2020 Mental Health Parity and Addiction Equity Act Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Chapter 110 of the Acts of 2017 Responses

	CY 2020 Mental Health Parity Certification						
	Chapter 110 of the Acts of 2017	Services covered, not covered, or covered through comparable service or other definition in 2020					
No.	Name of Carrier	(i) intensive care coordination for a child with serious emotional disturbances	(ii) Mobile crisis intervention	(iii) Family support and training[1]	(iv) In-home therapy	(v) Therapeutic mentoring services[1]	(vi) In-home behavioral services
1	Aetna Health Insurance Company	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.
2	Aetna Health, Inc.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.
3	Aetna Life Insurance Company	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.
4	AllWays Health Partners, Inc.	Carrier covers service as defined.	Carrier covers service as defined.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined.
5	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined.
6	Blue Cross and Blue Shield of Massachusetts, Inc.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined.
7	Boston Medical Center Health Net Plan, Inc.	Carrier covers service as defined.	Carrier covers service as defined.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined.
8	CIGNA Health and Life Insurance Company	Carrier covers service as defined.	Carrier covers service as defined.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined.
9	ConnectiCare of Massachusetts, Inc.	Carrier covers service as defined.	Carrier covers service as defined or comparable service.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined or comparable service.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined.
10	Fallon Community Health Plan, Inc.	Carrier covers service as defined.	Carrier covers service as defined.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined or comparable service.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined.
11	Fallon Health & Life Assurance Company, Inc.	Carrier covers service as defined.	Carrier covers service as defined.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined or comparable service.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined.
12	4 Ever Life Insurance Company	Carrier covers service as defined.	Carrier covers service as defined.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined or comparable service.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined or comparable service.

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	Chapter 110 of the Acts of 2017	Services covered, not covered, or covered through comparable service or other definition in 2020					
No.	Name of Carrier	(i) intensive care coordination for a child with serious emotional disturbances	(ii) Mobile crisis intervention	(iii) Family support and training[1]	(iv) In-home therapy	(v) Therapeutic mentoring services[1]	(vi) In-home behavioral services
13	**Harvard Pilgrim Health Care, Inc.**	Carrier covers service as defined.	Carrier covers service as defined or comparable service.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined or comparable service.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined or comparable service.
14	**Health New England, Inc.**	Carrier covers this services.	Carrier covers service as defined or comparable service.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined or comparable service.	As mandated, Carrier began offering this benefit in 2021.	Carrier began covering 07/01/2019.
15	**HPHC Insurance Company, Inc.**	Carrier covers service as defined.	Carrier covers service as defined or comparable service.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined or comparable service.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined or comparable service.
16	**Tufts Health Public Plans, Inc.**	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.
17	**Tufts Associated Health Maintenance Organization, Inc.**	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.
18	**Tufts Insurance Company**	Carrier covers services as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.
19	**UnitedHealthcare Insurance Company**	Carrier covers service as defined or comparable service.	Carrier covers service as defined or comparable service.	As mandated, Carrier began offering this benefit in of 2021.	Carrier covers service as defined or comparable service.	As mandated, Carrier began offering this benefit in 2021.	Carrier covers service as defined or comparable service.
20	**Wellfleet Insurance Company**	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.	Carrier covers service as defined.

[1] Family Support and Training and Therapeutic Mentoring Services were required to be covered as of July 1, 2021

Note: "Carrier covers service as defined" means carrier indicated service is covered and did not provide additional explanation or alternative definition.

Note: Carrier responses are based on the definitions of the services listed below as defined in Chapter 110 of the Acts of 2017

List of Services:

(i) intensive care coordination for a child with serious emotional disturbances
(ii) Mobile crisis intervention
(iii) Family support and training
(iv) In-home therapy
(v) Therapeutic mentoring services
(vi) In-home behavioral services

Means Covered or comparable service by carrier
Means coverage provided is something other than coverage as defined or comparable coverage
Means carrier does not cover defined nor comparable service

2020 Mental Health Parity and Addiction Equity Act
Summary of Responses to Federal Self-Compliance Tool

No.	Company Name	1 - Exempt?	2 - Med/Surg and MH/SU?	3 - Coverage in Every Classification?	4 - Comply with annual/lifetime dollar limits?	5 - Comply with financial/QTL requirements?	6 - Comply with cumulative financial/QTL requirements?	7 - Comply with NQTL requirements?	8 - Comply with disclosure requirements?
1	Aetna Health, Inc.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2	Aetna Health Insurance Company	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3	Aetna Life Insurance Company	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4	AllWays Health Partners	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5	Blue Cross and Blue Shield of Massachusetts, Inc.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
7	Boston Medical Center Health Plan, Inc.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8	CIGNA Health and Life Insurance Company	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9	ConnectiCare of Massachusetts, Inc.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10	Fallon Community Health Plan, Inc.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
11	Fallon Health & Life Assurance Company	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
12	4 Ever Life Insurance Company	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes

2020 Mental Health Parity and Addiction Equity Act
Summary of Responses to Federal Self-Compliance Tool

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13	Harvard Pilgrim Health Care, Inc.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
14	Health New England, Inc.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
15	HPHC Insurance Company, Inc.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
16	Tufts Health Public Plans, Inc.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
17	Tufts Associated Health Maintenance Organization, Inc.	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
18	Tufts Insurance Company	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
19	UnitedHealthcare Insurance Company	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes
20	Wellfleet Insurance Company	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes

2020 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	1.4.a - Practicing Physician Input - Mental Health	1.4.b - Practicing Physician Input - Medical	1.4.c - Explain if different process
1	**Aetna Health, Inc.**	**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 committees:** The process is comparable, with exception of area of expertise.	Internal: Level of Care Assessment Tool for Autism; Aetna Applied Behavioral Analysis guidelines, approved by the Behavioral Health Quality Oversight Committee External: American 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.	Behavioral Health Quality Advisory Committee, with 6-8 behavioral health practitioners (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. The processes for obtaining "input from practicing physicians are comparable with the only difference being the licensure and specialties/area of expertise of the practicing physicians and practitioners providing input.
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 committees:** The process is comparable, with exception of area of expertise.	Internal: Level of Care Assessment Tool for Autism; Aetna Applied Behavioral Analysis guidelines, approved by the Behavioral Health Quality Oversight Committee External: American 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.	Behavioral Health Quality Advisory Committee, with 6-8 behavioral health practitioners (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. The processes for obtaining "input from practicing physicians are comparable with the only difference being the licensure and specialties/area of expertise of the practicing physicians and practitioners providing input.
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 committees:** The process is comparable, with exception of area of expertise.	Internal: Level of Care Assessment Tool for Autism; Aetna Applied Behavioral Analysis guidelines, approved by the Behavioral Health Quality Oversight Committee External: American 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.	Behavioral Health Quality Advisory Committee, with 6-8 behavioral health practitioners (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. The processes for obtaining "input from practicing physicians are comparable with the only difference being the licensure and specialties/area of expertise of the practicing physicians and practitioners providing input.
4	**AllWays Health Partners**	**Medical:** NHP's Chief Medical Officer (CMO) **Behavioral Health:** Beacon's Chief Medical Officer **Reason for different persons:** Roles and responsibilities are parallel at the partner organizations. Two different individuals are responsible because of the need for experience and expertise in the respective fields.	**Medical:** Technical Assessment Team, comprised of the 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 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 utilization review criteria for mental health/substance use services. NHP reviews all mental health/substance use disorder criteria as they are modified or updated by Beacon, and NHP reviews and approves the mental health/substance use disorder criteria.	Uses both internally created utilization review criteria and Change Health's (formerly McKesson) InterQual criteria. Adheres to the NCQA's UM Standards governing clinical criteria for utilization management decisions for federal and state regulations.	NHP delegates mental health utilization review matters to Beacon because they are specialized in the area.	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. There are no notable differences in the process utilized to develop mental health/substance use and medical/surgical criteria.

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	1.4.a - Practicing Physician Input - Mental Health	1.4.b - Practicing Physician Input - Medical	1.4.c - Explain if different process
5	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical and Behavioral Health:** Medical Director; Vice President of Physician Review and Appeals, Vice President of Medical Operations, is responsible for the ultimate approval of BCBSMA's utilization review criteria.	**Medical and Behavioral Health:** Separate Technical Review Committees comprised of clinicians in relevant field for both services. Reason for different review committees: Necessary due to specialized clinical experience.	BCBSMA uses Change Healthcare's (formerly McKesson) InterQual criteria in order to maintain consistency - made up of 30 developers, 650 external consultants, and 110 experts in mental health.	BCBSMA uses Change Healthcare's (formerly McKesson) InterQual criteria in order to maintain consistency - made up of 30 developers, 650 external consultants, and 110 experts in mental health.	Both developed externally using InterQual criteria.	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	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	**Medical and Behavioral Health:** Medical Director; Vice President of Physician Review and Appeals, Vice President of Medical Operations, is responsible for the ultimate approval of BCBSMA's utilization review criteria.	**Medical and Behavioral Health:** Separate Technical Review Committees comprised of clinicians in relevant field for both services. Reason for different review committees: Necessary due to specialized clinical experience.	BCBSMA uses Change Healthcare's (formerly McKesson) InterQual criteria in order to maintain consistency - made up of 30 developers, 650 external consultants, and 110 experts in mental health.	BCBSMA uses Change Healthcare's (formerly McKesson) InterQual criteria in order to maintain consistency - made up of 30 developers, 650 external consultants, and 110 experts in mental health.	Both developed externally using InterQual criteria.	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.
7	**Boston Medical Center Health Plan, Inc.**	**Medical:** Medical Policy, Criteria, and Technology Assessment Committee (MPCTAC), guided by its Board Level Quality and Clinical Management Committee (Q&CMC) **Behavioral Health**: Chief Medical Officer and medical directors **Reason for difference:** Behavioral health delegated UR to Beacon Health strategies because of specialized nature of behavioral health services.	**Medical:** Board Level Quality and Clinical Management Committee **Behavioral Health:** Beacon's Quality Management, Utilization Management, Clinical Management Committee **Reason for different committees:** Behavioral health delegated UR to Beacon Health strategies because of specialized nature of behavioral health services.	Use Beacon's utilization review criteria. Beacon adheres to NCQA Utilization Management standards and compares national scientific and evidence based criteria sets.	Combination of internal and external review sources. Uses Change Healthcare's (formerly 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, and relying on experts to develop utilization review criteria. BMC also uses internally developed criteria for a small number of services.	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 MPCTAC, Q&CMC, and others	The processes are comparable. The external sources are nationally recognized standards.
8	**CIGNA Health and Life Insurance Company**	**Medical and Behavioral Health:** Chief Medical Officer is chiefly responsible and delegates oversight of quality activities to Cigna's Quality Management Governing Board.	**Medical and Behavioral Health:** CIGNA Medical Technology Assessment Committee (MTAC) - 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 that compose the MTAC. Updated at least every 2 years.	Combination of internal and external review sources, including MCG (formerly Milliman Care Guidelines) to determine medical necessity.	Need to rely on MCG to determine medical necessity where CIGNA has not developed its own coverage policy.	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 mental health and substance use disorder practicing physicians and non-physicians.

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9	**ConnectiCare of Massachusetts, Inc.**	**Medical:** Physician Quality Improvement Committee (PQIC) chaired by Chief Medical Officer or a Medical Director reporting to the Chief Medical Officer **Behavioral Health:** Optum's Utilization Management Committee (UMC), chaired by the Sr. VP, Medical Operations and VP, National Operations **Reason for difference:** Need for subject matter experts.	**Medical:** Criteria reviewed by clinical staff and Medical Directors. **Behavioral Health:** Optum's Utilization Management Committee (UMC), chaired by a Sr. Behavioral Medical Director and the Director, Care Advocacy **Reason for different committees:** Need for subject matter experts.	ConnectiCare uses utilization review criteria developed by Optum.	Contracts with National Imaging Associates (NIA) for Advanced radiology, Radiation Oncology and Muscoskeletal, interventional cardiology and pain management Utilization Management Criteria, and eviCore for genetic testing Utilization Management Criteria. Criteria are reviewed and approved by the PQIC at least annually.	Need for subject matter experts.	Optum obtains input from network providers, made up of practicing physicians and other behavioral health professionals from Optum's provider network. Optum also obtains condition-specific input from clinical subject matter experts.	ConnectiCare obtains input from its Physician Quality Improvement Committee which includes staff from ConnectiCare Healthcare Management and senior practicing physicians. All criteria are reviewed annually by clinical staff, Medical Directors, and the PQIC.	ConnectiCare and Optum utilize similar processes.
10	**Fallon Community Health Plan, Inc.**	**Medical:** Fallon Health's CMO **Behavioral Health:** Beacon's CMP and Medical Directors **Reason for difference:** Beacon has subject matter expertise and has NCQA accreditation in behavioral health services.	**Medical:** Fallon Health Technical Assessment Committee (TAC) **Behavioral Health:** Beacon's Quality Management, Utilization Management, Clinical Management Committee (QM/UM/CM) **Reason for different committees:** Beacon has subject matter expertise.	Fallon Health employs the expertise of Beacon for the development and management of MH/SA clinical criteria.Criteria developed externally using Beacon's Level of Care Criteria, which adhere to NCQA Utilization Management Standards.	InterQual Level of Care Criteria, and for some specialty areas, Fallon Health's internal criteria.	While Fallon Health maintains oversight over Beacon's utilization review criteria, Beacon has specialized breadth and depth of expertise in the area of behavioral health.	Medical Necessity Criteria developed, reviewed, revised, and updated by Beacon's Quality Management, Utilization Management, and Clinical Management Committee (QM/UM/CM).	Fallon Health uses the TAC that is tasked with reviewing and developing criteria. It is made up of network physicians from various specialty areas. Also reviewed by the QM/UM/CM.	Both Beacon and Fallon Health 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.
11	**Fallon Health & Life Assurance Company**	**Medical:** Fallon Health's CMO **Behavioral Health:** Beacon's CMP and Medical Directors **Reason for difference:** Beacon has subject matter expertise and has NCQA accreditation in behavioral health services.	**Medical:** Fallon Health Technical Assessment Committee (TAC) **Behavioral Health:** Beacon's Quality Management, Utilization Management, Clinical Management Committee (QM/UM/CM) **Reason for different committees:** Beacon has subject matter expertise.	Fallon Health employs the expertise of Beacon for the development and management of MH/SA clinical criteria.Criteria developed externally using Beacon's Level of Care Criteria, which adhere to NCQA Utilization Management Standards.	InterQual Level of Care Criteria, and for some specialty areas, Fallon Health's internal criteria.	While Fallon Health maintains oversight over Beacon's utilization review criteria, Beacon has specialized breadth and depth of expertise in the area of behavioral health.	Medical Necessity Criteria developed, reviewed, revised, and updated by Beacon's QM/UM/CM Committee	Fallon Health uses the TAC that is tasked with reviewing and developing criteria. It is made up of network physicians from various specialty areas. Also reviewed by the QM/UM/CM.	Both Beacon and Fallon Health 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	**4 Ever Life Insurance Company**	**Medical:** Chief Medical Officer **Behavioral Health:** Magellan Health Care Utilization Management Committee for	**Medical and Behavioral Health:** AmeriHealth (AHA), through the Quality Management (QM) process, reviews Utilization Management (UM) criteria on an annual basis. QM is performed through the Managed Care Quality Improvement Committee.	Utilization and Case Management is performed by Magellan Healthcare, Inc.	4 Ever Life uses InterQual Level of Care Criteria	Magellan utilizes nationally recognized criteria developed with broad input by subject matter experts for substance use disorders, inpatient mental health and some outpatient mental health conditions.	Criteria and Medical Policy is derived from conversations with practitioners and local clinical experts.	4 Ever Life uses a corporate Clinical Quality Committee comprised of network participating providers to review the guidelines annually. A corporate Medical Director coordinates mental health/substance abuse programs and oversees the UM Program.	The process for each is the same.

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	1.4.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.**	**Medical:** VP and Sr. Medical Director **Behavioral Health:** Optum's Utilization Management Committee (UMC), chaired by the Sr. VP, Medical Operations and the VP of National Operations **Reason for difference:** Optum has subject matter expertise in behavioral health	**Medical:** Harvard Pilgrim's Technology Assessment Committee and the Clinical Policy Operations Committee **Behavioral Health:** Optum's Utilization Management Committee (UMC) **Reason for different review committees:** Separate committees exist due to different expertise needs. Committees also work together across the two different fields.	Optum develops its utilization review criteria for use by Harvard Pilgrim. Harvard Pilgrim approves criteria by Optum for use with Harvard Pilgrim members.	Harvard Pilgrim's Clinical Policy Operations Committee develops and regularly reviews clinical guidelines. Coverage determinations based on Harvard Pilgrim's medical necessity criteria, with InterQual criteria utilized at acute care hospitals.	Review differences exist because Optum has the expertise to develop mental health utilization review criteria. Harvard Pilgrim reviews this criteria for consistency with federal and state mental health parity laws.	In updating level of care guidelines, Optum and Harvard Pilgrim's Clinical Policy Operations Committee get input from physicians and other clinicians. Also uses their 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.	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.**	**Medical and Behavioral Health:** Chief Medical Officer	**Medical and Behavioral Health:** Medical Technology Assessment Committee (MTAC), chaired by the CMO	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 Change Healthcare's (formerly McKesson) nationally recognized InterQual criteria.	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 Change Healthcare's (formerly McKesson) nationally recognized InterQual criteria.	HNE uses a combination of internally developed and externally licensed criteria for both mental health/substance use and medical/surgical services.	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 surgery, internal medicine, pediatrics, family medicine. Also board certified psychiatrist.	HNE believes that the use of two different committees to provide initial input is appropriate based on the clinical expertise of the respective committees.
15	**HPHC Insurance Company, Inc.**	**Medical:** VP and Sr. Medical Director **Behavioral Health:** Optum's Utilization Management Committee (UMC), chaired by the Sr. VP, Medical Operations and the VP of National Operations **Reason for difference:** Optum has subject matter expertise in behavioral health	**Medical:** Harvard Pilgrim's Technology Assessment Committee and the Clinical Policy Operations Committee **Behavioral Health:** Optum's Utilization Management Committee (UMC) **Reason for different review committees:** Separate committees exist due to different expertise needs. Committees also work together across the two different fields.	Optum develops its utilization review criteria for use by Harvard Pilgrim. Harvard Pilgrim approves criteria by Optum for use with Harvard Pilgrim members.	Harvard Pilgrim's Clinical Policy Operations Committee develops and regularly reviews clinical guidelines. Coverage determinations based on Harvard Pilgrim's medical necessity criteria, with InterQual criteria utilized at acute care hospitals.	Review differences exist because Optum has the expertise to develop mental health utilization review criteria. Harvard Pilgrim reviews this criteria for consistency with federal and state mental health parity laws.	In updating level of care guidelines, Optum and Harvard Pilgrim's Clinical Policy Operations Committee get input from physicians and other clinicians. Also uses their 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.	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.

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	1.4.a - Practicing Physician Input - Mental Health	1.4.b - Practicing Physician Input - Medical	1.4.c - Explain if different process
16	**Tufts Health Public Plans, Inc.**	**Medical and Behavioral Health:** Senior Vice President and Chief Medical Officer of Tufts Health Plan	**Medical and Behavioral Health:** Integrated Medical Policy Advisory Committee (IMPAC); the Medical Specialty Advisory Committee (MSPAC); Medical Technology Assessment Process	Criteria developed internally, as well as through McKesson's InterQual Criteria.	Criteria developed internally, as well as through McKesson's InterQual Criteria.	The process for both is done internally and externally.	Review criteria are developed using recommendations from practicing physicians and governmental agency policies. Criteria are reviewed internally by Behavioral Health Operations and Policy Committee (BHPAC).	Medical Specialty Policy Advisory Committee (MSPAC) evaluates new and emerging technology. Members include external practicing physicians as well as internal Medical Directors, medical policy managers, and clinical pharmacists. MSPAC also provides input on the development and annual review of medical necessity guidelines.	The process for each is the same.
17	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical and Behavioral Health:** Senior Vice President and Chief Medical Officer of Tufts Health Plan	**Medical and Behavioral Health:** Integrated Medical Policy Advisory Committee (IMPAC); the Medical Specialty Advisory Committee (MSPAC); Medical Technology Assessment Process	Criteria developed internally, as well as through McKesson's InterQual Criteria.	Criteria developed internally, as well as through McKesson's InterQual Criteria.	The process for both is done internally and externally.	Review criteria are developed using recommendations from practicing physicians and governmental agency policies. Criteria are reviewed internally by Behavioral Health Operations and Policy Committee (BHPAC).	Medical Specialty Policy Advisory Committee (MSPAC) evaluates new and emerging technology. Members include external practicing physicians as well as internal Medical Directors, medical policy managers, and clinical pharmacists. MSPAC also provides input on the development and annual review of medical necessity guidelines.	The process for both is the same.
18	**Tufts Insurance Company**	**Medical and Behavioral Health:** Senior Vice President and Chief Medical Officer of Tufts Health Plan	**Medical and Behavioral Health:** Integrated Medical Policy Advisory Committee (IMPAC); the Medical Specialty Advisory Committee (MSPAC); Medical Technology Assessment Process	Criteria developed internally, as well as through McKesson's InterQual Criteria.	Criteria developed internally, as well as through McKesson's InterQual Criteria.	The process for both is done internally and externally.	Review criteria are developed using recommendations from practicing physicians and governmental agency policies. Criteria are reviewed internally by Behavioral Health Operations and Policy Committee (BHPAC).	Medical Specialty Policy Advisory Committee (MSPAC) evaluates new and emerging technology. Members include external practicing physicians as well as internal Medical Directors, medical policy managers, and clinical pharmacists. MSPAC also provides input on the development and annual review of medical necessity guidelines.	The process for both is the same.

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	1.4.a - Practicing Physician Input - Mental Health	1.4.b - Practicing Physician Input - Medical	1.4.c - Explain if different process
19	**UnitedHealthcare Insurance Company**	**Medical:** National Medical Care and Management Committee (NMCMC) **Behavioral Health:** Optum's Utilization Management Committee (UMC), chaired by Sr. VP, Medical Operations & VP of National Operations **Reason for difference:** It is prudent to have appropriately trained and experienced specialists in their respective fields develop the utilization review and criteria.	**Medical:** National Medical Technology Assessment Committee **Behavioral Health:** Optum's UMC **Reason for difference:** It is prudent to have appropriately trained and experienced specialists in their respective fields develop the utilization review and criteria.	Optum/UBH's utilization review criteria are developed by mental health/substance use professionals within Optum/UBH.	UHC's medical internal clinical criteria developed by UHC's National Medical Care Committee. External criteria is purchased through vendor. Please see Item 1.4.b.	The review utilization processes used to develop medical necessity criteria for medical care and mental health/substance abuse services are similar.	Optum/UBH has developed Coverage Determination Guidelines. They are based on multi-disciplinary input from Optum/UBH's clinical staff, network providers, national behavioral health specialty societies, and clinical subject matter experts.	Medical policies developed and maintained in accordance with clinical evidence in published peer-reviewed medical literature.	Difference due to use of Optum/UBH as mental health expert.
20	**Wellfleet Insurance Company**	**Medical and Behavioral Health: The Chief Medical Officer** is chiefly responsible and delegates oversight of quality activities to Cigna's Quality Management Governing Board.	**Medical and Behavioral Health:** CIGNA Medical Technology Assessment Committee (MTAC) - scope of review includes medical/surgical and mental health matters. Current chair is a psychiatrist.	(Cigna) Criteria developed internally with team of physicians, nurses, psychologists, social workers, and substance use disorder clinicians that compose the MTAC. Updated at least every 2 years.	(Cigna) Combination of internal and external review sources, including MCG (formerly Milliman Care Guidelines) to determine medical necessity.	(Cigna) Need to rely on MCG to determine medical necessity where CIGNA has not developed its own coverage policy.	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 mental health and substance use disorder practicing physicians and non-physicians.

2020 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
1	**Aetna Health, Inc.**	**Medical and Behavioral Health:** 1. Provider communications 2. Utilization management clinicians and medical directors 3. Network staff 4. Utilization review and complaint, grievance and appeal member, and provider notification via denial and appeal correspondence.	**Medical and Behavioral Health:** Internet posting; mailed letters; provider postcards; provider contracts; quality management bulletins and digital communication via Aetna.com	**Medical and Behavioral Health:** Mail, phone, fax, or electronically. Instructions given via methods given in 2.2.
2	**Aetna Health Insurance Company**	**Medical and Behavioral Health:** 1. Provider communications 2. Utilization management clinicians and medical directors 3. Network staff 4. Utilization review and complaint, grievance and appeal member, and provider notification via denial and appeal correspondence.	**Medical and Behavioral Health:** Internet posting; mailed letters; provider postcards; provider contracts; quality management bulletins and digital communication via Aetna.com	**Medical and Behavioral Health:** Mail, phone, fax, or electronically. Instructions are given via methods given in 2.2.
3	**Aetna Life Insurance Company**	**Medical and Behavioral Health:** 1. Provider communications 2. Utilization management clinicians and medical directors 3. Network staff 4. Utilization review and complaint, grievance and appeal member, and provider notification via denial and appeal correspondence.	**Medical and Behavioral Health:** Internet posting; mailed letters; provider postcards; provider contracts; quality management bulletins and digital communication via Aetna.com	**Medical and Behavioral Health:** Mail, phone, fax, or electronically. Instructions are given via methods given in 2.2.
4	**AllWays Health Partners**	**Medical:** Website notification: Clinical Operations with Provider Relations and Corporate Communications; Written or eletronic notification: Provider Relations and Customer Care; Phone notification: Clinical Operations **Behavioral Health:** Website notification: Clinical and Quality with Provider Relations/Network Management and Corporate Communications; Written or electronic notification: Provider Relations, and Customer Care; Phone notification: Clinical Operations **Reason for difference:** NHP contracts with Beacon because of their knowledge and expertise in treatment of mental health and substance use disorders.	**Medical and Behavioral Health:** Website, phone, and written electronic communication via the Provider Manual	**Medical and Behavioral Health:** Online Provider Portal, fax, phone, and email
5	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical and Behavioral Health:** Secure online Provider Portal. Network Management Team responsible for all notifications.	**Medical and Behavioral Health:** Provider Portal and news alerts sent via email and regular mail	**Medical and Behavioral Health:** Provider feedback through Electric Blue Review (EBR); Comments from providers to carrier via dedicated email address which is listed in three different locations.

No.	Company Name	2.1 - Notification Process - Who is Responsible?	2.2 - Methods of media used for notification	2.3 - Instructions for contacting organization
6	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	**Medical and Behavioral Health:** Secure online Provider Portal. Network Management Team responsible for all notifications.	**Medical and Behavioral Health:** Provider Portal and news alerts sent via email and regular mail	**Medical and Behavioral Health:** Provider feedback through Electric Blue Review (EBR); Comments from providers to carrier via dedicated email address which is listed in three different locations.
7	**Boston Medical Center Health Plan, Inc.**	**Medical:** Quality Improvement Committee, chaired by Director of Quality Improvement **Behavioral Health:** Beacon's Network Department, Quality & Utilization Management departments **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:** Mailed network notifications, email, 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; or call toll free number. **Behavioral Health:** Mail, email, and Beacon Provider Portal
8	**CIGNA Health and Life Insurance Company**	**Medical and Behavioral Health:** Vicen President of Cigna's Provider Relations and Solutions Management is ultimately responsible for the processes and procedures used to notify network providers about utilization review criteria and other provider communications.	**Medical:** Articles in electronic quarterly newsletter, notice of updates on CIGNAforHCP.com. Copies of their coverage policies and the CIGNA Reference Guide are available to healthcare professionals upon request. **Behavioral Health:** Articles in electronic quarterly newsletter, notice of updates on CIGNAforHCP.com. Copies of Cigna Coverage Policies (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:** ConnectiCare's VP Network Management with input from ConnectiCare's VP, Clinical Operations and ConnectiCare's CMO. **Behavioral Health:** Optum's Utilization Management committee	**Medical:** Provider website at: https://www.connecticare.com/provider/medicalpolicy.aspx. **Behavioral Health:** Optum's provider web site, Provider Express: https://www.providerexpress.com/. Paper copies of Optum's guidelines available upon request.	**Medical:** Through the Physician Quality Improvement Committee or directly to a ConnectiCare Medical Director or CMO by phone, email, or letter. **Behavioral Health:** Through their specialty organization or directly to an Optum Medical Director via phone, email, or letter.

No.	Company Name	2.1 - Notification Process - Who is Responsible?	2.2 - Methods of media used for notification	2.3 - Instructions for contacting organization
10	**Fallon Community Health Plan, Inc.**	**Medical:** Executive VP/Chief Medical Officer (EVP/CMO); Sr. Medical Director (SMD); VP, Clinical Operations (VP/CO); Associate Medical Director(s) The Provider Relations Department, within the Network Development and Management area of the company, is responsible for notifying providers about medical/surgical utilization review criteria. **Behavioral Health:** VP, Utilization Management, Strategy, and Operations (VP UM); Director of Utilization Management	**Medical:** Newsletters, provider manuals, and other provider mailings **Behavioral Health:** Newsletters, email communications, and annual provider postcards.	**Medical:** Quarterly newsletter to providers; contact Provider Community Council (PCC) or Fallon Health representatives **Behavioral Health:** Contact Beacon's Provider Network Department via phone, email, or the Provider Portal, the Provider Advisory Council, or other Fallon Health representatives.
11	**Fallon Health & Life Assurance Company**	**Medical:** Executive VP/Chief Medical Officer (EVP/CMO); Sr. Medical Director (SMD); VP, Clinical Operations (VP/CO); Associate Medical Director(s) The Provider Relations Department, within the Network Development and Management area of the company, is responsible for notifying providers about medical/surgical utilization review criteria. **Behavioral Health:** VP, Utilization Management, Strategy, and Operations (VP UM); Director of Utilization Management	**Medical:** Newsletters, provider manuals, and other provider mailings **Behavioral Health:** Newsletters, email communications, annual provider postcards.	**Medical:** Quarterly newsletter to providers; contact Provider Community Council (PCC) or Fallon Health representatives **Behavioral Health:** Contact Beacon's Provider Network Department via phone, email, or the Provider Portal, the Provider Advisory Council, or other Fallon Health representatives.
12	**4 Ever Life Insurance Company**	**Behavioral Health:** VP, Utilization Management, Strategy, and Operations (VP UM); Director of Utilization Management	**Medical and Behavioral Health:** AHA send notices to providers via formal paper letter, verbal notification, and made available via AHA website.	**Medical and Behavioral Health:** Website
13	**Harvard Pilgrim Health Care, Inc.**	**Medical:** Provider Communications and Education team and the Medical Policy team **Behavioral Health:** Optum's Utilization Management Committee (UMC) is responsible for availability of clinical guidelines to providers. **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:** Provider manual; *Network Matters* - monthly e-newsletter (paper copies available upon requestion); provider website, Provider Service Center **Behavioral Health:** Level of Care Guidelines available on Optum's provider website (paper copies available upon request)	**Medical:** Medical Directors have periodic provider meetings & obtain input from community physicians in network. Provider manual also has instructions on contacting 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 Provider Relations Department working in conjunction with Communications.	**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 website, in provider manual, available upon request by phone.

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:** Provider Communications and Education team and the Medical Policy team **Behavioral Health:** Optum's Utilization Management Committee (UMC) is responsible for availability of clinical guidelines to providers. **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:** Provider manual; *Network Matters* - monthly e-newsletter (paper copies available upon requestion); provider website, Provider Service Center **Behavioral Health:** Level of Care Guidelines available on Optum's provider website (paper copies available upon request)	**Medical:** Medical Directors have periodic provider meetings & obtain input from community physicians in network. Provider manual also has instructions on contacting Physician Call Center. **Behavioral Health:** Input directly solicited from Optum's National Provider Advisory Council and Behavioral Specialty Advisory Council.
16	**Tufts Health Public Plans, Inc.**	**Medical and Behavioral Health:** Provider Communications Team, part of Provider Relations and Communications	**Medical and Behavioral Health:** Quarterly *Provider Update* newsletter, which is distributions in a print mailing and through email.	**Medical and Behavioral Health:** The Tufts Health Plan website and the Tufts Health Public Plans Provider Manual
17	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical and Behavioral Health:** Provider Communications Team, part of Provider Relations and Communications	**Medical and Behavioral Health:** Quarterly *Provider Update* newsletter, which is distributions in a print mailing and through email	**Medical and Behavioral Health:** The Tufts Health Plan website and the Tufts Health Plan Commercial Provider Manual
18	**Tufts Insurance Company**	**Medical and Behavioral Health:** Provider Communications Team, part of Provider Relations and Communications	**Medical and Behavioral Health:** Quarterly *Provider Update* newsletter, which is distributions in a print mailing and through email	**Medical and Behavioral Health:** The Tufts Health Plan website and the Tufts Health Plan Commercial Provider Manual
19	**UnitedHealthcare Insurance Company**	**Medical:** Medical Management Operations Teams are responsible for notifications. **Behavioral Health:** Optum's Utilization Management Committee is responsible for notifications.	**Medical and Behavioral Health:** Providers are notified by a monthly newsletter, *Provider Network* . Also notified on the provider portal, by phone, and in writing by UHC or Optum/UBH's Medical Directors.	**Medical and Behavioral Health:** Instructions available in the administrative guide/guidelines, Provider Portal, by phone or by writing to Medical Directors.
20	**Wellfleet Insurance Company**	**Medical and Behavioral Health: (Wellfleet)** Provider/Network Management Team. (Cigna) Provider Contracting Teams	**Medical and Behavioral Health:** (Cigna) Monthly newsletter to providers; emails, posted on website, regular mail by 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.

No.	Company Name	3.1 - Person Responsible	3.2 - Average Number and Medical Expertise	3.3 - Systems Used for Request for Services	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:** Executive Director, Clinical Solutions Head, Market Medical Management **Behavioral Health:** Executive Director, Behavioral Health Chief Medical Officer Both have same policies, procedures, and system platforms.	**Medical:** 541, including RN's, LPN's, LVN's, and physician medical directors. **Behavioral Health:** 274 staff members, including RN's, social workers, professional counselors, therapists and psychiatric medical directors. **Reason for difference:** There is a higher volume of medical cases.The number of licensed reviewers for mental health/substance use disorders is 174, consisting of registered nurses, social workers, professional counselors, marriage/family therapists and psychiatrist Medical Directors.The number of licensed reviewers for medical/surgical services is 1,015, consisting of RNs, LPNs, LVNs, and physician Medical Directors of various specialties.	**Medical and Behavioral Health:** Electronic Data Interchange, secure provider website, mail, telephone, and fax.	**Medical and Behavioral Health:** Normal business hours of Monday-Friday, 8AM-8PM. For urgent matters, available 24/7.	**Medical and Behavioral Health:** 1. Aetna website 2. Aetna's utilization management site 3. BH provider manual 4. The participating provider contract 5. Denial and appeal letters mailed to practitioners/providers Note exact sites may be different for medical and clinical but methods the same.	**Medical and Behavioral Health:** 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:** Phone, fax, mail or electronically
2	**Aetna Health Insurance Company**	**Medical:** Executive Director, Clinical Solutions Head, Market Medical Management Behavioral Health: Executive Director, Behavioral Health Chief Medical Officer Both have same policies, procedures, and system platforms.	**Medical:** 541, including RN's, LPN's, LVN's, and physician medical directors. **Behavioral Health**: 274 staff members, including RN's, social workers, professional counselors, therapists and psychiatric medical directors. **Reason for difference**: There is a higher volume of medical cases. The number of licensed reviewers for mental health/substance use disorders is 174, consisting of registered nurses, social workers, professional counselors, marriage/family therapists and psychiatrist Medical Directors.The number of licensed reviewers for medical/surgical services is 1,015, consisting of RNs, LPNs, LVNs, and physician Medical Directors of various specialties.	**Medical and Behavioral Health:** Electronic Data Interchange, secure provider website, mail, telephone, and fax.	**Medical and Behavioral Health:** Normal business hours of 8AM-8PM, M-F. For urgent matters, available 24/7.	**Medical and Behavioral Health:** 1. Aetna website 2. Aetna's utilization management site 3. BH provider manual 4. The participating provider contract 5. Denial and appeal letters mailed to practitioners/providers Note exact sites may be different for medical and clinical but methods the same.	**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.

No.	Company Name	3.1 - Person Responsible	3.2 - Average Number and Medical Expertise	3.3 - Systems Used for Request for Services	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
3	**Aetna Life Insurance Company**	**Medical:** Executive Director, Clinical Solutions Head, Market Medical Management **Behavioral Health:** Executive Director, Behavioral Health Chief Medical Officer Both have same policies, procedures, and system platforms.	Medical: 541, including RN's, LPN's, LVN's, and physician medical directors. Behavioral Health: 274 staff members, including RN's, social workers, professional counselors, therapists and psychiatric medical directors. Reason for difference: There is a higher volume of medical cases.The number of licensed reviewers for mental health/substance use disorders is 174, consisting of registered nurses, social workers, professional counselors, marriage/family therapists and psychiatrist Medical Directors.The number of licensed reviewers for medical/surgical services is 1,015, consisting of RNs, LPNs, LVNs, and physician Medical Directors of various specialties.	**Medical and Behavioral Health:** Electronic Data Interchange, secure provider website, mail, telephone, and fax.	**Medical and Behavioral Health:** Normal business hours of 8AM-8PM, M-F. For urgent matters, available 24/7.	**Medical and Behavioral Health:** 1. Aetna website 2. Aetna's utilization management site 3. BH provider manual 4. The participating provider contract 5. Denial and appeal letters mailed to practitioners/providers Note exact sites may be different for medical and clinical but methods the same.	**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	**AllWays Health Partners**	**Medical:** Chief Medical Officer, Assistant Vice President of Clinical Services, and the Senior Clinical Director of Utilization Management. and the Clinical Policy and Quality Committee. **Behavioral Health:** Vice President of Utilization Management, Strategy and Operations (VP UM); the Director of Utilization Management; Members of the utilization review process; Chief Medical Officer; Medical Directors; VP of Clinical Operations; Director of Behavioral Health; Pharmacy Manager; Manager of Utilization Management; Supervisor of Utilization Management; Utilization Management Care Managers; Supervisor of Clinical Support Services; Clinical Support Coordinators **Reason for difference:** NHP's	Medical: Staffing Ratios: Inpatient: 1:40,000; Non-inpatient: 1:30,000. Behavioral Health: Beacon Health Options: 1:50,000; eviCore, Inc.: 1:10,000 (413,742 members); CareCentrix: 1:77,000 (25,000). Reason for difference: Differences are insignificant based on membership and utilization numbers.	**Medical and Behavioral Health:** Fax, telephone, mail, and online Provider Portal.	**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:** Beacon staff are available on site 8A-6P M-F and a combination of on site and on call during nights and weekends.	**Medical and Behavioral Health:** online/ Provider Portal, via Provider Manual, and via telephone.	**Medical and Behavioral Health:** Via telephone and through peer to peer discussion with physician.	**Medical:** member history; treatment plan; office and hospital records; lab/diagnostic results; and other clinical information. Only clinical information that is need for making decisions is requested. **Behavioral Health:** presenting problems, current symptomatology; current/prior agency involvement; current/prior treatment history, and other clinical information. Only information that is needed for making a decision is requested. **Reason for difference:** Both NHP and Beacon identify clinical information commonly needed to make authorization decisions. The difference in documentation is only specific to the type of request.	**Medical and Behavioral Health:** Provider Manual; web; electronic communication; via mail, site training and education, new provider orientations.

No.	Company Name	3.1 - Person Responsible	3.2 - Average Number and Medical Expertise	3.3 - Systems Used for Request for Services	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
5	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical:** William Walsh, MD, Associate Medical Director for Behavioral Health **Behavioral Health:** Deborah Vona, Director, Health and Medical Management Business Operations; M. Elyce Kearns, MD, Associate Medical Director; Gregory G. Harris, MD, MPH, Associate Medical Director for Behavioral Health **Reason for difference:** Volume of work and required clinical expertise	**Medical:** On average, Medical Surgical Utilization Review Department employs approx. 35 (24) independently licensed clinicians; approx.. 11 (10) persons in the Medical Surgical Physician Review Unit **Behavioral Health:** On average, Behavioral Health Utilization Review Department employs approx. 27 (20) independently licensed behavioral health clinicians; approx.. 15 (12) persons in the Behavioral Health Physician and Psychologist Review Unit **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.	**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 and secure fax.	**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	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	**Medical:** William Walsh, MD, Associate Medical Director for Behavioral Health **Behavioral Health:** Deborah Vona, Director, Health and Medical Management Business Operations; M. Elyce Kearns, MD, Associate Medical Director; Gregory G. Harris, MD, MPH, Associate Medical Director for Behavioral Health **Reason for difference:** Volume of work and required clinical expertise	**Medical:** On average, Medical Surgical Utilization Review Department employs approx. 35 (24) independently licensed clinicians; approx.. 11 (10) persons in the Medical Surgical Physician Review Unit **Behavioral Health:** On average, Behavioral Health Utilization Review Department employs approx. 27 (20) independently licensed behavioral health clinicians; approx.. 15 (12) persons in the Behavioral Health Physician and Psychologist Review Unit **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.	**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 and secure fax.	**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.
7	**Boston Medical Center Health Plan, Inc.**	**Medical:** Chief Medical Officer; and Director of Utilization Management. **Behavioral Health:** Chief Medical Officer; Senior Vice President, Clinical Management (UM); Vice President, UM; Director of Utilization Management	**Medical and Behavioral Health:** Less than 5 FTE of staff to review service requests. For BMCHP, this included a Medical Director, Clinician (RN), and a non-clinical Specialist. For Beacon, included a Medical Director & Clinician	**Medical:** Same as behavioral health, except when via telephone, must be followed up with written request. **Behavioral Health:** Via telephone, fax or mail.	**Medical:** Available M-F, 8:00AM-5:00PM. 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 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 BMCHP's provider manual, BMCHP's and Beacon's web sites, electronic communications, written "bulletins", general provider orientations/trainings, and site-specific orientations/trainings

No.	Company Name	3.1 - Person Responsible	3.2 - Average Number and Medical Expertise	3.3 - Systems Used for Request for Services	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
8	**CIGNA Health and Life Insurance Company**	**Medical:** National Clinical Director - Consumer Health Engagement; Senior Medical Director **Behavioral Health:** Director, Behavioral Operations; Chief Medical Officer for Behavioral Health	**Medical and Behavioral Health:** No team dedicated to utilization review exclusively for Massachusetts. Average of 1,000 nurses, with RN degrees, that may be involved in a utilization review decision in MA - case managers hold MA or PhD degrees. Average of 380 case managers. **Medical:** 100 Medical Directors, all with MD degrees, and board certified in their specialty, perform medical/surgical reviews. **Behavioral Health:** 25 peer reviewers perform behavioral health/substance use reviews. **Reason for difference:** Difference exists due to difference in amount of utilization.	**Medical and Behavioral Health:** Requests done via mail, fax, phone, and sometimes secure email. Medical/surgical requests can also be made online through Navinet. This possibility does not exist for behavioral health requests.	**Medical:** Medical/surgical review staff available M-F 8AM to 5PM. **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 with the treating provider 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:** Overseen by VP; Chief Medical Officer; VP, Clinical Operations and Management; and the Manager, Audit and Regulatory Adherence **Behavioral Health:** Overseen by the Director, Care Advocacy and the Sr. VP, Medical Operations	**Medical:** 2 Management Level personnel; 3 supervisors; 7 Utilization Managers; 10 TPH Assistants; 5 TPH Navigators; 6 Appeals Coordinators **Behavioral Health:** 3 Sr. Medical Director, 14 Associate Medical Directors; 1 Regional Vice President; 4 Directors; 4 Managers; 107 Care Advocates. **Reason this is acceptable:** ConnectiCare and Optum both provide ample staffing levels to appropriately review requests. Optum maintains a 24 hours a day/7days a week operation which requires more staff.	**Medical:** Phone, fax and mail. **Behavioral Health:** Phone or online Provider Portal.	**Medical:** 8AM-5PM, Monday-Friday. **Behavioral Health:** 24/7	**Medical:** Provider website, Provider Manual, verbally through calls **Behavioral Health:** Provider Express website, Provider Manual, verbally through calls with Care Advocates	**Medical:** Notified via phone or letter **Behavioral Health:** Notified via phone or secure email on the Provider Portal	Depending on type of service requested, information such as presence of suicidal/homicidal ideation, substance use history, and mental status.	**Medical:** Instructions given through provider website and online provider manual. **Behavioral Health:** Instructions given through provider website and online provider manual.
10	**Fallon Community Health Plan, Inc.**	**Medical:** Executive Vice President/Chief Medical Officer. **Behavioral Health:** Beacon's VP UM; Director of Utilization Management	**Medical:** 3 licensed physicians; 12 registered nurses; and 9 support level personnel. **Behavioral Health:** 5.5 licensed Behavioral Health Clinicians; 1 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:** Phone, fax, or mail. **Behavioral Health:** Phone, electronically, fax or mail.	**Medical:** Monday-Friday, 8AM to 5PM. **Behavioral Health:** 24/7/365.	**Medical and Behavioral Health:** Phone, web or provider portal, provider trainings, and/or the provider manual	**Medical and Behavioral Health:** Additional information requested via telephone; also, offer 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.

No.	Company Name	3.1 - Person Responsible	3.2 - Average Number and Medical Expertise	3.3 - Systems Used for Request for Services	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
11	**Fallon Health & Life Assurance Company**	**Medical:** Executive Vice President/Chief Medical Officer. **Behavioral Health:** Beacon's VP UM; Director of Utilization Management	**Medical:** 3 licensed physicians; 12 registered nurses; and 9 support level personnel. **Behavioral Health:** 5.5 licensed Behavioral Health Clinicians; 1 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:** Phone, fax, or mail. **Behavioral Health:** Phone, electronically, fax or mail.	**Medical:** Monday-Friday, 8AM to 5PM. **Behavioral Health:** 24/7/365.	**Medical and Behavioral Health:** Phone, web or provider portal, provider trainings, and/or the provider manual	**Medical and Behavioral Health:** Additional information requested via telephone; also, offer 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.
12	**4 Ever Life Insurance Company**	**Medical and Behavioral Health:** Executive Vice President & Chief Medical Officer	**Medical and Behavioral Health:** Nurses perform the initial case review; only a Medical Director may deny coverage based on medical necessity/appropriateness. Independent medical consultants may also be used in specific cases. On average there are 20 persons are involved in day-to-day review of requests for medical/surgical services. On average MHC has 40 persons involved in day-to-day review of requests for mental health/substance use services.	**Medical and Behavioral Health:** Via mail, fax, telephone and provider portal.	**Medical and Behavioral Health:** Clinical Services Department available M-F, 8:30AM to 5PM; registered nurse and medical director on call after hours. MHC's Clinical Services Department is available Monday through Friday between the hours of 8:00 AM to 6:00 PM Eastern Time	**Medical and Behavioral Health:** AHA's Clinical Services Department and MHC will contact the provider.	**Medical and Behavioral Health:** AHA's Clinical Services Department and MHC will contact the provider.	**Medical and Behavioral Health:** There is no additional information required to be submitted from a provider for mental health/substance use services.	**Medical and Behavioral Health:** AHA's Clinical Services Department instructs providers to communicate with AHA electronically through its website.
13	**Harvard Pilgrim Health Care, Inc.**	**Medical:** Associate Director, Care, Disease, and Utilization Management; and the VP, Sr. Medical Director **Behavioral Health:** VP of National Operation; Sr. VP, Medical Operations; Behavioral Medical Director; and National VP, Assess and Triage Operations **Reason for differences:** Different people because of use of Optum as behavioral health specialist.	**Medical:** On average 7 FTE Utilization Review (UR) Nurses, 2 FTE UR Specialists, 2 FTE Supervisor/Manager, 3 FTE Physician Reviewers, 15 FTE Acute inpatient and SNF/Rehab UR Nurses/Specialists and 2 FTE Supervisors/Managers. Also 0.20 Medical Director for issues that are escalated **Behavioral Health:** 14 licensed Masters-level mental health professionals, 1 fully dedicated board-certified psychiatrist, 9 partially dedicated board-certified psychiatrists, 11 fully dedicated clinical care advocates, 55 partially dedicated licensed clinicians	**Medical:** For UM process, Provider Call Center via phone. For specific authorization or denial decisions or individual case management, UM staff via phone. For UM of select drugs, CVS-Novologix via phone. For UM of outpatient imaging services, National Imaging Associates (NIA) via phone and website. For UM of select diagnostic tests, AIM Specialty Health (AIM) via phone and their website. **Behavioral Health:** Reach Optum via HPHC's Behavioral Health Access Center on the phone or online.	**Medical:** HPHC: Monday-Friday 8AM to 5PM. NIA and AIM: 24/7/365. CVS: Monday-Friday 8AM-7PM. **Behavioral Health:** 24/7/365	**Medical:** Phone, online provider manuals, web, and direct mailings, where indicated. **Behavioral Health:** Phone, online provider manuals, provider contracts web, and regular mail upon request	**Medical:** Phone, online provider manual **Behavioral Health:** Phone, secure email through the Provider Portal.	**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 (online or paper if requested) or given through call center. **Behavioral Health:** Instructions found in Provider Manual or Provider Express or given by phone.

No.	Company Name	3.1 - Person Responsible	3.2 - Average Number and Medical Expertise	3.3 - Systems Used for Request for Services	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
14	**Health New England, Inc.**	**Medical:** Manager of Utilization Management **Behavioral Health:** Behavioral Health Manager Both report to the Director of Population Health Clinical Programs	**Medical:** Average of 9 review staff (RNs). Final review by MDs. Ratio of staff to requests: 1:1342 **Behavioral Health:** Average of 2 review staff (LSW, LMHC, LSWA, or LICSW). Final review by MDs. Ratio of staff to requests: 1:638 **Reason for difference:** HNE requires more prior authorization for medical than behavioral health; medical often paid for using DRG or bundles payment 9vs per diem or fee for service basis).	**Medical and behavioral health:** Fax for outpatient request; inpatient request takes place after admission.	**Medical and Behavioral Health:** Phone Monday-Friday 8AM-5PM and after-hours clinical available 24/7/365	**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:** Contact provider by phone to request information via fax and mail	**Medical and Behavioral Health:** Description of member's diagnoses, current treatment plan, treatment history, and clinical documentation . Inpatient stays reviewed for severity of illness on presentation and level or intensity of treatment	**Medical and Behavioral Health:** Provider manual gives instructions for both; forms available on website; fax & phone number same for both
15	**HPHC Insurance Company, Inc.**	**Medical:** Associate Director, Care, Disease, and Utilization Management; and the VP, Sr. Medical Director **Behavioral Health:** VP of National Operation; Sr. VP, Medical Operations; Behavioral Medical Director; and National VP, Assess and Triage Operations **Reason for differences:** Different people because of use of Optum as behavioral health specialist.	**Medical:** On average 7 FTE Utilization Review (UR) Nurses, 2 FTE UR Specialists, 2 FTE Supervisor/Manager, 3 FTE Physician Reviewers, 15 FTE Acute inpatient and SNF/Rehab UR Nurses/Specialists and 2 FTE Supervisors/Managers. Also 0.20 Medical Director for issues that are escalated **Behavioral Health:** 14 licensed Masters-level mental health professionals, 1 fully dedicated board-certified psychiatrist, 9 partially dedicated board-certified psychiatrists, 11 fully dedicated clinical care advocates, 55 partially dedicated licensed clinicians	**Medical:** For UM process, Provider Call Center via phone. For specific authorization or denial decisions or individual case management, UM staff via phone. For UM of select drugs, CVS-Novologix via phone. For UM of outpatient imaging services, National Imaging Associates (NIA) via phone and website. For UM of select diagnostic tests, AIM Specialty Health (AIM) via phone and their website. **Behavioral Health:** Reach Optum via HPHC's Behavioral Health Access Center on the phone or online.	**Medical:** HPHC: Monday-Friday, 8AM to 5PM. NIA and AIM: 24/7/365. CVS: Monday-Friday, 8AM-7PM. **Behavioral Health:** 24/7/365	**Medical:** Phone, online provider manuals, web, and direct mailings, where indicated. **Behavioral Health:** Phone, online provider manuals, provider contracts web, and regular mail upon request	**Medical:** Phone, online provider manual **Behavioral Health:** Phone, secure email through the Provider Portal.	**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 (online or paper if requested) or given through call center. **Behavioral Health:** Instructions found in Provider Manual or Provider Express or given by phone.
16	**Tufts Health Public Plans, Inc.**	**Medical:** Vice President of Pharmacy and Health Programs **Behavioral Health:** Vice President of Behavioral Health Both report to the Sr. Vice President, Health Care Services **Reason this is acceptable:** Comparable processes are followed with respect to administration of utilization review services.	**Medical: 2.0** FTE UM Physician Reviewers; 6 FTE RN for Precertification (2 for THPP commercial qualified health plan (QHP), 3 for inpatient management) **Behavioral Health:** 0.6 FTE UM Physician Reviewers; 4.6 FTE LICSW; 0.3 FTE Psychologist Clinical Reviewer.; supported by 2 Masters-level Managers **Reason for difference:** Different number of staff is due to different volume of use of services.	**Medical:** Fax or web. **Behavioral Health:** Phone, fax, other electronic means. **Reason for difference:** Mental health/substance use has more options.	**Medical and Behavioral Health:** Monday-Friday, 8:30AM-5PM.	**Medical and Behavioral Health:** Provider Manual and website	**Medical and Behavioral Health:** Phone or fax	**Medical and Behavioral Health:** The information requested is pertinent to the specific service being requested and required to meet any applicable medical necessity criteria.	**Medical and Behavioral Health:** Phone, fax, or in writing.
17	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical:** Vice President of Pharmacy and Health Programs **Behavioral Health:** Vice President of Behavioral Health Both report to the Sr. Vice President, Health Care Services **Reason this is acceptable:** Comparable processes are followed with respect to	**Medical:** 1.2 FTE UM Physician Reviewers; 7 FTE RN for Precertification; 12 FTE RN for Inpatient Management **Behavioral Health:** 0.6 FTE UM Physician Reviewers; 5.7 FTE LICSW; 1 FTE RN; 0.5 FTE Psychologist Clinical Reviewer; supported by 1 Masters-level Manager	**Medical:** Preauthorization: fax, mail. Inpatient: fax, web portal. **Behavioral Health:** Preauthorization: Interactive Voice Response (IVR), web portal, and phone. Inpatient: fax, web portal, secure email. **Reason for difference:** Process is very similar, only difference is administrative.	**Medical and Behavioral Health:** Monday-Friday, 8:30AM-5PM.	**Medical and Behavioral Health:** Commercial Provider Manual and website	**Medical and Behavioral Health:** Written notification, fax, or phone	**Medical and Behavioral Health:** The information requested is pertinent to the specific service being requested and required to meet any applicable medical necessity criteria.	**Medical and Behavioral Health:** Phone, fax, or in writing.

No.	Company Name	3.1 - Person Responsible	3.2 - Average Number and Medical Expertise	3.3 - Systems Used for Request for Services	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
18	**Tufts Insurance Company**	**Medical:** Vice President of Pharmacy and Health Programs **Behavioral Health:** Vice President of Behavioral Health Both report to the Sr. Vice President, Health Care Services **Reason this is acceptable:** Comparable processes are followed with respect to administration of utilization review services.	**Medical: 1.2** FTE UM Physician Reviewers; 7 FTE RN for Precertification; 12 FTE RN for Inpatient Management **Behavioral Health:** 0.6 FTE UM Physician Reviewers; 5.7 FTE LICSW; 1 FTE RN; 0.5 FTE Psychologist Clinical Reviewer; supported by 1 Masters-level Manager **Reason for difference:** Different number of staff is due to different volume of use of services.	**Medical:** Preauthorization: fax, mail. Inpatient: fax, web portal. **Behavioral Health:** Preauthorization: Interactive Voice Response (IVR), web portal, and phone. Inpatient: fax, web portal, secure email. **Reason for difference:** Process is very similar, only difference is administrative.	**Medical and Behavioral Health:** Monday-Friday, 8:30AM-5PM.	**Medical and Behavioral Health:** Commercial Provider Manual and website	**Medical and Behavioral Health:** Written notification, tax, or phone	**Medical and Behavioral Health:** The information requested is pertinent to the specific service being requested and required to meet any applicable medical necessity criteria.	Medical and Behavioral Health: Phone, fax, or in writing.
20	**UnitedHealthcare Insurance Company**	**Medical:** National VP, Inpatient Care Management; National VP, Clinical Operations **Behavioral Health:** Director, Care Advocacy; Sr. VP, Medical Operations	**Medical:** 515 MD's and DO's; 2621 RNs, 25 LPNs/LVNs; 35 Physicians Assistants **Behavioral Health:** 1385 Masters-level mental health professionals, RNs, and licensed Ph.D. psychologists; 64 board certified psychiatrists	**Medical and Behavioral Health:** Phone or provider portal	**Medical:** Staff available Monfay-Friday, 8AM-6PM, according to varying time zones and as appropriate per legal requirements. Staff available 24/7 for emergency cases per legal requirements, etc. **Behavioral Health:** 24/7/365	**Medical:** Guidelines and processes on Provider site, uhcprovider.com; phone; hard copy upon request. **Behavioral Health:** Optum's site, providerexpress.com; phone; in contracts; by hard copy upon request	**Medical:** At least two attempts via telephone, facsimile or secure E-mail. **Behavioral Health:** At least two attempts via telephone or secure E-mail.	**Medical and Behavioral Health:** The information collected is specific to the service being requested.	**Medical:** administrative guide provides information on communications and processes that include communicating by telephone, Provider Portal, and online network provider bulletins. **Behavioral Health:** Optum/UBH's Guidelines provides information on communications, as well as the Provider Portal.
19	**Wellfleet Insurance Company**	**Medical:** Amy Dinovo, National Clinical Director - Consumer Health Engagement; Jeff Hankoff, M.D., Senior Medical Director **Behavioral Health:** Karen Cierzan, Director, Behavioral Operations; Douglas Nemecek, M.D., Chief Medical Officer for Behavioral Health	Cigna: approximately 1000 nurses may be involved in a UR decision in MA. MH/SUD Care Managers hold either a Master's, PhD, or RN degree (with psychiatric experience), and have an active unrestricted license for independent MH/SUD practice in at least one state. Approximately 380 care managers may be involved in a UR decision in MA.	**Medical and Behavioral Health:** Phone, fax, or internal portal	**Medical:** Monday-Friday, 8:30AM-5PM **Behavioral Health:** 24/7/365	**Medical and Behavioral Health:** Fax or, in some cases, by phone	**Medical and Behavioral Health:** Phone, 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:** Fax, but phone also acceptable

2020 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	**AllWays Health Partners**	**Medical and Behavioral Health:** Chief Medical Officer; VP, Corporate Clinical Management; Director of Bheavioral Health; Director of Product Management and Benfits Administration Director of Clinica Compliance and Education; AVP, Quality; Director of Utilization Management; Clinical Director, Utilization Review; Program Director; Clinical Analyst; Director of Regulatory Affairs and Compliance Manager, Appreals and Grievances; Associate General Counsel/Director, Parity Compliance
5	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical and Behavioral Health:** At least 31 people involved in the review of compliance with federal parity standards, with a combination of medical and behavioral health expertise.
6	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	**Medical and Behavioral Health:** At least 31 people involved in the review of compliance with federal parity standards, with a combination of medical and behavioral health expertise.
7	**Boston Medical Center Health Plan, Inc.**	**Medical:** BMCHP CMO; BMCHP VP, Quality and Clinicla Program Oversight; BMCHP Director, Utilization Management; BMCHP Director, Utilization Program Oversight, Member Appeals, and Grievances; BMCHP Director, BH Programs and Strategy; BMCHP Compliance Offier; BMCHP Assc General Counsel; BMCHP Director, Pharmacy **Behavioral Health:** Beacon CMO; Beacon Sr VP, Utilization Management; Beacom VP, Clinical Management; Becon Director, Utilization Management; Beacom Accounts Partnership Director; Beacon Compliance Officer; Beacon VP Government Affairs and Assc General Counsel
8	**CIGNA Health and Life Insurance Company**	**Medical and Behavioral Health:** CMO, Behavioral Health; Sr. Medical Director, Cigna; Compliance Director, Behavioral Health; Federal Compliance Leader; Sr Legal Counsel; Operations Director, Behavioral Health; Operations Directors, Cigna; Product Leader, Behavioral Health; Product Manager, Cigna; Finance Lead, Behavioral Health; Underwriting Manager; Director, Behavioral Health Network Management; Director, Cigna; Claims Sr. Specialist, Behavioral Health; Claims Sr. Specialist, Cigna
9	**ConnectiCare of Massachusetts, Inc.**	**Behavioral Health:** VP, Chief Medical Officer; Manager, Audit & Regulatory Adherence; VP, Clinical Operations; Managers, Total Population Health
10	**Fallon Community Health Plan, Inc.**	**Medical:** Behavioral Health Director; Sr. Director, Integrated Care Management and Utilization Management; Regulatory Affairs Directors, Chief Compliance Officer; Sr. Director, Network Development and Contracting **Behavioral Health:** Associate General Counsel and Director of Parity Compliance; VP, Clinical Management; Director, Clinical Operations; Chief Medical Officer; VP, Network; VP, Account Partnerships; AVP, Account Partnerships

No.	Company Name	4.1 - Who Conducted Federal Parity Review?
11	**Fallon Health & Life Assurance Company**	**Medical:** Behavioral Health Director; Sr. Director, Integrated Care Management and Utilization Management; Regulatory Affairs Directors, Chief Compliance Officer; Sr. Director, Network Development and Contracting **Behavioral Health:** Associate General Counsel and Director of Parity Compliance; VP, Clinical Management; Director, Clinical Operations; Chief Medical Officer; VP, Network; VP, Account Partnerships; AVP, Account Partnerships
12	**4 Ever Life Insurance Company**	**Medical and Behavioral Health:** Compliance Analyst; Assistant Vice President and Compliance Attorney; Regulatory Compliance
13	**Harvard Pilgrim Health Care, Inc.**	**Medical:** VP of Population health and Clinical Operations; Lead Vendor Contract Manager; Vendor Relations Specialist from Health Services **Behavioral Health:** Optum's Regional VP; the Clinical Operations Director, Sr. Director of Clinical Operations; VP for Strategic Accounts; Strategic Account Executive
14	**Health New England, Inc.**	**Medical and Behavioral Health:** Vice President and CMO; General Counsel; Associate General Counsel; Nurse Specialist, Behavioal Health Manager
15	**HPHC Insurance Company, Inc.**	**Medical:** VP of Population Health and Clinical Operations; Lead Vendor Contract Manager; Vendor Relations Specialist from Health Services **Behavioral Health:** Optum's Regional VP; the Clinical Operations Director, Sr. Director of Clinical Operations; VP for Strategic Accounts; Strategic Account Executive
16	**Tufts Health Public Plans, Inc.**	**Medical and Behavioral Health:** Product Manager, QHP, Tufts Health Public Plans (THPP); Commercial Compliance Officer, Tufts Health Plan (THP); Program Manager, Commercial Compliance, THP; Director of Behavioral Health, THPP; Sr. Manager, Precertification Operations, THP; Director, Precertification Operation, THP; Director, Inpatient Management, THP; Director of Merical Affair, THP; Director, Appeals and Grienvances, THP; Manager, Medical Policy, THP; Director, Clinical Services Business Operations, THP
17	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical and Behavioral Health:** Assistant General Counsel; Commercial Compliance Officer, and other Directors, Managers, and Analysts
18	**Tufts Insurance Company**	**Medical and Behavioral Health:** Assistant General Counsel; Commercial Compliance Officer, and other Directors, Managers, and Analysts
19	**UnitedHealthcare Insurance Company**	**Medical and Behavioral Health:** Optum's CMO, chair of Behavioral Policy & Analytics Committee, leads the team that concludes the federal Mental Health Parity standards reviews.
20	**Wellfleet Insurance Company**	**Medical and Behavioral Health:** (Cigna) CMO, Behavioral Health; Sr. Medical Director, Compliance Director, Behavioral Health; Federal Compliance Leader; Sr Legal Counsel; Operations Director, Behavioral Health; Operations Directors, Product Leader, Behavioral Health; Product Manager,Finance Lead, Behavioral Health; Underwriting Manager; Director, Behavioral Health Network Management; Director, Claims Sr. Specialist, Behavioral Health; Claims Sr. Specialist.

2020 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[2] (5c)	Percent Authorized [5c/5a]	No. of Requests Modified[2] (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[3]															
Medical	Inpatient Days	Outpatient Visits / Services	Total # of Services	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical	Medical
709,668	387,610	27,252,203	27,639,813	639,352	90.1%	14,759	2.1%	55,557	7.8%	3,502	1,900	1,554	44.4%	92	48	44
	Behavioral Health[3]															
Behavioral Health	Inpatient Days	Outpatient Visits / Services	Total # of Services	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health	Behavioral Health
49,993	135,629	3,107,905	3,243,534	46,282	92.6%	2,638	5.3%	1,071	2.1%	160	57	103	64.4%	6	5	1

[1]**Reported information is for all 2020 non-governmental insured coverage issued in Massachusetts for requests made and appeals heard during calendar year 2020.**
[2]**Requests authorized + modified + denied may not add up to total requests made because some requests may be classified as both authorized and modified, some requests may have been withdrawn, or some requests may have been pending and had not yet been classified as approved, modified or denied.**
[3]**Information as reported by carriers in response to Bulletin 2013-06, Item 5, was submitted as part of annual mental health parity certifications required under 211 CMR 154.00.**
The information is aggregated based on responses from the following carriers:

Aetna Health Inc.
Aetna Health Insurance Company
Aetna Life Insurance Company
AllWays Health Partners, Inc.
Blue Cross and Blue Shield of Massachusetts, Inc.
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Boston Medical Center Health Plan, Inc.
CIGNA Health and Life Insurance Company
ConnectiCare of Massachusetts, Inc.
Fallon Community Health Plan, Inc.
Fallon Health & Life Assurance Company, Inc.
4 Ever Life Insurance Company
Harvard Pilgrim Health Care, Inc.
HPHC Insurance Company, Inc.
Health New England, Inc.
Tufts Associated Health Maintenance Org., Inc.
Tufts Insurance Company
Tufts Health Public Plans, Inc.
UnitedHealthcare Insurance Company
Wellfleet Insurance Company

2020 Mental Health Parity and Addiction Equity Supplemental Response Letter
Summary of Responses to Bulletin 2013-06: Item #5

No.	Company Name	5.2 - Confirm Fully Insured Only	5.3 - Confirm Massachusetts Lives Only	5.4 - Confirm Excludes Prescription Data	5.5.a - Number of Requests for Authorization of Services Definition	5.5.b - Differences in Definition of Number of Services Requested	5.5.c - Definition of Number of Requests Authorized	5.5.d - Definition of Number of Requests Modified
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:** Information presented for report Item 5 does not include requests for prescription medications.	**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.	**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.
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:** Information presented for report Item 5 does not include requests for prescription medications.	**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.	**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.
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:** Information presented for report Item 5 does not include requests for prescription medications.	**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.	**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.
4	**AllWays Health Partners**	**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 information presented for report Item 5 does not include requests for prescription medications.	**Medical and Behavioral Health:** Information included initial requests, modified requests, notifications and requests denied. **Reason for difference:** Durable medical equipment requests were not included in medical because there is no parallel behavioral service request.	**Medical:** inpatient: 1 unit = 1 day. For other categories, the number of units can vary. DME requests again not included because no parallel behavioral health service request. **Behavioral Health:** 1 unit = 1 day. For other categories, the number of units can vary.	**Medical:** Requests authorized are initial and modified request approved and may include services requests that resulted in partial approval. Partially approved requests would then be counted under the number of requests authorized and the number denied. **Behavioral Health:** Requests authorized are initial and modified requests approved.	**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.
5	**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:** The information presented for report Item 5 does not include requests for prescription medications.	**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.	**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.
6	**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:** The information presented for report Item 5 does not include requests for prescription medications.	**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.	**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.
7	**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:** The information presented for report Item 5 does not include requests for prescription medications.	**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. Request denied when at the completion of review, request doesn't meet medical necessity UR criteria.	**Medical and Behavioral Health:** Modification is a reduction in the number of visits or units that both parties agree is sufficient to meet the medical needs of the member.
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 and Behavioral Health:** The information presented for this report item does not include requests for prescription medications.	**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.	**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.

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No.	Company Name	5.2 - Confirm Fully Insured Only	5.3 - Confirm Massachusetts Lives Only	5.4 - Confirm Excludes Prescription Data	5.5.a - Number of Requests for Authorization of Services Definition	5.5.b - Differences in Definition of Number of Services Requested	5.5.c - Definition of Number of Requests Authorized	5.5.d - Definition of Number of Requests Modified
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:** The information presented for report Item 5 does not include requests for prescription medications.	**Medical and Behavioral Health:** Requests 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.	**Medical and Behavioral Health:** Not applicable; ConnectiCare and Optum do not modify requests.
10	**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 information presented for report Item 5 does not include requests for prescription medications.	**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 or modified requests not included in authorizations.	**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.
11	**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 information presented for report Item 5 does not include requests for prescription medications.	**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 or modified requests not included in authorizations.	**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.
12	**4 Ever Life Insurance Company**	**N/A - no data to report**	**N/A - no data to report**	**N/A - no data to report**	**Medical and Behavioral Health:** When Insured or physician contacts insurer or designee to provide specified services for a number of days or for a specific number of visits.	**Medical and Behavioral Health:** No differences in definition.	**Medical:** Approval of request only after reviewing clinical information against established criteria; InterQual, medical policy, benefit level and upon review from medical director. **Behavioral Health:** Approval only after review of information utilizing ASAM and Magellan Necessity Criteria.	**Medical and Behavioral Health:** If requested service did not meet the level of criteria, but met a lower level; requestor is notified that lower level of care criteria is met.
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:** The information presented for report Item 5 does not include requests for prescription medications.	**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.	**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.
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:** The information presented for report Item 5 does not include requests for prescription medications.	**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.	**Medical and Behavioral Health:** A modification of the request, such as approval of service, but not for amount or frequency requested.

No.	Company Name	5.2 - Confirm Fully Insured Only	5.3 - Confirm Massachusetts Lives Only	5.4 - Confirm Excludes Prescription Data	5.5.a - Number of Requests for Authorization of Services Definition	5.5.b - Differences in Definition of Number of Services Requested	5.5.c - Definition of Number of Requests Authorized	5.5.d - Definition of Number of Requests Modified
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:** The information presented for report Item 5 does not include requests for prescription medications.	**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.	**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.
16	**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:** The information presented for report Item 5 does not include requests for prescription medications.	**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:** Request whose decision has been approved by THPP	**Medical and Behavioral Health:** an approval of services that are less than the requested service.
17	**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:** The information presented for report Item 5 does not include requests for prescription medications.	**Medical and Behavioral Health:** Receipt of a request by phone, fax or other electronic means.	Not applicable	**Medical and Behavioral Health:** Request whose decision has been approved by THP	**Medical and Behavioral Health:** Not applicable.
18	**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:** The information presented for report Item 5 does not include requests for prescription medications.	**Medical and Behavioral Health:** Receipt of a request by phone, fax or other electronic means.	Not applicable	**Medical and Behavioral Health:** Request whose decision has been approved by THP	**Medical and Behavioral Health:** Not applicable.
19	**UnitedHealthcare Insurance Company**	**Medical and Behavioral Health:** Reported information for Massachusetts fully insured members only.	**Medical and Behavioral Health:** Reported information for plans issued or renewed in Massachusetts.	**Medical and Behavioral Health:** The information presented for report Item 5 does not include requests for prescription medications.	**Medical and Behavioral Health:** Number presents the amount of requests received by UHC or Optum/UBH for review of a benefit or review for coverage of a health service.	**Medical and Behavioral Health:** A request could be for more than 1 day of visit, the request is counted as 1 request for a day/days or a service/services.	**Medical and Behavioral Health:** The number represents the amount of decisions to cover the health care service, meaning the health care service was authorized.	**Medical and Behavioral Health:** Not applicable.
20	**Wellfleet 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:** The information presented for report Item 5 does not include requests for prescription medications.	**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 authorized once utilization review department has reviewed clinical information from provider and determined that request meets requirements for coverage.	**Medical and Behavioral Health:** Modification is an initial denial, but during re-consideration, some of requested services are approved.

2020 Mental Health Parity and Addiction Equity Supplemental Response Letter
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No.	Company Name	5.5.e - Definition of Number of Requests Denied	5.5.f - Definition of Requests Denied or Modified Sent for Internal Review	5.5.g - Definition of Internally Appealed Requests Approved	5.5.h - Definition of Internally Appealed Requests Denied	5.5.i - Definition of Internally Appealed Requests Sent for External Appeal	5.5.j - Definition of External Appeals Overturned	5.5.k - Definition of External Appeals Upheld
1	**Aetna Health, Inc.**	**Medical and Behavioral Health:** Denial is full or partial denial of the service or level of care requested.	**Medical and Behavioral Health:** A denied or modified internal request is a verbal or written request to change initial determination decision.	**Medical and Behavioral Health:** An internal appeal approval is the reversal of the initial determination or subsequent appeal determination.	**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 is a 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:** Denial is full or partial denial of the service or level of care requested.	**Medical and Behavioral Health:** A denied or modified internal request is a verbal or written request to change initial determination decision.	**Medical and Behavioral Health:** An internal appeal approval is the reversal of the initial determination or subsequent appeal determination.	**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:** Denial is full or partial denial of the service or level of care requested.	**Medical and Behavioral Health:** A denied or modified internal request is a verbal or written request to change initial determination decision.	**Medical and Behavioral Health:** An internal appeal approval is the reversal of the initial determination or subsequent appeal determination.	**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	**AllWays Health Partners**	**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. Partial denials are also included.	**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.	**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.
5	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical and Behavioral Health:** Requests that are given final denial.	**Medical and Behavioral Health:** Number of unique 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.	**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	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	**Medical and Behavioral Health:** Requests that are given final denial.	**Medical and Behavioral Health:** Number of unique 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.	**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.
7	**Boston Medical Center Health Plan, Inc.**	**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.	**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.
8	**CIGNA Health and Life Insurance Company**	**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.	**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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9	**ConnectiCare of Massachusetts, Inc.**	**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.	**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	**Fallon Community Health Plan, Inc.**	**Medical:** Denial is a request for services that has not been approved and has not been modified. **Behavioral Health:** Includes clinical or administrative (procedural) denials, partial or complete	**Medical and Behavioral Health:** Initial adverse determination issued and member requests appeal.	**Medical and Behavioral Health:** An internal appeal request which has been approved is one where the previous adverse determination has been wholly overturned for payment of services.	**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.
11	**Fallon Health & Life Assurance Company**	**Medical:** Denial is a request for services that has not been approved and has not been modified. **Behavioral Health:** Includes clinical or administrative (procedural) denials, partial or complete	**Medical and Behavioral Health:** Initial adverse determination issued and member requests appeal.	**Medical and Behavioral Health:** An internal appeal request which has been approved is one where the previous adverse determination has been wholly overturned for payment of services.	**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	**4 Ever Life Insurance Company**	**Medical:** Denial of request only after reviewing clinical information against established criteria; InterQual, medical policy, benefit level and upon review from medical director. **Behavioral Health:** Denial only after review of information utilizing ASAM and Magellan Necessity Criteria.	**Medical and Behavioral Health:** Request must be received for appeal upon receipt of denial/adverse determination. The appeal is reviewed by appeals specialist. A determination is made of clinical vs. administrative.	**Medical and Behavioral Health:** Appeal letters are sent to appellant/provider/facility and state that decision made based on clinical information provided.	**Medical and Behavioral Health:** Appeal letters are sent to appellant/provider/facility and state that decision made based on clinical information provided. Denial letters state review done by peer consultant and include a denial reason code and rationale for denial.	**Medical and Behavioral Health:** Upon receipt of external appeal, request is reviewed for eligibility and appropriateness. Member has opportunity to submit additional information. Case is investigated and information obtained regarding nature of appeal.	**Medical and Behavioral Health:** After determination, nurse calls appellant. Also sent via mail.	**Medical and Behavioral Health:** After determination, nurse calls appellant. Also sent via mail.
13	**Harvard Pilgrim Health Care, Inc.**	**Medical and Behavioral Health:** Denial of authorization or payment or UM 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. Includes denial of a service sought by a member and denial of payment for a service that a member has received. Clinical and non-clinical mental health appeals sent to HPHC Behavior Health Access Center and reviewed by UBH/Optum; medical sent to Harvard Pilgrim Appeals and Grievances and reviewed by Harvard Pilgrim. Final decision for non-clinical mental health made by UBH/Optum; final decision for clinical mental health and medical made by Harvard Pilgrim.	**Medical and Behavioral Health:** Non-clinical internal appeal: overturned if appeal wasn't adjudicated in line with member's evidence of coverage. Clinical internal appeal: appeal undergoes a medical necessity review. Appeals can be partly approved	**Medical and Behavioral Health:** Non-clinical internal appeal: denied if appeal was adjudicated in line with member's evidence of coverage. Clinical internal appeal: appeal undergoes a medical necessity review.	**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:** 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	**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.

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15	**HPHC Insurance Company, Inc.**	**Medical and Behavioral Health:** Denial of authorization or payment or UM 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. Includes denial of a service sought by a member and denial of payment for a service that a member has received. Clinical and non-clinical mental health appeals sent to HPHC Behavior Health Access Center and reviewed by UBH/Optum; medical sent to Harvard Pilgrim Appeals and Grievances and reviewed by Harvard Pilgrim. Final decision for non-clinical mental health made by UBH/Optum; final decision for clinical mental health and medical made by Harvard Pilgrim.	**Medical and Behavioral Health:** Non-clinical internal appeal: overturned if appeal wasn't adjudicated in line with member's evidence of coverage. Clinical internal appeal: appeal undergoes a medical necessity review. Appeals can be partly approved	**Medical and Behavioral Health:** Non-clinical internal appeal: denied if appeal was adjudicated in line with member's evidence of coverage. Clinical internal appeal: appeal undergoes a medical necessity review.	**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.
16	**Tufts Health Public Plans, Inc.**	**Medical and Behavioral Health:** An adverse determination made by THPP	**Medical and Behavioral Health:** Adverse determinations for which a member or provider have requested a first level appeal by THPP	**Medical and Behavioral Health:** Internal appeal requests in which the appeal decision by THPP is to overturn the original adverse determination.	**Medical and Behavioral Health:** Internal appeal requests in which the appeal decision by THPP is to uphold or partially uphold the original adverse determination.	**Medical and Behavioral Health:** When a member of provider have requested a second level appeal by an independent external reviewer after an initial internal denial by THPP	**Medical and Behavioral Health:** External reviewer fully or partially overturns the initial denial by THPP	**Medical and Behavioral Health:** External reviewer upholds the initial denial by THPP
17	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical and Behavioral Health:** An adverse determination made by THP	**Medical and Behavioral Health:** Adverse determinations for which a member or provider have requested a first level appeal by THP	**Medical and Behavioral Health:** Internal appeal requests in which the appeal decision by THP is to overturn the original adverse determination.	**Medical and Behavioral Health:** Internal appeal requests in which the appeal decision by THP is to uphold or partially uphold the original adverse determination.	**Medical and Behavioral Health:** When a member of provider have requested a second level appeal by an independent external reviewer after an initial internal denial by THP	**Medical and Behavioral Health:** External reviewer fully or partially overturns the initial denial by THP	**Medical and Behavioral Health:** External reviewer upholds the initial denial by THP
18	**Tufts Insurance Company**	**Medical and Behavioral Health:** An adverse determination made by THP	**Medical and Behavioral Health:** Adverse determinations for which a member or provider have requested a first level appeal by THP	**Medical and Behavioral Health:** Internal appeal requests in which the appeal decision by THP is to overturn the original adverse determination.	**Medical and Behavioral Health:** Internal appeal requests in which the appeal decision by THP is to uphold or partially uphold the original adverse determination.	**Medical and Behavioral Health:** When a member of provider have requested a second level appeal by an independent external reviewer after an initial internal denial by THP	**Medical and Behavioral Health:** External reviewer fully or partially overturns the initial denial by THP	**Medical and Behavioral Health:** External reviewer upholds the initial denial by THP
19	**UnitedHealthcare Insurance Company**	**Medical and Behavioral Health:** Number represents the amount of reviews performed that result in adverse decision (modification, reduction, or denial of a health care service based on failure to meet the medical necessity criteria). Non-coverage determinations are those denials that are based on policy terms such as eligibility, non-payment of premiums, etc.	**Medical and Behavioral Health:** Number represents the amount of requests for clinical review of an adverse decision (denial, modification, reduction of health care service based on failure to meet medical necessity criteria.	**Medical and Behavioral Health:** The number represents the amount of approvals resulting from a request for review of an adverse decision.	**Medical:** UHC Indicated 17 internal appeals denied. Medical and Behavioral Health: The number represents the amount of appeals of an adverse decision that were denied or portion of health care service denied.	**Medical and Behavioral Health:** When Office of Patient Protection submits notice of an external review of an adverse decision.	**Medical and Behavioral Health:** External appeal overturned decisions are those that these external reviewer approves the health care service that was denied by UHC or Optum/UBH.	**Medical and Behavioral Health:** External appeal upheld decisions are those that external reviewer continues to deny the health care service that was denied by UHC or Optum/UBH.
20	**Wellfleet Insurance Company**	**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:** Appropriate clinical specialist clinical information received to support internal appeal and determine if coverage can be approved based on carrier guidelines.	**Medical and Behavioral Health:** Appropriate clinical specialist clinical information received to support internal appeal and determine if coverage can be changed based on carrier guidelines.	**Medical and Behavioral Health:** Request from a 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.

2020 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: ExecutiveC2:E12 Director, Clinical Solutions Head, Market Medical Management Behavioral Health: Executive Director, Behavioral Health Chief Medical Officer Both have same policies, procedures, and system platforms.	**Medical and Behavioral Health:** Electronic Data Interchange (secure online provider portal); mail; telephone.	**Medical and Behavioral Health:** There is no difference in the information we request from the provider. For both mental health/substance use and medical/surgical requests for out-of-network services. Aetna asks what services are being requested and why provider believes services not reasonably available in-network.
2	**Aetna Health Insurance Company**	**Medical:** Executive Director, Clinical Solutions Head, Market Medical Management **Behavioral Health:** Executive Director, Behavioral Health Chief Medical Officer Both have same policies, procedures, and system platforms.	**Medical and Behavioral Health:** Electronic Data Interchange (secure online provider portal); mail; telephone.	**Medical and Behavioral Health**: There is no difference in the information we request from the provider. For both mental health/substance use and medical/surgical requests for out-of-network services. Aetna asks what services are being requested and why provider believes services not reasonably available in-network.
3	**Aetna Life Insurance Company**	**Medical:** Executive Director, Clinical Solutions Head, Market Medical Management **Behavioral Health:** Executive Director, Behavioral Health Chief Medical Officer Both have same policies, procedures, and system platforms.	**Medical and Behavioral Health:** Electronic Data Interchange (secure online provider portal); mail; telephone.	**Medical and Behavioral Health:** There is no difference in the information we request from the provider. For both mental health/substance use and medical/surgical requests for out-of-network services. Aetna asks what services are being requested and why provider believes services not reasonably available in-network.
4	**AllWays Health Partners**	**Medical:** NHP's Chief Medical Officer and Medical Directors. **Behavioral Health:** Beacon's Chief Medical Officer & Medical Directors **Reason for difference:** Roles and responsibilities are parallel at the partner organizations. Two different individuals are responsible because of the need for experience and expertise in the respective fields.	**Medical and Behavioral Health:** Requests for coverage via fax, telephone, mail, e-mail and internet portal.	**Medical and Behavioral Health:** Same as in-network, plus, supportive documents to support necessity for service delivery including evidence of prior relationship, provider qualification specific to condition, evidence of ongoing treatment for an acute or chronic condition, or treatment for terminal conditions. **Medical Only:** verification of pregnancy and whether provider is a PCP. Reason for difference: Pregnancy and PCP care is only for medical because Behavioral health providers are not PCPs or OB providers.

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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
5	**Blue Cross and Blue Shield of Massachusetts, Inc.**	**Medical:** Frederick Dekow, MD, Vice President of Physician Review and Appeals Behavioral Health: Gregory G. Harris, MD, MPH, Associate Medical Director for Behavioral Health; M. Elyce Kearns, MD, Associate Medical Director; William Walsh, MD, Associate Medical Director for the Medical Surgical Physician Review Unit Reason for difference: Behavioral health still reports to Frederick Dekow	**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.
6	**Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.**	**Medical:** Frederick Dekow, MD, Vice President of Physician Review and Appeals **Behavioral Health:** Gregory G. Harris, MD, MPH, Associate Medical Director for Behavioral Health; M. Elyce Kearns, MD, Associate Medical Director; William Walsh, MD, Associate Medical Director for the Medical Surgical Physician Review Unit **Reason for difference:** Behavioral health still reports to Frederick Dekow	**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.
7	**Boston Medical Center Health Plan, Inc.**	**Medical:** BMCHP Chief Medical Officer; medical directors; and Director of Utlization Management oversee authorization for out-of-network requests for service. **Behavioral Health:** Beacon's Chief Medical Officer; medical directors; and clinicians. **Reason for differences:** Although they are in different entities with different titles, they are comparable positions.	**Medical and Behavioral Health:** Requests for coverage via phone, email, provider portal, and fax.	**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.

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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
8	**CIGNA Health and Life Insurance Company**	**Medical and Behavioral Health:** Out-of-network services treated the same way as in-network. Therefore, the same people are responsible.	**Medical and Behavioral Health:** Out-of-network services treated the same way as in-network. Therefore, the same people are responsible.	**Medical and Behavioral Health:** Out-of-network services treated the same way as in-network. Therefore, the same people are responsible.
9	**ConnectiCare of Massachusetts, Inc.**	**Medical:** Overseen by VP, Clinical Operations; VP, Chief Medical Officer; and the Manager, Audit and Regulatory Adherence **Behavioral Health:** Overseen by the Director, Care Advocacy and the Sr. VP, Medical Operations	**Medical and Behavioral Health: P**hone, fax or mail.	**Medical and Behavioral Health:** Depending on type of service requested, information such as presence of suicidal/homicidal ideation, substance use history, and mental status.
10	**Fallon Community Health Plan, Inc.**	**Medical:** Chief Medical Officer and Associate Medical Directors **Behavioral Health:** Beacon's Chief Medical Officer Affairs and Medical Directors **Reason for difference:** These are comparable positions within each entity.	**Medical:** Fax or phone **Behavioral Health:** Fax, phone, or email **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.
11	**Fallon Health & Life Assurance Company**	**Medical:** Chief Medical Officer and Associate Medical Directors **Behavioral Health:** Beacon's Chief Medical Officer Affairs and Medical Directors **Reason for difference:** These are comparable positions within each entity.	**Medical:** Fax or phone **Behavioral Health:** Fax, phone, or email **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	**4 Ever Life Insurance Company**	**Medical:** For out-of-network medical services, the Chief Medical Officer of AmeriHealth Administrators is responsible for oversight of authorization of medical services. **Behavioral Health:** Out-of-network mental health/substance use disorder services are provided by Magellan Health Care. Specifically, the CMO of Magellan Health has oversight of the program.	**Medical and Behavioral Health:** Providers can use a toll free number or fax.	**Medical and Behavioral Health:** Process is the same for in-network and out-of-network. Both require medical history, diagnostic test results, list of medications.

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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
13	**Harvard Pilgrim Health Care, Inc.**	**Medical:** Senior Medical Director **Behavioral Health:** VP of national Operations and Sr. VP, Medical Operations **Reason for difference:** Differences exist based on different entities responsible for each type of service.	**Medical:** Contact Provider Service Center or website. **Behavioral Health:** Providers request services via phone. For services not requiring preauthorization, providers may submit claims for processing.	**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, info explaining why they requested OON services. **Reason for differences:** Different health conditions.
14	**Health New England, Inc.**	**Medical:** Integrated Care Manager - Utilization Manager **Behavioral Health:** Behavioral Health Manager All OON requests must be reviewed by an HNE clinician	**Medical and behavioral health:** Fax for outpatient request; inpatient request takes place after admission.	**Medical and Behavioral Health:** Description of member's diagnoses, current treatment plan, treatment history, and clinical documentation . Inpatient stays reviewed for severity of illness on presentation and level or intensity of treatment
15	**HPHC Insurance Company, Inc.**	**Medical:** Senior Medical Director **Behavioral Health:** VP of national Operations and Sr. VP, Medical Operations **Reason for difference:** Differences exist based on different entities responsible for each type of service.	**Medical:** Contact Provider Service Center or website. **Behavioral Health:** Providers request services via phone. For services not requiring preauthorization, providers may submit claims for processing.	**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, info explaining why they requested OON services. **Reason for differences:** Different health conditions.
16	**Tufts Health Public Plans, Inc.**	**Medical and Behavioral Health:** THPP Medical Directors, physician UM reviewers, Directors of Behavioral Health services, and Medical Management	**Medical:** Fax or mail **Behavioral Health:** Fax or phone **Reason this is acceptable:** Behavioral Health has options that offer more direct communication.	**Medical and Behavioral Health:** Clinical information that is pertinent to the service being requested.

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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
17	**Tufts Associated Health Maintenance Organization, Inc.**	**Medical and Behavioral Health:** THP Medical Directors, physician UM reviewers, Directors of Behavioral Health services, and Pre-certification operations	**Medical:** Fax or mail **Behavioral Health:** Fax or phone **Reason this is acceptable:** Behavioral Health has options that offer more direct communication.	**Medical and Behavioral Health:** Clinical information that is pertinent to the service being requested.
18	**Tufts Insurance Company**	**Medical and Behavioral Health:** THP Medical Directors, physician UM reviewers, Directors of Behavioral Health services, and Pre-certification operations	**Medical:** Fax or mail **Behavioral Health:** Fax or phone **Reason this is acceptable:** Behavioral Health has options that offer more direct communication.	**Medical and Behavioral Health:** Clinical information that is pertinent to the service being requested.
19	**UnitedHealthcare Insurance Company**	**Medical:** National Vice President of Inpatient Care Management and National Vice President of Clinical Operations. **Behavioral Health:** Optum's Vice President of National Operations.	**Medical**: Telephone, internet, and/or fax. **Behavioral Health:** telephone, fax.	**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.
20	**Wellfleet Insurance Company**	**Medical and Behavioral Health:** (Cigna) Out-of-network services treated the same way as in-network. Therefore, the same people are responsible.	**Medical and Behavioral Health**: (Cigna) Out-of-network services treated the same way as in-network. Therefore, the same people are responsible.	**Medical and Behavioral Health:** (Cigna) Out-of-network services treated the same way as in-network. Therefore, the same people are responsible.

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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.**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.
2	**Aetna Health Insurance Company**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.
3	**Aetna Life Insurance Company**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.
4	**AllWays Health Partners**	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, 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	**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.
7	**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.
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	**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.
11	**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.
12	**4 Ever Life Insurance Company**	There are no differences in any cost-sharing features between medical/surgical and mental health/substance use services in any of the plans offered.
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.

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Summary of Responses to Bulletin 2013-06: Item #7

No.	Company Name	7.1 - List of Any Differences in Cost-sharing Features
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	**Tufts Health Public Plans, Inc.**	For both inpatient and outpatient services, cost-sharing features are the same, or better, for mental health services and medical services.
17	**Tufts Associated Health Maintenance Organization, Inc.**	For both inpatient and outpatient services, cost-sharing features are the same, or better, for mental health services and medical services.
18	**Tufts Insurance Company**	For both inpatient and outpatient services, cost-sharing features are the same, or better, for mental health services and medical services.
19	**UnitedHealthcare Insurance Company**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.
20	**Wellfleet Insurance Company**	For both inpatient and outpatient services, cost-sharing features are the same for mental health services and medical services.