**Medical:** On average 42 licensed clinicians in Medical Surgical Utilization Review Department. On average 13 persons in Medical Surgical Physician Review Unit responsible for utilization management. **Behavioral Health:** On average 25 independently licensed mental health clinicians. On average 11 members of mental Health Physician and Psychologist Review Unit responsible for utilization management operations. **Reason for difference:** Differences reflective of volume of requests.	**Medical and Behavioral Health:** Requests primarily sent via fax for both medical and mental health requests. Some requests sent via Erndeon electronic transactions for: Hospital Admission, Nutritional Counseling, Home Care, Speech Therapy, Occupational Therapy, Physical Therapy and Outpatient referrals for specialists. Type of communication is at discretion of provider.
6	**Boston Medical Center Health Plan, Inc.**	**Medical:** Chief Medical Officer; Senior Director of Prior Authorization, Provider Audit and Other Liability; Director of Acute Care Coordination, Clinical Training and Special Hospital Programs. **Behavioral Health:** Vice President of Medical Affairs; Senior Clinical Director; Clinical Director of Utilization Management.	**Medical and Behavioral Health:** Less than 1 FTE of staff to review service requests. Beacon: Medical Director and Clinician. Medical: Medical Director, Clinician (RN) and a non-specialist. For both, the volume is appropriate based on number of services used.	**Medical:** Same as behavioral health, except when via telephone, must be followed up with written request. **Behavioral Health:** Via telephone, fax or mail.

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Summary of Responses to Bulletin 2013-06: Item #3

No.	Company Name	3.1 - Person Responsible	3.2 - Average Number and Medical Expertise	3.3 - Systems Used for Request for Services
7	**CeltiCare Health Plan of Massachsuetts, Inc.**	**Medical and Behavioral Health:** Celticare Health Chief Medical Officer.	**Medical:** Two. 1 - Utilization management concurrent review (RN) and 1 - Prior Authorization (RN). **Behavioral Health:** 1 - Utilization management concurrent review (LICSW), 1 - Prior Authorization (LICSW). **Reason for difference:** Both RN and LICSW degree holders provide the appropriate level of clinical expertise to evaluate requests for coverage in their applicable domains.	**Medical and Behavioral Health:** Toll-free phone line, fax, mail, and electronic submission via the secure provider web portal.
8	**CIGNA Health and Life Insurance Company**	**Medical:** National Clinical Director – Consumer Health Engagement is responsible for the day-to-day operations involved in utilization review processes for medical/surgical disorders. Senior Medical Director is responsible for the physicians and utilization management for medical/surgical reviews. Differences exist due to special expertise in respective fields. **Behavioral Health:** Director of Behavioral Operations responsible for day-to-day operations of utilzation review process. Chief Medical Officer for Behavioral Health is responsible for the physicians and utilization management for behavioral health and substance use disorder reviews.	**Medical and Behavioral Health:** No team dedicated to utilization review exclusively for Massachusetts. Average of 38 nurses, with RN degrees, that may be involved in a utilization review decision in MA - case managers hold MA or PhD degrees. Average of 166 care managers. **Medical:** 43 Medical Directors, all with MD degrees, and board certified in their specialty, perform medical/surgical reviews. **Behavioral Health:** 11 Medical Directors peform behavioral health/substance use reviews. **Reason this is acceptable:** Difference exists due to difference in amount of utilization.	**Medical and Behavioral Health:** Requests done via mail, fax, phone, and sometimes secure e-mail. Medical/surgical requests can also be made online through Navinet. This possibility does not exist for behavioral health requests.
9	**ConnectiCare of Massachusetts, Inc.**	**Medical:** Overseen by Senior Vice President of Healthcare Management and Vice President, Chief Medical Officer, Director of Utilization Management, and Manager of Clinical Compliance. **Behavioral Health:** Overseen by the Senior Vice President of Operations, along with various other Vice Presidents of other departments.	**Medical:** 5 Management Level personnel; 11 Utilization Mangers (RN's); 6 UMA's; 5 UMS's; 2 Data Entry personnel; and 3 Appeals Coordinators. Listed are the various levels of expertise required for each position. **Behavioral Health:** 5 Regional Medical Directors; 30 Associate Medical Directors; 4 National Directors; 11 Senior Managers; 16 Managers; 370 Care Advocates. Listed are levels of expertise required for each position.	**Medical:** phone, fax and mail. No online portal at this time. **Behavioral Health:** telephone or online provider portal.
10	**Connecticut General Life Insurance Company**	**Medical:** National Clinical Director – Consumer Health Engagement is responsible for the day-to-day operations involved in utilization review processes for medical/surgical disorders. Senior Medical Director is responsible for the physicians and utilization management for medical/surgical reviews. Differences exist due to special expertise in respective fields. **Behavioral Health:** Director of Behavioral Operations responsible for day-to-day operations of utilzation review process. Chief Medical Officer for Behavioral Health is responsible for the physicians and utilization management for behavioral health and substance use disorder reviews.	**Medical and Behavioral Health:** No team dedicated to utilization review exclusively for Massachusetts. Average of 38 nurses, with RN degrees, that may be involved in a utilization review decision in MA - case managers hold MA or PhD degrees. Average of 166 care managers. **Medical:** 43 Medical Directors, all with MD degrees, and board certified in their specialty, perform medical/surgical reviews. **Behavioral Health:** 11 Medical Directors peform behavioral health/substance use reviews. **Reason this is acceptable:** Difference exists due to difference in amount of utilization.	**Medical and Behavioral Health:** Requests done via mail, fax, phone, and sometimes secure e-mail. Medical/surgical requests can also be made online through Navinet. This possibility does not exist for behavioral health requests.
11	**Fallon Community Health Plan, Inc.**	**Medical:** Executive Vice President/Chief Medical Officer. **Behavioral Health:** Vice President of Medical Affairs; Senior Clinical Director; Clinical Director of Utilization Management.	**Medical:** 3 licensed physicians; 1 registered nurses; and 9 Bachelors level support personnel. **Behavioral Health:** 5.5 licensed behavioral health clinicians; 1.0 FTE licensed physicians; and 0.5 Bachelors level support personnel. **Reason for difference:** Differences exist, and are permitted, due to volume and type of service under review.	**Medical:** Via telephone fax, or mail. **Behavioral Health:** Via telephone, electronically, fax or mail.

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Summary of Responses to Bulletin 2013-06: Item #3

No.	Company Name	3.1 - Person Responsible	3.2 - Average Number and Medical Expertise	3.3 - Systems Used for Request for Services
12	**Fallon Health & Life Assurance Company**	**Medical:** Executive Vice President/Chief Medical Officer. **Behavioral Health:** Vice President of Medical Affairs; Senior Clinical Director; Clinical Director of Utilization Management.	**Medical:** 3 licensed physicians; 1 registered nurses; and 9 Bachelors level support personnel. **Behavioral Health:** 5.5 licensed behavioral health clinicians; 1.0 FTE licensed physicians; and 0.5 Bachelors level support personnel. **Reason for difference:** Differences exist, and are permitted, due to volume and type of service under review.	**Medical:** Via telephone fax, or mail. **Behavioral Health:** Via telephone, electronically, fax or mail.
13	**Harvard Pilgrim Health Care, Inc.**	**Medical:** Director of Care Management; Senior Medical Director. **Behavioral Health:** Senior Vice President. **Reason for differences:** Different people because of use of Optum as behavioral health specialist.	**Medical:** On average 3-4 FTE UM physician advisors, 1 FTE physician assistant clinical advisor, 3 UM nurse reviewers, and 9 FTE specialty coordinators. 1 UM Medical Director, 5 FTE Nurse Case Managers for Acute Care/SNF/Rehab and Home Care settings. **Behavioral Health:** 36 licensed Master's level mental health professionals, licensed PhD's or registered psychiatric nurses. 8 board certified psychiatrists.	**Medical:** Provider Call Center, UM staff via phone. **Behavioral Health:** Optum Behavioral Health Access Center. National Imaging Associates (NIA): phone and website. Care Core National (CCN): phone and web portal.
14	**Health New England, Inc.**	**Medical and Behavioral Health:** Integrated Care Manager of Utilization Management is responsible.	**Medical:** Average of 6 review staff (RN's). Final review takes place by MD's. Ratio: 1 FTE per 285 requests per month. **Behavioral Health:** Average of 1 review staff (LSW, LMHC, LSWA, or LICSW). Final review done by MD's. Ratio: 1 FTE per 230 requests per month.	**Medical:** Via fax for outpatient request. Inpatient request takes place after admission. No request required for behavioral inpatient visit. **Behavioral Health:** via fax for outpatient requests.
15	**HPHC Insurance Company, Inc.**	**Medical:** Director of Care Management; Senior Medical Director. **Behavioral Health:** Senior Vice President. **Reason for differences:** Different people because of use of Optum as behavioral health specialist.	**Medical:** On average 3-4 FTE UM physician advisors, 1 FTE physician assistant clinical advisor, 3 UM nurse reviewers, and 9 FTE specialty coordinators. 1 UM Medical Director, 5 FTE Nurse Case Managers for Acute Care/SNF/Rehab and Home Care settings. **Behavioral Health:** 36 licensed Master's level mental health professionals, licensed PhD's or registered psychiatric nurses. 8 board certified psychiatrists.	**Medical:** Provider Call Center, UM staff via phone. **Behavioral Health:** Optum Behavioral Health Access Center. National Imaging Associates (NIA): phone and website. Care Core National (CCN): phone and web portal.

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No.	Company Name	3.1 - Person Responsible	3.2 - Average Number and Medical Expertise	3.3 - Systems Used for Request for Services
16	**Neighborhood Health Plan, Inc.**	**Medical:** Chief Medical Officer and the Clinical Policy and Quality Committee. **Behavioral Health:** Chief Medical Officer in conjunction with the Director of Behavioral Health and the Clinical Policy and Quality Committee. **Reason for difference:** NHP's CMO is responsible for delegation and operational oversight of its behavioral health partner in conjunction with NHP's Director of Behavioral Health.	**Medical:** Staffing Ratios:Inpatient: 1:45,000; Non-inpatient: 1:32,000. **Behavioral Health:** 1:50,000. MedSolutions, Inc.: 1:10,000. SMS: 1:77,000. **Reason for difference:** Differences are insignificant based on membership and utilization numbers.	**Medical and Behavioral Health:** Fax, telephone, mail, and online Provider Portal.
17	**Network Health, LLC (now known as Tufts Health Public Plans, Inc.)**	**Medical and Behavioral Health:** The Vice President for Clinical Affairs and the Vice President for Clinical Services was responsible to oversee the day-to-day administration of the utilization review processes.	**Medical:** 18 FTE Registered Nurses; 1.5 FTE Physician Reviewers. **Behavioral Health:** 14 FTE LCSWs and substance abuse counselors; 1.5 FTE physician reviewers. **Reason for difference:** Different number of staff is due to different level of use of services.	**Medical and Behavioral Health:** Notification is accepted by telephone, fax or other electronic means.
18	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical:** Vice President of Clinical Services responsible for medical/surgical utilization management. **Behavioral Health:** Vice President of Pharmacy and Health Programs responsible for mental health/substance use utilization management. **Reason this is acceptable:** Both report to Senior Vice President of Health Care Services.	**Medical:** UM Physician Reviewers: 2.66 FTE; Licensed Practical Nurse: 7; Registered Nurse: 11 for medical UM. **Behavioral Health:** UM Physician Reviewers day to day: 0.5 FTE; Clinical Review and Case Managers: 8.77 FTEs (Licensded Independent Clinical Social Workers and Licensed Mental Health Counselors). **Reason for difference:** Different number of staff is due to different level of use of services.	**Medical:** Can submit requests via fax and telephone. **Behavioral Health:** Can submit requests via fax, Interactive Voice Response, and internet web portal or telephone. **Reason for difference:** Process is very similar, and any differences are administrative.
19	**Tufts Insurance Company**	**Medical:** Vice President of Clinical Services responsible for medical/surgical utilization management. **Behavioral Health:** Vice President of Pharmacy and Health Programs responsible for mental health/substance use utilization management. **Reason this is acceptable:** Both report to Senior Vice President of Health Care Services.	**Medical:** UM Physician Reviewers: 2.66 FTE; Licensed Practical Nurse: 7; Registered Nurse: 11 for medical UM. **Behavioral Health:** UM Physician Reviewers day to day: 0.5 FTE; Clinical Review and Case Managers: 8.77 FTEs (Licensded Independent Clinical Social Workers and Licensed Mental Health Counselors). **Reason for difference:** Different number of staff is due to different level of use of services.	**Medical:** Can submit requests via fax and telephone. **Behavioral Health:** Can submit requests via fax, Interactive Voice Response, and internet web portal or telephone. **Reason for difference:** Process is very similar, and any differences are administrative.
20	**UniCare Life & Health Insurance Company**	**Medical and Behavioral Health:** Medical Director.	**Medical and Behavioral Health:** 18, including 1 manager, 1 physician, 15 RN's (5 with CCM), and 21 LPN's.	**Medical and Behavioral Health:** Via fax, via telephone, or internet portal.

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No.	Company Name	3.1 - Person Responsible	3.2 - Average Number and Medical Expertise	3.3 - Systems Used for Request for Services
21	**UnitedHealthcare Insurance Company**	**Medical:** National Vice President of Inpatient Care Management and National Vice President of Clinical Operations. **Behavioral Health:** Senior Vice President of Medical Clinical Operations.	**Medical:** 259 MD's and DO's; 1955 RN's 109 LPN/LVN's. **Behavioral Health:** 300 master's level mental health professionals; licensed P.h.D. or registered psychiatric nurses; 32 board certified psychiatrists.	**Medical and Behavioral Health:** Telephone or Provider Portal.

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Summary of Responses to Bulletin 2013-06: Item #3

No.	Company Name	3.4 - Working Hours and Off-Hours Availability	3.5 - Methods of Communication for Utilization Review	3.6 - Methods of Communication for Additional Information for Utilization Review	3.7 - Different Type of Information Requested?	3.8 - Instructions for communication
1	**Aetna Health, Inc.**	**Medical and Behavioral Health:** Normal business hours of 8AM-5PM, M-F. For urgent matters, available 24/7.	**Medical and Behavioral Health:** Through company website policies and guidelines; Aetna Health Care Provider Toolkit; Participating Provider Contract; Annual Quality Management Bulletin. **Behavioral Health:** Behavioral Health Provider Manual.	**Medical and Behavioral Health:** Via phone or fax. For non-urgent matters, sometimes via letters.	**Medical and Behavioral Health:** Information requested necessary to determine if care requested meets clinical criteria for coverage.	**Medical and Behavioral Health:** Via phone, fax, mail or electronically.
2	**Aetna Health Insurance Company**	**Medical and Behavioral Health:** Normal business hours of 8AM-5PM, M-F. For urgent matters, available 24/7.	**Medical and Behavioral Health:** Through company website policies and guidelines; Aetna Health Care Provider Toolkit; Participating Provider Contract; Annual Quality Management Bulletin. **Behavioral Health:** Behavioral Health Provider Manual.	**Medical and Behavioral Health:** Via phone or fax. For non-urgent matters, sometimes via letters.	**Medical and Behavioral Health:** Information requested necessary to determine if care requested meets clinical criteria for coverage.	**Medical and Behavioral Health:** Via phone, fax, mail or electronically.
3	**Aetna Life Insurance Company**	**Medical and Behavioral Health:** Normal business hours of 8AM-5PM, M-F. For urgent matters, available 24/7.	**Medical and Behavioral Health:** Through company website policies and guidelines; Aetna Health Care Provider Toolkit; Participating Provider Contract; Annual Quality Management Bulletin. **Behavioral Health:** Behavioral Health Provider Manual.	**Medical and Behavioral Health:** Via phone or fax. For non-urgent matters, sometimes via letters.	**Medical and Behavioral Health:** Information requested necessary to determine if care requested meets clinical criteria for coverage.	**Medical and Behavioral Health:** Via phone, fax, mail or electronically.
4	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical and Behavioral Health:** Utilization review staff available for both medical and mental health requests 8:30 AM - 4:30 PM on weekdays. Utilization Review not conducted outside of those times.	**Medical and Behavioral Health:** choice of communication is up to clinical provider. Can be standardized authorization request forms or phone calls.	**Medical and Behavioral Health:** Follow-up takes place via telephone.	**Medical and Behavioral Health:** Type of information is the same for both - only information that is necessary to make a decision, such as diagnosis, clinical symptoms, functional impairments and clinical history.	**Medical and Behavioral Health:** Providers instructed to contact carrier via phone or fax.
5	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	**Medical and Behavioral Health:** Utilization review staff available for both medical and mental health requests 8:30 AM - 4:30 PM on weekdays. Utilization Review not conducted outside of those times.	**Medical and Behavioral Health:** choice of communication is up to clinical provider. Can be standardized authorization request forms or phone calls.	**Medical and Behavioral Health:** Follow-up takes place via telephone.	**Medical and Behavioral Health:** Type of information is the same for both - only information that is necessary to make a decision, such as diagnosis, clinical symptoms, functional impairments and clinical history.	**Medical and Behavioral Health:** Providers instructed to contact carrier via phone or fax.
6	**Boston Medical Center Health Plan, Inc.**	**Medical:** Available M-F, 7:30AM-5:30PM. After hours, can send authorization requests via fax or e-mail. **Behavioral Health:** Available 24/7/365.	**Medical and Behavioral Health:** Communication via telephone, via web or provider portal, newsletters, and through Plan's provider manual.	**Medical and Behavioral Health:** Via telephone, and sometimes via fax.	**Medical and Behavioral Health:** The information requested is based on a member's individual needs and to determine medical necessity and authorization of services.	**Medical and Behavioral Health:** Via provider manual, via respective websites, electronic communications, written bulletins, orientations and trainings.

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No.	Company Name	3.4 - Working Hours and Off-Hours Availability	3.5 - Methods of Communication for Utilization Review	3.6 - Methods of Communication for Additional Information for Utilization Review	3.7 - Different Type of Information Requested?	3.8 - Instructions for communication
7	**CeltiCare Health Plan of Massachsuetts, Inc.**	**Medical and Behavioral Health:** All calls answered 24/7. After hours and weekends, calls answered through NurseWise, with a Behavioral Health clinician available 24/7 and a licensed RN available 24/7.	**Medical and Behavioral Health:** InterQual policies are available by request and will be transmitted via paper, fax, or electronic means, as requested. Additionally, all non-InterQual policies are accessible on the CeltiCare Health public website.	**Medical and Behavioral Health:** additional information requested via telephone or fax.	**Medical and Behavioral Health:** Both Celticare and Cenpatico request only the minimum amount of information necessary to make a determination for coverage.	**Medical and Behavioral Health:** All providers are asked to FAX additional clinical documentation in order to complete the UR process. The providers may call with additional information, but are asked to follow up by FAX.
8	**CIGNA Health and Life Insurance Company**	**Medical:** Medical/surgical review staff available M-F 8 AM to 5 PM. **Behavioral Health:** Behavioral health/substance use staff available 24/7/365.	**Medical and Behavioral Health:** For prior authorization communications, information is communicated via phone or fax. Peer-to-peer conversation also takes place.	**Medical and Behavioral Health:** Follow-up takes place via telephone or fax, sometimes via letter.	**Medical and Behavioral Health:** Information that is requested includes information to identify the customer, the provider's name, the place of service, the date or dates of service, the expected length of service, the diagnosis and clinical information necessary to meet the criteria for approval of the service.	Medical and Behavioral Health: Information given to providers through the health care professionals guide at time of joining the CIGNA network of providers. Additional resources also through CIGNA website.
9	**ConnectiCare of Massachusetts, Inc.**	**Medical:** 8AM-5PM, M-F. **Behavioral Health:** Utilization Review staff available 24/7.	**Medical:** Through provider website and online provider office manual. **Behavioral Health:** Guidelines found in the provider website Provider Express. No differences in the way notification takes place.	**Medical:** Notified via phone or letter. CCI makes at least three attempts to collect information. Phone and/or written communication are used in both behavioral and medical matters. **Behavioral Health:** Notified via telephone, secure e-mail (Provider Portal). Care Advocates make at least two attempts to collect information.	**Medical:** These information requests do not pertain to medical matters. **Behavioral Health:** Various items, such as suicidal/homicidal thoughs, substance use history, mental status, and others. **Reason for differences:** Differences exist because of the nature of the difference of the type of services that are being requested.	**Medical:** Instructions given through provider website and online provider office manual. **Behavioral Health:** Instructions located in Provider Manual or Provider Express, the provider website.
10	**Connecticut General Life Insurance Company**	**Medical:** Medical/surgical review staff available M-F 8 AM to 5 PM. **Behavioral Health:** Behavioral health/substance use staff available 24/7/365.	**Medical and Behavioral Health:** For prior authorization communications, information is communicated via phone or fax. Peer-to-peer conversation also takes place.	**Medical and Behavioral Health:** Follow-up takes place via telephone or fax, sometimes via letter.	**Medical and Behavioral Health:** Information that is requested includes information to identify the customer, the provider's name, the place of service, the date or dates of service, the expected length of service, the diagnosis and clinical information necessary to meet the criteria for approval of the service.	Medical and Behavioral Health: Information given to providers through the health care professionals guide at time of joining the CIGNA network of providers. Additional resources also through CIGNA website.
11	**Fallon Community Health Plan, Inc.**	**Medical and Behavioral Health:** 24/7/365.	**Medical and Behavioral Health:** Via telephone, web, provider portal, provider trainings, and/or the provider manual.	**Medical and Behavioral Health:** Additional information requested via telephone. Also, offer of peer to peer clinical discussion.	**Medical and Behavioral Health:** The minimum amount of information is requested that allows for a review decision to be made.	**Medical and Behavioral Health:** Provider manual, respective websites, electronic communications, written bulletins, general provider orientations and trainings, and site specific trainings and orientations.

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Summary of Responses to Bulletin 2013-06: Item #3

No.	Company Name	3.4 - Working Hours and Off-Hours Availability	3.5 - Methods of Communication for Utilization Review	3.6 - Methods of Communication for Additional Information for Utilization Review	3.7 - Different Type of Information Requested?	3.8 - Instructions for communication
12	**Fallon Health & Life Assurance Company**	**Medical and Behavioral Health:** 24/7/365.	**Medical and Behavioral Health:** Via telephone, web, provider portal, provider trainings, and/or the provider manual.	**Medical and Behavioral Health:** Additional information requested via telephone. Also, offer of peer to peer clinical discussion.	**Medical and Behavioral Health:** The minimum amount of information is requested that allows for a review decision to be made.	**Medical and Behavioral Health:** Provider manual, respective websites, electronic communications, written bulletins, general provider orientations and trainings, and site specific trainings and orientations.
13	**Harvard Pilgrim Health Care, Inc.**	**Medical:** 8:30-5, M-F. Non-business hours: leave voice mail and return within 1 business day. **Behavioral Health:** Available 24/7. NIA: someone available 24/7/365. CCN: 7 AM-7PM M-F.	**Medical:** online provider manual. **Behavioral Health:** Guidelines found on Provider Express. Also verbal instructions. No difference in ways to communicate.	**Medical:** Online provider manual. **Behavioral Health:** Via telephone or secure e-mail through Provider Portal. No differences - both use phone, electronic and paper communications.	**Medical:** Same basic information as Optum, then depends on medical issue. **Behavioral Health:** Name, Date of Birth, ID number, Level of Care requested, Facility, Attending Physician, UR Contact Name and Info, Diagnoses, Abnormal lab values, reason for admission, and other information. **Reason for differences:** Differences exist due to different health conditions.	**Medical:** Instructions found in Provider Manual or given through call center. **Behavioral Health:** Instructions found in Provider Manual or Provider Express or given by phone.
14	**Health New England, Inc.**	**Medical and Behavioral Health:** contact via phone 8AM-5PM M-F. After-hours clinician available 5PM-8PM M-F, and 8AM-5PM on weekends and holidays to answer general questions.	**Medical and Behavioral Health:** Methods for communication are the same. They are noted on prior authorization forms as well as the addendum to prior authorization form.	**Medical and Behavioral Health:** by telephone or by fax and mail. The letter template is the same for both.	**Medical and Behavioral Health:** description of member diagnoses, current treatment plan, treatment history, and clinical documentation. Inpatient authorizations reviewed for severity of illness and level of intensity of treatment.	**Medical and Behavioral Health:** Provider manual gives instructions for both. Website and phone and fax numbers are the same for both.
15	**HPHC Insurance Company, Inc.**	**Medical:** 8:30-5, M-F. Non-business hours: leave voice mail and return within 1 business day. **Behavioral Health:** Available 24/7. NIA: someone available 24/7/365. CCN: 7 AM-7PM M-F.	**Medical:** online provider manual. **Behavioral Health:** Guidelines found on Provider Express. Also verbal instructions. No difference in ways to communicate.	**Medical:** Online provider manual. **Behavioral Health:** Via telephone or secure e-mail through Provider Portal. No differences - both use phone, electronic and paper communications.	**Medical:** Same basic information as Optum, then depends on medical issue. **Behavioral Health:** Name, Date of Birth, ID number, Level of Care requested, Facility, Attending Physician, UR Contact Name and Info, Diagnoses, Abnormal lab values, reason for admission, and other information. **Reason for differences:** Differences exist due to different health conditions.	**Medical:** Instructions found in Provider Manual or given through call center. **Behavioral Health:** Instructions found in Provider Manual or Provider Express or given by phone.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #3

No.	Company Name	3.4 - Working Hours and Off-Hours Availability	3.5 - Methods of Communication for Utilization Review	3.6 - Methods of Communication for Additional Information for Utilization Review	3.7 - Different Type of Information Requested?	3.8 - Instructions for communication
16	**Neighborhood Health Plan, Inc.**	**Medical:** 8:30AM -5:30PM Monday through Friday and on call during afterhours Monday through Thursday 5:30 PM - 8:30 AM and Friday through Monday 5:30PM -8:30 AM **Behavioral Health:** 8:30AM -12AM Monday through Friday and on call during afterhours and weekends	**Medical and Behavioral Health:** online/ Provider Portal, via Provider Manual, and via telephone.	**Medical and Behavioral Health:** Via telephone, or if requested, peer to peer discussion with physician.	**Medical:** member history; treatment plan; office and hospital records; lab/diagnostic results; and other clinical information. Only minimum necessary information is requested. **Behavioral Health:** presenting problems, current symptamatology; current/prior agency involvment; current/prior treatment history, and other clinical information. Only minimum necessary information is requested. **Reason for difference:** Both NHP and Beacon identify clinical information commonly needed to make authorization decisions. Different documentation needed to make determination.	**Medical and Behavioral Health:** Provider Manual; web; electronic communication; via mail, site training and education, new provider orientations.
17	**Network Health, LLC (now known as Tufts Health Public Plans, Inc.)**	**Medical and Behavioral Health:** M-F, 8AM-5PM; additional items available online and via member and provider portal.	**Medical and Behavioral Health:** Company website and provider portal;	**Medical and Behavioral Health: D**one via telephone or by faxed request. Requests for additional information specify what information is needed to complete the review.	**Medical and Behavioral Health:** The information requested is pertinent to the specific service being requested.	**Medical and Behavioral Health:** Via phone or in writing.
18	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical and Behavioral Health:** M-F, 8:30AM-5PM. For off-hours emergency, members instructed to go to ER.	**Medical and Behavioral Health:** Tufts Health Plan Commercial Provider Manual is used to communicate information a provider must submit for processing of request for authorization.	**Medical and Behavioral Health:** Via telephone and/or written notification.	**Medical and Behavioral Health:** The information requested is pertinent to the specific service being requested.	**Medical and Behavioral Health:** Tufts Health Plan instructs mental health/substance use providers and medical/surgical providers via the Tufts Health Plan Commercial Provider Manual to complete the utilization review process.
19	**Tufts Insurance Company**	**Medical and Behavioral Health:** M-F, 8:30AM-5PM. For off-hours emergency, members instructed to go to ER.	**Medical and Behavioral Health:** Tufts Health Plan Commercial Provider Manual is used to communicate information a provider must submit for processing of request for authorization.	**Medical and Behavioral Health:** Via telephone and/or written notification.	**Medical and Behavioral Health:** The information requested is pertinent to the specific service being requested.	**Medical and Behavioral Health:** Tufts Health Plan instructs mental health/substance use providers and medical/surgical providers via the Tufts Health Plan Commercial Provider Manual to complete the utilization review process.
20	**UniCare Life & Health Insurance Company**	**Medical and Behavioral Health:** Clinical staff available from 8:30AM to 5:00PM.	**Medical and Behavioral Health:** Utilization review done via faxed form, or in some cases via telephone.	**Medical and Behavioral Health:** Follow-up correspondence done via telephone, and then via mail, if necessary.	**Medical and Behavioral Health:** Diagnosis, planned procedure or treatment, medical history, goal of treatment or discharge plan.	**Medical and Behavioral Health:** Communicate via fax, but telephone is also acceptable.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #3

No.	Company Name	3.4 - Working Hours and Off-Hours Availability	3.5 - Methods of Communication for Utilization Review	3.6 - Methods of Communication for Additional Information for Utilization Review	3.7 - Different Type of Information Requested?	3.8 - Instructions for communication
21	**UnitedHealthcare Insurance Company**	**Medical:** Minimum 8 hours and minimum 8 AM to 4PM; some areas 8AM-6PM; Additional availability on weekends and holidays. **Behavioral Health:** Utilization review staff available 24/7.	**Medical and Behavioral Health:** via guidelines and processes and via provider website.	**Medical:** At least two attempts via phone, fax or mail. **Behavioral Health:** At least two attempts via phone or secure e-mail.	**Medical and Behavioral Health:** The information collected is specific to the service being requested.	**Medical:** Instructions in provider administrative guide. Updates posted online or in Network Bulletin. **Behavioral Health:** online or in provider manual.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #4

No.	Company Name	4.1 - Who Conducted Federal Parity Review?
1	**Aetna Health, Inc.**	**Medical and Behavioral Health:** Federal Parity Task Force, a cross-functional leadership group, consisting of about 50 members.
2	**Aetna Health Insurance Company**	**Medical and Behavioral Health:** Federal Parity Task Force, a cross-functional leadership group, consisting of about 50 members.
3	**Aetna Life Insurance Company**	**Medical and Behavioral Health:** Federal Parity Task Force, a cross-functional leadership group, consisting of about 50 members.
4	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical and Behavioral Health:** At least 36 people involved in the review of compliance with federal parity standards, with a combination of medical and behavioral health expertise.
5	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	At least 36 people involved in the review of compliance with federal parity standards, with a combination of medical and behavioral health expertise.
6	**Boston Medical Center Health Plan, Inc.**	**Medical:** Chief Medical Officer; Senior Director of Clinical and Quality Management; Director of ACC Clinical Training and Special Hospital Programs (now known as Director of Utilization Management); Senior Utilization Management Program Manager; Director of BH Programs; Assistant General Counsel; and Senior Director of Prior Authorization, Provider Audit and Other Party Liability (now known as Senior Director of Provider Audit and Special Investigations). **Behavioral Health:** Beacon Vice President, Medical Affairs; Beacon Vice President of Quality Management; Beacon Director of Quality Management; Beacon Senior Clinical Director; Beacon Clinical Director, Utilization Review; Beacon State Program Director - MA; Beacon General Counsel; Beacon Director of Network Operations.
7	**CeltiCare Health Plan of Massachsuetts, Inc.**	**Medical and Behavioral Health:** Compliance Review Committee, made up of Chief Medical Officer, Senior Director of Quality Improvement, Vice President of Compliance, Senior Vice President of Clinical Operations, and Senior Medical Director.
8	**CIGNA Health and Life Insurance Company**	**Medical and Behavioral Health:** Group of 15 people with a combination of medical and behavioral health expertise.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #4

No.	Company Name	4.1 - Who Conducted Federal Parity Review?
9	**ConnectiCare of Massachusetts, Inc.**	Medical: VP, Chief Medical Officer; Director, Credentialing & Vendor Management; Manager, Clinical Compliane Behavioral Health: N/A ConnectiCare and Optum's clinical staff work together to ensure that any differences in standards, processes, or criteria are based solely upon the differences in treatment related to treating a medical versus behavioral health disorder.
10	**Connecticut General Life Insurance Company**	**Medical and Behavioral Health:** Group of 15 people with a combination of medical and behavioral health expertise.
11	**Fallon Community Health Plan, Inc.**	**Medical:** Chief Medical Officer; Sr. Medical Director, Medical Affairs; Behavioral Health Director; Vice President, Clinical Operations; Regulatory Affairs Director; Vice President, Regulatory Affairs and Compliance; Sr. Director, Actuarial Pricing; and Executive Director, MassHealth. **Behavioral Health:** Vice President of Quality Management; Director of Quality Management; Assistant Vice President of Clinical Operations; Senior Clinical Director, Utilization Review; Vice President, Medical Affairs; Director of Network Operations; State Program Director - MA; and General Counsel.
12	**Fallon Health & Life Assurance Company**	**Medical:** Chief Medical Officer; Sr. Medical Director, Medical Affairs; Behavioral Health Director; Vice President, Clinical Operations; Regulatory Affairs Director; Vice President, Regulatory Affairs and Compliance; Sr. Director, Actuarial Pricing; and Executive Director, MassHealth. **Behavioral Health:** Vice President of Quality Management; Director of Quality Management; Assistant Vice President of Clinical Operations; Senior Clinical Director, Utilization Review; Vice President, Medical Affairs; Director of Network Operations; State Program Director - MA; and General Counsel.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #4

No.	Company Name	4.1 - Who Conducted Federal Parity Review?
13	**Harvard Pilgrim Health Care, Inc.**	**Medical:** Quantitative analysis: Manager for Actuarial Services, Lead Product Specialist, Assistant General Counsel; Non-quantitative analysis: Sr. Vice President of Provider Network and Health Services, Medical Director and other senior staff. **Behavioral Health:** For Non-quantitative analysis: Regional Vice President, Clinical Operations Director, Senior Director of Clinical Operations, Vice President for Strategic Accounts, and the Strategic Account Executive. Also, the Behavioral Policy & Analytic Committee conducts an analysis of the federal parity standards. Quantitative Treatments Limits Analysis performed by: Manager for Actuarial Services, Lead Product Specialist, Assistant General Counsel.
14	**Health New England, Inc.**	**Medical and Behavioral Health:** Vice President & General Counsel
15	**HPHC Insurance Company, Inc.**	**Medical:** Quantitative analysis: Manager for Actuarial Services, Lead Product Specialist, Assistant General Counsel; Non-quantitative analysis: Sr. Vice President of Provider Network and Health Services, Medical Director and other senior staff. **Behavioral Health:** For Non-quantitative analysis: Regional Vice President, Clinical Operations Director, Senior Director of Clinical Operations, Vice President for Strategic Accounts, and the Strategic Account Executive. Also, the Behavioral Policy & Analytic Committee conducts an analysis of the federal parity standards. Quantitative Treatments Limits Analysis performed by: Manager for Actuarial Services, Lead Product Specialist, Assistant General Counsel.
16	**Neighborhood Health Plan**	**Medical and Behavioral Health:** Vice President, Medical Affairs; Vice President, Clinical Operations; Vice President, Quality Management; various Directors and Senior Directors; Chief Actuary; Actuarial Analyst; Senior Clinical Analyst; Manager of Compliance; Manager, Appeals and Grievances; and General Counsel.
17	**Network Health, LLC (now known as Tufts Health Public Plans, Inc.)**	**Medical and Behavioral Health:** Regulatory Affairs Manager; Government Affairs Manager; Director of Behavioral Health; Director of Medical Management.
18	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical and Behavioral Health:** Manager of Regulatory Affairs; Associate General Counsel; Director of Pricing and Provider Risk Management; and Manager of Behavioral Health Clinical Programs.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #4

No.	Company Name	4.1 - Who Conducted Federal Parity Review?
19	**Tufts Insurance Company**	**Medical and Behavioral Health:** Manager of Regulatory Affairs; Associate General Counsel; Director of Pricing and Provider Risk Management; and Manager of Behavioral Health Clinical Programs.
20	**UniCare Life & Health Insurance Company**	**Medical and Behavioral Health:** WellPoint, Inc. uses a cross-functional team, including legal department. A similar cross-function team, including many of the same members, has been put together to implement the MHP regulations.
21	**UnitedHealthcare Insurance Company**	**Medical and Behavioral Health:** Optum's CMO, who is also chair of Behavioral Policy & Analytics Committee.

2013 Requests for Medical and Behavioral Services in Insured Massachusetts Health Plans [1]

No. of Requests Made (5a)	No. of Services Requested (5b)			No. of Requests Authorized (5c)	Percent Authorized [5c/5a]	No. of Requests Modified (5d)	Percent Modified [5d/5a]	No. of Requests Denied (5e)	Percent Denied [5e/5a]	No. of Internal Appeals Filed (5f)	No. of Appeals Approved (5g)	No. of Appeals Denied (5h)	Percent of Appeals Denied [5h/5f]	No. Sent For External Appeal (5i)	No. External Appeals Overturned (5j)	No. of External Appeals Upheld (5k)
	Medical[2]															
Medical	Inpatient Days	Outpatient Visits / Services	Total # of Services	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical
550,369	305,623	2,105,189	2,410,812	516,799	93.9%	11,301	2.1%	22,269	4.0%	3,594	1,522	1,995	55.5%	79	33	46
	Behavioral Health[2,3]															
Behavioral Health	Inpatient Days	Outpatient Visits / Services	Total # of Services	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health
148,555	83,460	2,934,937	3,018,397	144,236	97.1%	1,034	0.7%	2,760	1.9%	907	328	544	60.0%	80	37	43

[1]**Reported information is for all 2013 non-governmental insured coverage issued in Massachusetts for requests made and appeals heard during calendar year 2013.**

[2]**Information as reported by carriers in response to Bulletin 2013-06, Item 5, was submitted as part of annual mental health parity certifications required under 211 CMR 154.00. The information is aggregated based on responses from the following carriers:**

Aetna Health Inc.
Aetna Health Insurance Company
Aetna Life Insurance Company
Blue Cross and Blue Shield of Massachusetts, Inc.
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Boston Medical Center Health Plan, Inc.
CeltiCare Health Plan of Massachusetts, Inc.
CIGNA Health and Life Insurance Company
ConnectiCare of Massachusetts, Inc.
Connecticut General Life Insurance Company
Fallon Community Health Plan, Inc.
Fallon Health & Life Assurance Company, Inc.
Harvard Pilgrim Health Care, Inc.
HPHC Insurance Company, Inc.
Health New England, Inc.
Neighborhood Health Plan, Inc.
Network Health, LLC[4]
Tufts Associated Health Maintenance Organization, Inc.
Tufts Insurance Company
UniCare Life & Health Insurance Company
UnitedHealthcare Insurance Company

[3]**Behavioral health authorization information for Boston Medical Center, Inc., Fallon Community Health Plan, Inc., and Neighborhood Health Plan, Inc. for 2013 differs from what was reported in 2012 due to changes in recording authorizations in 2013. Havard Pilgrim Health Care, Inc. and UnitedHealthcare Insurance Company behavioral health information for 2013 differs from what was reported in 2012 due to changes in the way these companies code for visits.**

[4]**Effective July 1, 2014, Network Health, LLC converted from a LLC to a nonprofit corporation, and upon this conversion changed its name to Tufts Health Public Plans, Inc.**

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #5

No.	Company Name	5.1 - Confirm Fully Insured Only	5.2 - Confirm Massachusetts Lives Only	5.2.a - Number of Requests for Authorization of Services Definition	5.2.b - Differences in Definition of Number of Services Requested	5.2.c - Definition of Number of Requests Authorized
1	**Aetna Health, Inc.**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** Entire inpatient stay = one request for inpatient service; any services for outpatient event = one request.	**Medical and Behavioral Health:** No differences in definition.	**Medical and Behavioral Health:** Authorization is approval of all services requested.
2	**Aetna Health Insurance Company**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** Entire inpatient stay = one request for inpatient service; any services for outpatient event = one request.	**Medical and Behavioral Health:** No differences in definition.	**Medical and Behavioral Health:** Authorization is approval of all services requested.
3	**Aetna Life Insurance Company**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** Entire inpatient stay = one request for inpatient service; any services for outpatient event = one request.	**Medical and Behavioral Health:** No differences in definition.	**Medical and Behavioral Health:** Authorization is approval of all services requested.
4	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** Unique authorizations requiring prior authorization other than prescription drugs.	**Medical and Behavioral Health:** No differences. Based on total requested length of stay measured in either inpatient days or outpatient visits.	**Medical and Behavioral Health:** Those requests that have been approved for both medical/surgical and mental health/substance use disorder services.
5	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** Unique authorizations requiring prior authorization other than prescription drugs.	**Medical and Behavioral Health:** No differences. Based on total requested length of stay measured in either inpatient days or outpatient visits.	**Medical and Behavioral Health:** Those requests that have been approved for both medical/surgical and mental health/substance use disorder services.
6	**Boston Medical Center Health Plan, Inc.**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** A submitted prior authorization request which contains enough information to allow carrier to respond to request.	**Medical and Behavioral Health:** Within inpatient, 1 unit = 1 day; within outpatient, 1 unit has multiple units depending on type of service requested.	**Medical and Behavioral Health:** Number of requests authorized is when at completion of authorization request review, medical necessity criteria was met, and approval letter was issued.
7	**CeltiCare Health Plan of Massachsuetts, Inc.**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** Each individual service or procedure that requires prior authorization is counted as one request. When a request for services spans multiple dates of services, the entire block is counted as one service request.	**Medical and Behavioral Health:** Inpatient services measured on a number of days basis. The outpatient services are aggregated by service type over the requested date span as one service.	**Medical and Behavioral Health:** Request determined to be authorized when all services requested which require prior authorization or medical necessity review have been approved. No differences in definition.
8	**CIGNA Health and Life Insurance Company**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical:** Request for review of services for medical necessity. **Behavioral Health:** Request for specific treatment for authorization of coverage under enrolled member's benefits.	**Medical and Behavioral Health:** No differences in definition.	**Medical:** Service has been approved. **Behavioral Health:** Approval that medical necessity criteria has been met.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #5

No.	Company Name	5.1 - Confirm Fully Insured Only	5.2 - Confirm Massachusetts Lives Only	5.2.a - Number of Requests for Authorization of Services Definition	5.2.b - Differences in Definition of Number of Services Requested	5.2.c - Definition of Number of Requests Authorized
9	**ConnectiCare of Massachusetts, Inc.**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** Requsts for pre-service reviews, concurrent reviews, and post-service (medical necessity) reviews.	**Medical and Behavioral Health:** Each inpatient admission = 1 service.	**Medical and Behavioral Health:** Request has been authorized when the decision is made to approve a request for an admission, service, procedure, or an extension of an inpatient stay.
10	**Connecticut General Life Insurance Company**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical:** Request for review of services for medical necessity. **Behavioral Health:** Request for specific treatment for authorization of coverage under enrolled member's benefits.	**Medical and Behavioral Health:** No differences in definition.	**Medical:** Service has been approved. **Behavioral Health:** Approval that medical necessity criteria has been met.
11	**Fallon Community Health Plan, Inc.**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** The number of authorization requests both approved and denied.	**Medical:** 1 service = 1 day or 1 visit; **Behavioral Health:** 1 service can have multiple units.	**Medical and Behavioral Health:** Request has been authorized when it has been approved. Partial of modified requests not included in authorizations.
12	**Fallon Health & Life Assurance Company**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** The number of authorization requests both approved and denied.	**Medical:** 1 service = 1 day or 1 visit; **Behavioral Health:** 1 service can have multiple units.	**Medical and Behavioral Health:** Request has been authorized when it has been approved. Partial of modified requests not included in authorizations.
13	**Harvard Pilgrim Health Care, Inc.**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** Request made by a provider for a service that requires prior approval by the plan and is reviewed against medical review criteria.	**Medical and Behavioral Health:** No differences in definition.	**Medical and Behavioral Health:** Approval of a request for services that requires prior approval.
14	**Health New England, Inc.**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** Submission of prior authorization request form.	**Medical and Behavioral Health:** No differences given.	**Medical and Behavioral Health:** Approval of request without modification.
15	**HPHC Insurance Company, Inc.**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** Request made by a provider for a service that requires prior approval by the plan and is reviewed against medical review criteria.	**Medical and Behavioral Health:** No differences in definition.	**Medical and Behavioral Health:** Approval of a request for services that requires prior approval.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #5

No.	Company Name	5.1 - Confirm Fully Insured Only	5.2 - Confirm Massachusetts Lives Only	5.2.a - Number of Requests for Authorization of Services Definition	5.2.b - Differences in Definition of Number of Services Requested	5.2.c - Definition of Number of Requests Authorized
16	**Neighborhood Health Plan**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** inpatient requests include those in which there is a clinical review to determine medical necessity and notice of admission. **Medical:** There are no services within the outpatient group that have a parallel notification requirement	**Medical:** inpatient: 1 unit = 1 day. For other categories, the number of units can vary. **Behavioral Health:** 1 unit = 1 day. For other categories, the number of units can vary.	**Medical:** Requests authorized are those that are authorized without adverse action and may include services requests that resulted in a partial approval. Single authorization determinations are counted as an authorization and denial request. **Behavioral Health:** Requests authorized are those that are authorized without adverse action. Denials, modifications, and partial denials are adverse actions.
17	**Network Health, LLC (now known as Tufts Health Public Plans, Inc.)**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** Receipt of a request by phone, fax or other electronic means.	**Medical and Behavioral Health:** No differences in definition.	**Medical and Behavioral Health:** Network Health defines an authorized request as a request that has been reviewed and met medical necessity for that service.
18	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** Count of valid request for services in which a decision was made.	Not applicable	**Medical and Behavioral Health:** Of those services counted in 5.2.a., the number authorized.
19	**Tufts Insurance Company**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** Count of valid request for services in which a decision was made.	Not applicable	**Medical and Behavioral Health:** Of those services counted in 5.2.a., the number authorized.
20	**UniCare Life & Health Insurance Company**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** Certain services require prior authorization. When notification is sent to the carrier it is considered a request for authorization.	**Medical and Behavioral Health:** Breakdown of service days requested between inpatient and outpatient	**Medical and Behavioral Health:** Request has been authorized once utilization review department has reviewed clinical information from provider and determined that request meets requirements for coverage.
21	**UnitedHealthcare Insurance Company**	**Medical and Behavioral Health:** Reported information for fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical:** Information submitted to initiate process of benefit coverage/utilization review. **Behavioral Health:** Benefit coverage request or utilization review request received by Optum.	**Medical:** Single request always = one visit, even if request is for more than one visit. **Behavioral Health:** All visits are counted for each request.	**Medical:** Request authorized is approval of request for service because it is acovered service. **Behavioral Health:** Request is authorized when staff make determination of coverage.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #5

No.	Company Name	5.2.d - Definition of Number of Requests Modified	5.2.e - Definition of Number of Requests Denied	5.2.f - Definition of Requests Denied or Modified Sent for Internal Review	5.2.g - Definition of Internally Appealed Requests Approved
1	**Aetna Health, Inc.**	**Medical and Behavioral Health:** Modification is a denial of service or level of care, but alternative service or less intensive level of care is authorized.	**Medical and Behavioral Health:** Denial is full or partial denial of the service or level of care requested.	**Medical and Behavioral Health:** A verbal or written request to change initial determination decision.	**Medical and Behavioral Health:** A reversal of the initial determination or subsequent appeal determination.
2	**Aetna Health Insurance Company**	**Medical and Behavioral Health:** Modification is a denial of service or level of care, but alternative service or less intensive level of care is authorized.	**Medical and Behavioral Health:** Denial is full or partial denial of the service or level of care requested.	**Medical and Behavioral Health:** A verbal or written request to change initial determination decision.	**Medical and Behavioral Health:** A reversal of the initial determination or subsequent appeal determination.
3	**Aetna Life Insurance Company**	**Medical and Behavioral Health:** Modification is a denial of service or level of care, but alternative service or less intensive level of care is authorized.	**Medical and Behavioral Health:** Denial is full or partial denial of the service or level of care requested.	**Medical and Behavioral Health:** A verbal or written request to change initial determination decision.	**Medical and Behavioral Health:** A reversal of the initial determination or subsequent appeal determination.
4	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical:** Partial denials and diversions to lower level of care. **Behavioral Health:** Partial denials. Modified mental health/substance use service requests processed through clinical peer review not lower level of care.	**Medical and Behavioral Health:** Requests that are given final denial.	**Medical and Behavioral Health:** Number of uinque clinical appeals with a decision.	**Medical and Behavioral Health:** Appeals that have been overturned internally due to additional clinical information. Does not include partially upheld appeals.
5	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	**Medical:** partial denials and diversions to lower level of care. **Behavioral Health:** partial denials. Modified mental health/substance use service requests processed through clinical peer review not lower level of care.	**Medical and Behavioral Health:** Requests that are given final denial.	**Medical and Behavioral Health:** Number of uinque clinical appeals with a decision.	**Medical and Behavioral Health:** Appeals that have been overturned internally due to additional clinical information. Does not include partially upheld appeals.
6	**Boston Medical Center Health Plan, Inc.**	**Medical and Behavioral Health:** Modification is a reduction in the number of visitis or units that both parties agree is sufficient to meet the medical needs of the member.	**Medical and Behavioral Health:** A denial is when after completion of authorization request review, medical necessity criteria is not met and an adverse determination letter is issued to member.	**Medical and Behavioral Health:** An internal appeal of denied or modified services takes place when the denial or modification is issued, and the member, within 180 days, requests verbally or in writing an internal appeal of the decision.	**Medical and Behavioral Health:** The internal appeal is considered approved if a Plan physician reviewer overturns the initial Adverse Determination.
7	**CeltiCare Health Plan of Massachsuetts, Inc.**	**Medical and Behavioral Health:** The modified services are those in which only some, but not all, of the requested amount of services are approved, and the remainder is denied. No difference in definition.	**Medical and Behavioral Health:** The denied services are requests where all of the services requested are denied. No difference in definition.	**Medical and Behavioral Health:** The appeals follow a specific process where a written request for appeal is received by a member for denied services, or a written release that allows a provider or authorized appeal representative to request an appeal. No differences in process for physical or behavioral health.	**Medical and Behavioral Health:** The appeals are approved when the requested appealed services are approved in whole or in part. No difference in definition.
8	**CIGNA Health and Life Insurance Company**	**Medical:**N/A. Request is either approved or denied. **Behavioral Health:** N/A. Request is either approved or denied. For services that are not approved alternate care may be offered.	**Medical:** Request for service has been denied. **Behavioral Health:** Service that is not covered under member plan is denied.	**Medical and Behavioral Health:** Internal review submissions are those that are either based upon adverse determinations or grievances.	**Medical and Behavioral Health:** Those internal review submissions that are approved.

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No.	Company Name	5.2.d - Definition of Number of Requests Modified	5.2.e - Definition of Number of Requests Denied	5.2.f - Definition of Requests Denied or Modified Sent for Internal Review	5.2.g - Definition of Internally Appealed Requests Approved
9	**ConnectiCare of Massachusetts, Inc.**	Medical and Behavioral Health: Not applicable; ConnectiCare and Optum do not modify requests.	**Medical and Behavioral Health:** Request has been denied when the decision is made to deny a request for an admission, service, procedure, or an extension of an inpatient stay.	**Medical and Behavioral Health:** Request received for a review of a decision to deny a request for an admission, service, procedure, or an extension of an inpatient stay that is reviewed through the internal appeals process.	**Medical and Behavioral Health:** Determinations made through the internal appeals process to overturn the original decision to deny a request for an admission, service, procedure, or an extension of an inpatient stay.
10	**Connecticut General Life Insurance Company**	**Medical:**N/A. Request is either approved or denied. **Behavioral Health:** N/A. Request is either approved or denied. For services that are not approved alternate care may be offered.	**Medical:** Request for service has been denied. **Behavioral Health:** Service that is not covered under member plan is denied.	**Medical and Behavioral Health:** Internal review submissions are those that are either based upon adverse determinations or grievances.	**Medical and Behavioral Health:** Those internal review submissions that are approved.
11	**Fallon Community Health Plan, Inc.**	**Medical:** Modification is partial approval and not all services have been authorized. **Behavioral Health:** Modification is authorization for services for fewer units than requested. Does not include when different level of care is authorized.	**Medical and Behavioral Health:** Denial is a request for services that has not been approved and has not been modified.	**Medical and Behavioral Health:** Initial adverse determination issued and member requests appeal.	**Medical and Behavioral Health:** Reviewer overturns initial decision of adverse determination.
12	**Fallon Health & Life Assurance Company**	**Medical:** Modification is partial approval and not all services have been authorized. **Behavioral Health:** Modification is authorization for services for fewer units than requested. Does not include when different level of care is authorized.	**Medical and Behavioral Health:** Denial is a request for services that has not been approved and has not been modified.	**Medical and Behavioral Health:** Initial adverse determination issued and member requests appeal.	**Medical and Behavioral Health:** Reviewer overturns initial decision of adverse determination.
13	**Harvard Pilgrim Health Care, Inc.**	**Medical and Behavioral Health:** A request that requires prior approval that was either partially approved or denied, or modified to a lower level of care while still meeting member's needs, or reduced from original number of visit requests.	**Medical and Behavioral Health:** Denial of authorization or payment or physician ends coverage because Medical Review Criteria have not been met.	**Medical and Behavioral Health:** Internal appeal may be filed when request for coverage is denied. Appeal may be sent to either Behavioral Health Access Center in the case of mental health/substance use requests, and directly to Harvard Pilgrim for medical/surgical requests.	**Medical and Behavioral Health:** Approval of internal appeal has taken place when letter has been sent to member in writing informing member of the decision of the appeal after investigation and review of appeal.
14	**Health New England, Inc.**	**Medical and Behavioral Health:** A modification of the request, such as approval of service, but not for amount or frequency requested.	**Medical and Behavioral Health:**A denial is where company did not approve any of services as requested.	**Medical and Behavioral Health:** A request for service that was either denied or modified and was sent internally for appeal.	**Medical and Behavioral Health:** When all requested services have been approved in full, with no reduction in the amount or frequency of services that were requested
15	**HPHC Insurance Company, Inc.**	**Medical and Behavioral Health:** A request that requires prior approval that was either partially approved or denied, or modified to a lower level of care while still meeting member's needs, or reduced from original number of visit requests.	**Medical and Behavioral Health:** Denial of authorization or payment or physician ends coverage because Medical Review Criteria have not been met.	**Medical and Behavioral Health:** Internal appeal may be filed when request for coverage is denied. Appeal may be sent to either Behavioral Health Access Center in the case of mental health/substance use requests, and directly to Harvard Pilgrim for medical/surgical requests.	**Medical and Behavioral Health:** Approval of internal appeal has taken place when letter has been sent to member in writing informing member of the decision of the appeal after investigation and review of appeal.

No.	Company Name	5.2.d - Definition of Number of Requests Modified	5.2.e - Definition of Number of Requests Denied	5.2.f - Definition of Requests Denied or Modified Sent for Internal Review	5.2.g - Definition of Internally Appealed Requests Approved
16	**Neighborhood Health Plan**	**Medical:** Only modified approved requests. A subsequent/concurrent request resulting in a denial is not included. A subsequent/concurrent request resulting in a denial is included in "requests denied". **Behavioral Health:** Adverse Determination/Modifications where lesser units are authorized than requested. Does not include instances where a different level of care is authorized than requested, which are counted under denials, and then authorizations.	**Medical and Behavioral Health:** Requests denied include denial determinations made as the result of a medical necessity review and denial determinations based on administrative reasons. Due to the utilization management system, denials listed under service type is an aggregate of medical and administrative denials.	**Medical:** Withdrawn appeals are not accounted for in this total. **Behavioral Health:** Withdrawn appeals are not accounted for in this total. Appeals are inclusive of denials and modifications.	**Medical and Behavioral Health:** Requests in which, after further investigation by a different reviewer of the initial denial upon a member's appeal, it is determined that initial denial decision should be reversed and approved in favor of the member.
17	**Network Health, LLC (now known as Tufts Health Public Plans, Inc.)**	**Medical and Behavioral Health:** Network defines a modified request as an approval of services that are less than the requested service.	**Medical and Behavioral Health:** Network Health defines that a request has been denied when it has been reviewed by a medical director and determined to not meet medical necessity.	**Medical and Behavioral Health:** Network Health defines that a request has been denied and sent for review through the internal appeals process when there is an adverse determination and a member or provider expresses that they believe that the denied service is medically necessary.	**Medical and Behavioral Health:** Network Health defines that an internal appeal request has been approved when the original denial of services is overturned, because the services are determined to be medically necessary.
18	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical and Behavioral Health:** Not applicable.	**Medical and Behavioral Health:** Of those service counted in a., the number denied.	**Medical and Behavioral Health:** Internal member appeal of a Utilization Management decision.	**Medical and Behavioral Health:** Counts internal member appeals from the requests denied or modified in which the appeal decision was to overturn or partially pay
19	**Tufts Insurance Company**	**Medical and Behavioral Health:** Not applicable.	**Medical and Behavioral Health:** Of those service counted in a., the number denied.	**Medical and Behavioral Health:** Internal member appeal of a Utilization Management decision.	**Medical and Behavioral Health:** Counts internal member appeals from the requests denied or modified in which the appeal decision was to overturn or partially pay
20	**UniCare Life & Health Insurance Company**	**Medical and Behavioral Health:** Modification is an initial denial, but during re-consideration, some of requested services are approved.	**Medical and Behavioral Health:** Upon review, the request for service does not meet the criteria for coverage.	**Medical and Behavioral Health:** Internal appeal is considered an initial or first appeal upon review of services that were initially denied or modified.	**Medical and Behavioral Health:** Upon review by utilization review department, request is determined to meet criteria for coverage.
21	**UnitedHealthcare Insurance Company**	**Medical and Behavioral Health:** Not applicable.	**Medical:** Administrative or clinical review decision resulting in full or partial reduction or termination, non-coverage, or non-certification of care or services. **Behavioral Health:** Denial, reduction or termination of coverage or failure to make payment.	**Medical and Behavioral Health:** An adverse determination must have been made and communication made to the company.	**Medical and Behavioral Health:** The original non-coverage determination has been overturned and therefore approved.

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No.	Company Name	5.2.h - Definition of Internally Appealed Requests Denied	5.2.i - Definition of Internally Appealed Requests Sent for External Appeal	5.2.j - Definition of External Appeals Overturned	5.2.k - Definition of External Appeals Upheld
1	**Aetna Health, Inc.**	**Medical and Behavioral Health:** An internal appeal denial can be a partial denial or a full denial of the original request.	**Medical and Behavioral Health:** A consumer external appeal of partial or full denial of the appeal determination.	**Medical and Behavioral Health:** A decision by external reviewer to overturn the initial internal appeal decision.	**Medical and Behavioral Health:** A decision by external review to agree with the initial internal appeal decision.
2	**Aetna Health Insurance Company**	**Medical and Behavioral Health:** An internal appeal denial can be a partial denial or a full denial of the original request.	**Medical and Behavioral Health:** A consumer external appeal of partial or full denial of the appeal determination.	**Medical and Behavioral Health:** A decision by external reviewer to overturn the initial internal appeal decision.	**Medical and Behavioral Health:** A decision by external review to agree with the initial internal appeal decision.
3	**Aetna Life Insurance Company**	**Medical and Behavioral Health:** An internal appeal denial can be a partial denial or a full denial of the original request.	**Medical and Behavioral Health:** A consumer external appeal of partial or full denial of the appeal determination.	**Medical and Behavioral Health:** A decision by external reviewer to overturn the initial internal appeal decision.	**Medical and Behavioral Health:** A decision by external review to agree with the initial internal appeal decision.
4	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical and Behavioral Health:** Upheld denials of appeals.	**Medical and Behavioral Health:** Member appeals sent for external review.	**Medical and Behavioral Health:** Member appeals that are overturned by an external third party organization.	**Medical and Behavioral Health:** All upheld appeals, fully upheld appeals, and partially upheld appeals.
5	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	**Medical and Behavioral Health:** Upheld denials of appeals.	**Medical and Behavioral Health:** Member appeals sent for external review.	**Medical and Behavioral Health:** Member appeals that are overturned by an external third party organization.	**Medical and Behavioral Health:** All upheld appeals, fully upheld appeals, and partially upheld appeals.
6	**Boston Medical Center Health Plan, Inc.**	**Medical and Behavioral Health:** If after review of all information a Plan physician reviewer upholds the initial denial, the appeal is considered denied.	**Medical and Behavioral Health:** If the initial decision to deny services is upheld after internal review process, the member is notified of option to request an external appeal through the Office of Patient Protection.	**Medical and Behavioral Health:** When an external review agency approves, in part or in whole, the services initially requested which had been denied.	**Medical and Behavioral Health:** When an external review agency upholds, in whole, the initial decision to deny the services requested.
7	**CeltiCare Health Plan of Massachsuetts, Inc.**	**Medical and Behavioral Health:** The appeals are counted as denied when all appealed services are denied. No difference in definition.	**Medical and Behavioral Health:** Internally appeals request sent for external appeal once the member has requested an external appeal. No difference in definition.	**Medical and Behavioral Health:** The external appeals are overturned when the requested appealed services are overturned by the external appeal body in whole or in part. No difference in definition.	**Medical and Behavioral Health:** The external appeals are upheld when all appealed services are upheld in whole or in part. No difference in definition.
8	**CIGNA Health and Life Insurance Company**	**Medical and Behavioral Health:** Those internal review submissions that are denied.	**Medical and Behavioral Health:** Review by external review panel of internal appeal that was denied in whole or in part.	**Medical and Behavioral Health:** External appeals that the external review panel overturns or partially overturns.	**Medical and Behavioral Health:** External appeals that the external review panel does not partially or fully overturns.

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No.	Company Name	5.2.h - Definition of Internally Appealed Requests Denied	5.2.i - Definition of Internally Appealed Requests Sent for External Appeal	5.2.j - Definition of External Appeals Overturned	5.2.k - Definition of External Appeals Upheld
9	**ConnectiCare of Massachusetts, Inc.**	**Medical and Behavioral Health:** Determinations made through the internal appeals process to uphold the original decision to deny a request for an admission, service, procedure, or an extension of an inpatient stay.	**Medical and Behavioral Health:** External appeal request has been assigned by the Office of Patient Protection to an external review agency.	Medical and Behavioral Health: An externally appealed adverse determination has been overturned when the external review agency makes the decision to reverse ConnectiCare's adverse determination.	Medical and Behavioral Health: An externally appealed adverse determination has been upheld when the external review agency makes the decision to affirm ConnectiCare's adverse determination.
10	**Connecticut General Life Insurance Company**	**Medical and Behavioral Health:** Those internal review submissions that are denied.	**Medical and Behavioral Health:** Review by external review panel of internal appeal that was denied in whole or in part.	**Medical and Behavioral Health:** External appeals that the external review panel overturns or partially overturns.	**Medical and Behavioral Health:** External appeals that the external review panel does not partially or fully overturns.
11	**Fallon Community Health Plan, Inc.**	**Medical and Behavioral Health:** Reviewer upholds initial decision of adverse determination.	**Medical and Behavioral Health:** External appeal is a request from member to have HPC's OPP review the initial requests denial after internal appeal.	**Medical and Behavioral Health:** An external review agency overturns the internal appeal denial and approves the requested service, either in whole or in part.	**Medical and Behavioral Health:** An external review agency upholds the internal appeal denial in whole.
12	**Fallon Health & Life Assurance Company**	**Medical and Behavioral Health:** Reviewer upholds initial decision of adverse determination.	**Medical and Behavioral Health:** external appeal is a request from member to have HPC's OPP review the initial requests denial after internal appeal.	**Medical and Behavioral Health:** An external review agency overturns the internal appeal denial and approves the requested service, either in whole or in part.	**Medical and Behavioral Health:** An external review agency upholds the internal appeal denial in whole.
13	**Harvard Pilgrim Health Care, Inc.**	**Medical and Behavioral Health:** Denial of internal appeal has taken place when letter has been sent to member in writing informing member of the decision of the appeal after investigation and review of appeal.	**Medical and Behavioral Health:** An internally appealed request which was denied, for which the member has filed an external appeal.	**Medical and Behavioral Health:** External appeal where the Office of Patient Protection is notified by External Review Agency, and carrier is notified by Office of Patient Protection that the original adverse determination has been overturned.	**Medical and Behavioral Health:** External appeal where the Office of Patient Protection is notified by External Review Agency, and carrier is notified by Office of Patient Protection that the original adverse determination has been upheld.
14	**Health New England, Inc.**	**Medical and Behavioral Health:** Upheld original decision.	**Medical and Behavioral Health:** Upheld original decision and member exercised external appeal rights.	**Medical and Behavioral Health:** External appeal where original decision is overturned, allowing member to receive original service or item requested.	**Medical and Behavioral Health:** External appeal where original decision upheld, leaving decision to deny service or item requested intact.
15	**HPHC Insurance Company, Inc.**	**Medical and Behavioral Health:** Denial of internal appeal has taken place when letter has been sent to member in writing informing member of the decision of the appeal after investigation and review of appeal.	**Medical and Behavioral Health:** An internally appealed request which was denied, for which the member has filed an external appeal.	**Medical and Behavioral Health:** External appeal where the Office of Patient Protection is notified by External Review Agency, and carrier is notified by Office of Patient Protection that the original adverse determination has been overturned.	**Medical and Behavioral Health:** external appeal where the Office of Patient Protection is notified by External Review Agency, and carrier is notified by Office of Patient Protection that the original adverse determination has been upheld.

No.	Company Name	5.2.h - Definition of Internally Appealed Requests Denied	5.2.i - Definition of Internally Appealed Requests Sent for External Appeal	5.2.j - Definition of External Appeals Overturned	5.2.k - Definition of External Appeals Upheld
16	**Neighborhood Health Plan**	**Medical and Behavioral Health:** Requests in which, after further investigation by a different reviewer of the initial denial upon a member's appeal, it is determined that the initial denial should remain.	**Medical and Behavioral Health:** Request in which a member's appeal was upheld and the member exercised their right to have the decision reviewed by an external entity.	**Medical and Behavioral Health:** Requests in which, after further review of the member's upheld appeals request, it is determined by the external entity that the upheld denial decision should be reversed and approved in favor of the member.	**Medical and Behavioral Health:** Requests in which, after further review of the member's upheld appeals request, it is determined by the external entity that the upheld denial should remain.
17	**Network Health, LLC (now known as Tufts Health Public Plans, Inc.)**	**Medical and Behavioral Health:** Network Health defines that an internal appeal request has been denied when after a medical director has reviewed the appeal and decided that the original denial is upheld.	**Medical and Behavioral Health:** Network Health defines that an appeal has been denied and been sent by the consumer to external appeals when a request isreceived from the Office of Patient Protection that a member is requesting an external appeal and that additional information is be be provided on the original denial.	**Medical and Behavioral Health:** Network Health defines that an externally appealed adverse determination has been overturned when notice is received from the external review agency of the decision to overturn the decision.	**Medical and Behavioral Health:** Network Health defines that an externally appealed adverse determination has been upheld when notice is received from the external review agency that the member's denial has been upheld.
18	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical and Behavioral Health:** Of those counted in 5.2.f., the number of initial denials upheld.	**Medical and Behavioral Health:** Counts of external member appeals of a Utilization Management decision.	**Medical and Behavioral Health:** Counts external member appeals in which the decision was to overturn or partially pay.	**Medical and Behavioral Health:** Counts from external appeals in which the decision was to uphold.
19	**Tufts Insurance Company**	**Medical and Behavioral Health:** Of those counted in 5.2.f., the number of initial denials upheld.	**Medical and Behavioral Health:** Counts of external member appeals of a Utilization Management decision.	**Medical and Behavioral Health:** Counts external member appeals in which the decision was to overturn or partially pay.	**Medical and Behavioral Health:** Counts from external appeals in which the decision was to uphold.
20	**UniCare Life & Health Insurance Company**	**Medical and Behavioral Health:** Denial of internal appeal has taken place when a specialty match physician determines that the initial decision to deny or modify services should be upheld.	**Medical and Behavioral Health:** External appeal is a request from member to have HPC's OPP review the initial requests denial after internal appeal.	**Medical and Behavioral Health:** When HPC's OPP overturns the initial decision to deny or modify the authorization for services.	**Medical and Behavioral Health:** When HPC's OPP confirms or upholds the initial decision to deny or modify the authorization for services.
21	**UnitedHealthcare Insurance Company**	**Medical:** Not given. **Behavioral Health:** Appeal is denied if any portion of the appeal is denied.	**Medical:** When UHC's appeals unit receives an appeal. **Behavioral Health:** When OPP submits notice of appeal to UBH.	**Medical:** UHC appeals unit only tracks volume but not decisions. External organization sends letter to UHC notifying it of decision to overturn denial. **Behavioral Health:** Appeal overturned when notified by OPP.	**Medical:** UHC is notified by external appeals organization that appeal has been upheld. **Behavioral Health:** Appeal upheld when notified by OPP.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #6

No.	Company Name	6.1 - Out of Network Authorizations - Who is Responsible?	6.2 - Methods Used for Out of Network Requests	6.3 - Differences in Information Requested for Out of Network Requests
1	**Aetna Health, Inc.,**	**Medical and Behavioral Health:** Northeast Regional Medical Director	**Medical and Behavioral Health:** Electronic Data Interchange (secure online provider portal); mail; telephone; fax.	**Medical and Behavioral Health:** Aetna asks what services are being requested and why provider believes why not reasonably available in-network.
2	**Aetna Health Insurance Company**	**Medical and Behavioral Health:** Northeast Regional Medical Director	**Medical and Behavioral Health:** Electronic Data Interchange (secure online provider portal); mail; telephone; fax.	**Medical and Behavioral Health:** Aetna asks what services are being requested and why provider believes why not reasonably available in-network.
3	**Aetna Life Insurance Company**	**Medical and Behavioral Health:** Northeast Regional Medical Director	**Medical and Behavioral Health:** Electronic Data Interchange (secure online provider portal); mail; telephone; fax.	**Medical and Behavioral Health:** Aetna asks what services are being requested and why provider believes why not reasonably available in-network.
4	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical:** Medical Director for Utilization and Case Management. **Behavioral Health:** Medical Director for Behavioral Health. **Reason for difference:** Difference is because process goes through different departments. The processes are comparable and both Medical Directors report to Associate Chief Medical Officer.	**Medical and Behavioral Health:** Faxed or mailed standardized out of network services request form.	**Medical and Behavioral Health:** Out of network service requests are approved when 1) urgent need of care; 2) service otherwise not available in network; 3) transition of care after enrolling from other plan.
5	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	**Medical:** Medical Director for Utilization and Case Management. **Behavioral Health:** Medical Director for Behavioral Health. **Reason for difference:** Difference is because process goes through different departments. The processes are comparable and both Medical Directors report to Associate Chief Medical Officer.	**Medical and Behavioral Health:** Faxed or mailed standardized out of network services request form.	**Medical and Behavioral Health:** Out of network service requests are approved when 1) urgent need of care; 2) service otherwise not available in network; 3) transition of care after enrolling from other plan.

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Summary of Responses to Bulletin 2013-06: Item #6

No.	Company Name	6.1 - Out of Network Authorizations - Who is Responsible?	6.2 - Methods Used for Out of Network Requests	6.3 - Differences in Information Requested for Out of Network Requests
6	**Boston Medical Center Health Plan, Inc.**	**Medical:** BMCHP Chief Medical Officer; medical directors; Senior Director of Prior Authorization; Provider Audit and Other Party Liability; and Director of Acute Care Coordination. **Behavioral Health:** Beacon's Vice President of Medical Affairs; medical directors; and clinicians. **Reason for differences:** Although they are in different entities with different titles, they are respective counterparts.	**Medical and Behavioral Health:** Requests for coverage via fax, phone, or secure e-mail.	**Medical:** demographic information, requested service/procedure, member diagnosis, and others. **Behavioral health:** Minimum amount necessary to make decision from: current symptomatology, current and prior agency involvement, current and prior treatment history, medical history and individual needs, substance use history and others. **Reason for difference:** There are differences based on individual needs. Outcome need not be the same, but the process is the same.
7	**CeltiCare Health Plan of Massachsuetts, Inc.**	**Medical and Behavioral:** Chief Medical Officer	**Medical and Behavioral Health:** The system that non-participating providers can access are all of the same systems as participating providers to request authorization: Toll-free line, Fax, secure web portal, mail.	**Medical and Behavioral Health:** There is no difference in the information requested
8	**CIGNA Health and Life Insurance Company**	**Medical and Behavioral Health:** OON treated the same way as in-network. Therefore, the same people are responsible.	**Medical and Behavioral Health:** OON treated the same way as in-network. Therefore, the same methods are used.	**Medical and Behavioral Health:** The information requested is the same for medical and mental health services. OON is treated the same way as in-network services.
9	**ConnectiCare of Massachusetts, Inc.**	**Medical:** Overseen by Senior VP, Healthcare Management; VP, Chief Medical Offiecer; Director of Utilization Management; Manager, Clinical Compliance. **Behavioral Health:** Day to day administration of UR processes overseen by Senior Vice President and various other Vice Presidents. **Reason for difference:** Differences due to different areas of expertise.	**Medical:** Can be requested via telephone, fax or mail. **Behavioral Health:** Can be requested via telephone, fax or mail.	**Medical and Behavioral Health:** Depending on type of service requested: Level of care requested; past substance use, mental status, presence of suicidal/homicidal ideation, vital signs, fall history, biopsychosocial information.
10	**Connecticut General Life Insurance Company**	**Medical and Behavioral Health:** OON treated the same way as in-network. Therefore, the same people are responsible.	**Medical and Behavioral Health:** OON treated the same way as in-network. Therefore, the same methods are used.	**Medical and Behavioral Health:** The information requested is the same for medical and mental health services. OON is treated the same way as in-network services.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #6

No.	Company Name	6.1 - Out of Network Authorizations - Who is Responsible?	6.2 - Methods Used for Out of Network Requests	6.3 - Differences in Information Requested for Out of Network Requests
11	**Fallon Community Health Plan, Inc.**	**Medical:** Chief Medical Officer and Associate Medical Directors. **Behavioral Health:** Beacon's Vice President of Medical Affairs and Medical Directors. **Reason for difference:** These are comparable positions within each entity.	**Medical:** Via fax or telephone. **Behavioral Health:** Via fax, telephone, or e-mail. **Reason for difference:** The methods are comparable for each entity.	**Medical and Behavioral Health:** Information requested is the information clinically necessary to make a utilization review determination.
12	**Fallon Health & Life Assurance Company**	**Medical:** Chief Medical Officer and Associate Medical Directors. **Behavioral Health:** Beacon's Vice President of Medical Affairs and Medical Directors. **Reason for difference:** These are comparable positions within each entity.	**Medical:** Via fax or telephone. **Behavioral Health:** Via fax, telephone, or e-mail. **Reason for difference:** The methods are comparable for each entity.	**Medical and Behavioral Health:** Information requested is the information clinically necessary to make a utilization review determination.
13	**Harvard Pilgrim Health Care, Inc.**	**Medical:** Senior Medical Director. **Behavioral Health:** Regional Vice President at Optum. **Reason for difference:** Differences exist based on different entities responsible for each type of service.	**Medical:** Providers can call Provider Service Center; or visit website. **Behavioral Health:** For OON services requiring pre-authorization, via telephone. For those not requiring pre-authorization, providers submit claims for processing.	**Medical and Behavioal Health:** Process same as for in-network requests for authorization of services. **Differences** between medical and behavioral health services exist due to different entities responsible for each.
14	**Health New England, Inc.**	**Medical:** Medical requests reviewed by Medical Director who is licensed physician. **Behavioral Health:** Mental health requests reviewed by Medical Director who is licensed psychiatrist. **Reason for difference:** Both report to HNE Integrated Care Manager - Utilization Management.	**Medical:** via fax or, for inpatient admission, submit notification after admission. **Behavioral Health:** No notification necessary prior to inpatient admission for mental health service. **Reason for Difference:** In-network and OON processes are the same; same for mental health and medical service.	**Medical and Behavioral Health:** current treatment plan, treatment history and clinical documentation.
15	**HPHC Insurance Company, Inc.**	**Medical:** Senior Medical Director. **Behavioral Health:** Regional Vice President at Optum. **Reason for difference:** Differences exist based on different entities responsible for each type of service.	**Medical:** Providers can call Provider Service Center; or visit website. **Behavioral Health:** For OON services requiring pre-authorization, via telephone. For those not requiring pre-authorization, providers submit claims for processing.	**Medical and Behavioal Health:** Process same as for in-network requests for authorization of services. **Differences** between medical and behavioral health services exist due to different entities responsible for each.

No.	Company Name	6.1 - Out of Network Authorizations - Who is Responsible?	6.2 - Methods Used for Out of Network Requests	6.3 - Differences in Information Requested for Out of Network Requests
16	**Neighborhood Health Plan**	**Medical:** Chief Medical Officer and Medical Directors. **Behavioral Health:** Vice President of Medical Affairs and Medical Directors. **Reason for difference:** Medical CMO also oversees Beacon out of network authorizations; but Beacon has its separate experts.	**Medical and Behavioral Health:** Requests for coverage via fax, telephone, or mail.	**Medical and Behavioral Health: S**ame as in-network, plus, for **Medical**: Whether prior relationship with member; provider qualification specific to condition; and for new members, whether provider is PCP. **Behavioral Health:** Geographic, medical emergency, moral or religious considerations; student status; confidentiality issues; new members/continuity of care. **Reason for difference: S**upportive documents differ in order to substantiate necessity for service delivery.
17	**Network Health, LLC**	**Medical and Behavioral Health:** Network Health Medical Directors oversee the authorization of out-of-network mental health/substance use disorder services and out-of-network medical/surgical services.	**Medical and Behavioral Health:** Out of Network mental health/substance use providers and medical/surgical providers have the ability to submit requests for authorization via fax, telephone, and through the web (Network Health Connect).	**Medical and Behavioral Health:** Network Health requests information to conduct the utilization review that is pertinent to the services being requested.
18	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical and Behavioral Health:** Tufts Health Plan Medical Directors	**Medical:** Via fax or telephone. **Behavioral Health:** Via fax, telephone, or interactive voice response (IVR). **Reason for difference:** Behavioral Health providers have more options for submitting requests for prior authorization.	**Medical and Behavioral Health:** Information is requested that is pertinent to the service being requested.
19	**Tufts Insurance Company**	**Medical and Behavioral Health:** Tufts Health Plan Medical Directors	**Medical:** Via fax or telephone. **Behavioral Health:** Via fax, telephone, or interactive voice response (IVR). **Reason for difference:** Behavioral Health providers have more options for submitting requests for prior authorization.	**Medical and Behavioral Health:** Information is requested that is pertinent to the service being requested.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #6

No.	Company Name	6.1 - Out of Network Authorizations - Who is Responsible?	6.2 - Methods Used for Out of Network Requests	6.3 - Differences in Information Requested for Out of Network Requests
20	**UniCare Life & Health Insurance Company**	**Medical and Behavioral Health:** Review of out of network services is the same as for in-network, and is overseen by Senior VP of Care Management.	**Medical and Behavioral Health:** Mailed claim form, telephone, e-mail, internet portal.	**Medical and Behavioral Health**: Patient diagnosis; provider name; license type, address, and other information necessary to process a claim for services.
21	**UnitedHealthcare Insurance Company**	**Medical:** National Vice President of Inpatient Care Management and National Vice President of Clinical Operations. **Behavioral Health:** Senior Vice President of Medical Clinical Operations.	**Medical**: Telephone, internet, and/or fax. **Behavioral Health:** telephone.	**Medical and Behavioral Health:** For both UHC and Optum, the information requested is specific to the service requested. **Medical:** Providers can view the information on UHC website. **Behavioral Health:** Providers can find this information on UBH website.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #7

No.	Company Name	7.1 - List of Any Differences in Cost-sharing Features
1	**Aetna Health, Inc.**	Copays were the same for medical and behavioral health matters and removed the ability to select inpatient day and outpatient visit limits for behavioral health matters.
2	**Aetna Health Insurance Company**	Copays were the same for medical and behavioral health matters and removed the ability to select inpatient day and outpatient visit limits for behavioral health matters.
3	**Aetna Life Insurance Company**	Copays were the same for medical and behavioral health matters and removed the ability to select inpatient day and outpatient visit limits for behavioral health matters.
4	**Blue Cross and Blue Shield of Massachusetts, Inc.**	Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.
5	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.
6	**Boston Medical Center Health Plan, Inc.**	There are no differences in any cost-sharing features between medical/surgical and mental health/substance use services in any of the plans offered.
7	**CeltiCare Health Plan of Massachsuetts, Inc.**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.
8	**CIGNA Health and Life Insurance Company**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.
9	**ConnectiCare of Massachusetts, Inc.**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.
10	**Connecticut General Life Insurance Company**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.
11	**Fallon Community Health Plan, Inc.**	Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.
12	**Fallon Health & Life Assurance Company**	Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.

2013 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #7

No.	Company Name	7.1 - List of Any Differences in Cost-sharing Features
13	**Harvard Pilgrim Health Care, Inc.**	Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.
14	**Health New England, Inc.**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.
15	**HPHC Insurance Company, Inc.**	Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.
16	**Neighborhood Health Plan**	Use of copayments, co-insurance, deductible, out of pocket maximums, and other benefit limitations for mental health are either the same as, or more beneficial than those for medical services.
17	**Network Health, LLC (now known as Tufts Health Public Plans, Inc.)**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.
18	**Tufts Associated Health Maintenance Organization, Inc.**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.
19	**Tufts Insurance Company**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.
20	**UniCare Life & Health Insurance Company**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.
21	**UnitedHealthcare Insurance Company**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.