Massachusetts Division of Insurance
Mental Health Parity Summary Report
For the Period of
Calendar Year 2022

Acknowledgements

The enclosed report was prepared by the Massachusetts Division of Insurance ("Division"). It is being furnished to the Clerk of the Massachusetts Senate, the Clerk of the Massachusetts House of Representatives, the Joint Committee on Mental Health, Substance Use and Recovery, and the Joint Committee on Health Care Financing in accordance with M.G.L. c. 26, section 8M.

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Mental Health Parity Reports

This report represents the initial report of the Division of Insurance to present information regarding carriers' compliance with state and federal Mental Health Parity rules. According to section 8M(d) of M.G.L. 26, the report is to include the following:

> "(i) the methodology the commissioner is using to check for compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act;
> (ii) the methodology the commissioner is using to check for compliance with section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and section 4M of chapter 176G;
> (iii) the report of each market conduct examination conducted or completed during the immediately preceding calendar year regarding access to behavioral health services or compliance with parity in mental health and substance use disorder benefits under state and federal laws and any actions taken as a result of such market conduct examinations;
> (iv) a breakdown of treatment authorization data for each carrier for mental health treatment services, substance use disorder treatment services and medical and surgical treatment services for the immediately preceding calendar year indicating for each treatment service: (A) the number of inpatient days, outpatient services and total services requested; (B) the number and per cent of inpatient day requests authorized, inpatient day requests modified, inpatient day requests modified resulting in a lower amount of inpatient days authorized than requested and the reason for the modification, inpatient day requests denied and the reason for the denial, inpatient day requests where an internal appeal was filed and approved, inpatient day requests where an internal appeal was filed and denied, inpatient day requests where an external appeal was filed and upheld and inpatient day requests where an external appeal was filed and overturned; and (C) the number and per cent of outpatient service requests authorized, outpatient service requests modified, outpatient service requests modified resulting in a lower amount of outpatient service authorized than requested and the reason for the modification, outpatient service requests denied and the reason for the denial, outpatient service requests where an internal appeal was filed and approved, outpatient service requests where an internal appeal was filed and denied, outpatient service requests where an external appeal was filed and upheld and outpatient service requests where an external appeal was filed and overturned;
> (v) the number of consumer complaints received by the division of insurance under subsection (f) of section 8K in the immediately preceding calendar year and a summary of all such complaints resolved by the division during that time period, including: (A) the number of complaints resolved in favor of the consumer; (B) the number of complaints resolved in favor of the carrier; and (C) any enforcement actions taken in response to such complaints; and
> (vi) information about any educational or corrective actions the commissioner has taken to ensure carrier compliance with the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and said section 47B of said chapter 175, said section 8A of said chapter 176A, said section 4A of said chapter 176B and said section 4M of said chapter 176G.
>
> The summary report shall be written in nontechnical, readily understandable language and made available to the public by posting the report on the division's website."

1. Methodology to Check for Compliance with the Federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)

One of the central features of MHPAEA is the requirement that carriers that are subject to MHPAEA cannot impose annual or lifetime dollar limits on mental health and substance use benefits that are less favorable than any such limits imposed on medical/surgical benefits.

Additionally, while financial treatment limits are permitted, the law requires that any financial treatment limits are no more restrictive for mental health/substance use services in the following categories: inpatient in-network, inpatient out-of-network, outpatient in-network, outpatient out-of-network, emergency, and prescription drugs. The Division reviews health carriers' evidences of coverage and schedules of benefit to ensure compliance with this requirement.

Prior to the enactment of Chapter 177 of the Acts of 2022, the Division of Insurance issued Bulletin 2013-06, dated May 31, 2013, requiring that commercial health insurers and health maintenance organizations, as well as Blue Cross and Blue Shield of Massachusetts, Inc. issuing or renewing insured products in Massachusetts (collectively, "Carriers") submit certain information to the Division annually by July 1 to demonstrate compliance with a broad array of mental health parity requirements, including MHPAEA and Massachusetts state mental health parity laws and regulations. This information is generally comprised of the following:

- Signed Certification of Compliance;
- Completed Federal Self-Compliance Tool, including copies of NQTL analyses;
- Confirmation of coverage of the following behavioral health services for children and adolescents required pursuant to Chapter 110 of the Acts of 2017:
    - Intensive care coordination for a child with serious emotional disturbances;
    - Mobile crisis intervention;
    - Family support and training;
    - In-home therapy;
    - Therapeutic mentoring services; and
    - In-home behavioral services (collective referred to as "Behavioral Health for Children and Adolescents" or "BHCA"); and
- Additional Massachusetts-specific information, including Prior Authorization Data, as outlined in Bulletin 2013-06 and subsequent annual request memoranda to Carriers.

The Division's instructions to Carriers for the 2022 Mental Health Parity Report, issued on May 5, 2023, consisted of all the aforementioned items, but replaced the previous requests outlined in Bulletin 2013-06 with new requests targeting compliance with M.G.L. c. 26, section 8M, as enacted by Chapter 177 of the Acts of 2022.

None of the Carriers that submitted a 2022 Mental Health Parity Annual Report to the Division identified any areas of deficiency or any corrective actions arising from the certification process, and according to the Division's review each carrier appeared to be in compliance with this section of the law.

Summary of Reports Pursuant to M.G.L. c. 26, Section 8M(a)(i)-(iv)

The Division received reports from 21 carriers in response to the Division's Filing Guidance 2023-E – Annual Mental Health Parity Compliance Certifications. Carriers were required to submit responses for the following categories.

(i) the specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations and a description of all mental health and substance use disorder benefits and medical and surgical benefits to which each term applies in each respective benefits classification; provided, however, that the nonquantitative treatment limitations shall include the processes, strategies, evidentiary standards or other factors used to develop and apply the carrier's reimbursement rates for mental health and substance use disorder benefits and medical and surgical benefits in each respective benefits classification;

(ii) the factors used to determine that the nonquantitative treatment limitations will apply to mental health and substance use disorder benefits and medical and surgical benefits;

(iii) the evidentiary standards used for the factors identified in clause (ii), when applicable, and any other source or evidence relied upon to design and apply the nonquantitative treatment limitations to mental health and substance use disorder benefits and medical and surgical benefits; provided, however, that every factor shall be defined;

(iv) a comparative analysis demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to mental health and substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to medical and surgical benefits in the benefits classification;

(v) the specific findings and conclusions reached by the carrier with respect to health insurance coverage, including any results of the analysis described in clause (iv) that indicate whether the carrier is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including, but not limited to, 45 CFR Part 146.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3).

Carrier Responses

A summary of each carrier's specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations and a description of all mental health and substance use disorder benefits and medical and surgical benefits to which each term applies in each respective benefits classification is provided in Appendix C below.

None of the Carriers that submitted a 2022 Mental Health Parity Annual Report to the Division identified any areas of deficiency or any corrective actions arising from the certification process.

A summary of each carrier's factors and evidentiary standards used to determine that the nonquantitative treatment limitations will apply to mental health and substance use disorder benefits and medical and surgical benefits is provided in Appendix D. The following are the categories included in each carrier's comparative analysis.

4 Ever Life Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization Review
Concurrent Review
Retrospective Review
Emergency Services
Pharmacy Services
Prescription Drug Formulary Design
Case Management
New Technologies
Provider Credentialing and Contracting
Completing Course of Treatment Review
Provider Reimbursement

Aetna Health, Inc. (a Pennsylvania Corporation)

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization

Concurrent Review
Retrospective Review
Sequenced Treatment
Network Provider Reimbursement
Facility Provider Reimbursement
Non-participating Provider Reimbursement
Non-participating Facility Reimbursement
Provider Admission Standards/Credentialing
Pharmacy/Step Therapy

Aetna Health Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization
Concurrent Review
Retrospective Review
Sequenced Treatment
Network Provider Reimbursement
Facility Provider Reimbursement
Non-participating Provider Reimbursement
Non-participating Facility Reimbursement
Provider Admission Standards/Credentialing
Pharmacy/Step Therapy

Aetna Life Insurance Company
Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

- Prior Authorization
- Concurrent Review
- Retrospective Review
- Sequenced Treatment
- Network Provider Reimbursement
- Facility Provider Reimbursement
- Non-participating Provider Reimbursement
- Non-participating Facility Reimbursement
- Provider Admission Standards/Credentialing
- Pharmacy/Step Therapy

Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

- Prior Authorization and Retrospective Authorization
  - Inpatient Care
  - Ambulance Services
  - Assisted Reproductive Technologies
  - Gene Therapy/Orphan Drugs
  - Short-Term Rehabilitation Services (Homecare, OT, PT)
  - Neuropsychological and Psychological Testing
  - Outpatient Non-Surgical Procedures and Outpatient Surgical Procedures
  - Radiation Therapy, Radiology Imaging and Sleep Management Services
  - Genetic Testing
  - Urine Drug Testing
  - Applied Behavior Analysis (ABA)
  - Intermediate Levels of Care and Intensive Community-Based Treatment
  - Ketamine/Esketamine
  - Transcranial Magnetic Stimulation (TMS)
  - Out-of-Network Care
- Concurrent Review
- Pharmacy
- Provider Admission
- Reimbursement Rates
- Geographic Restrictions

Blue Cross and Blue Shield of Massachusetts, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

- Prior Authorization and Retrospective Authorization
  - Inpatient Care
  - Ambulance Services
  - Assisted Reproductive Technologies
  - Gene Therapy/Orphan Drugs
  - Short-Term Rehabilitation Services (Homecare, OT, PT)
  - Neuropsychological and Psychological Testing
  - Outpatient Non-Surgical Procedures and Outpatient Surgical Procedures
  - Radiation Therapy, Radiology Imaging and Sleep Management Services
  - Genetic Testing
  - Urine Drug Testing
  - Applied Behavior Analysis (ABA)
  - Intermediate Levels of Care and Intensive Community-Based Treatment
  - Ketamine/Esketamine
  - Transcranial Magnetic Stimulation (TMS)
  - Out-of-Network Care
- Concurrent Review
- Pharmacy
  - Provider Admission
  - Reimbursement Rates
  - Geographic Restrictions

Boston Medical Center Health Plan, Inc. (d/b/a WellSense Health Plan)

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

- Prior Authorization
- Concurrent Review
- Retrospective Review
- Fail First Policy
- Reimbursement
- Provider Credentialing
- Provider Type Exclusions
- Certification Requirement
- Geographic Restrictions
- UCR Rate Determination

Cigna Health and Life Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization – In-Network, Inpatient
Prior Authorization – Out-of-Network, Inpatient
Prior Authorization – In-Network, Outpatient
Prior Authorization – Out-of-Network, Outpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – Out-of-Network, Inpatient
Concurrent Review – Out-of-Network, Outpatient
Retrospective Review – In-Network, Inpatient
Retrospective Review – Out-of-Network, Inpatient
Retrospective Review – In-Network, Outpatient
Retrospective Review – Out-of-Network, Outpatient
Network Admissions / Credentialing / Reimbursement
Pharmacy / Step Therapy

ConnectiCare of Massachusetts, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization – In-Network, Inpatient
Prior Authorization – Out-of-Network, Inpatient
Prior Authorization – In-Network, Outpatient
Prior Authorization – Out-of-Network, Outpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – Out-of-Network, Inpatient
Concurrent Review – Out-of-Network, Outpatient
Retrospective Review – In-Network, Inpatient
Retrospective Review – Out-of-Network, Inpatient
Retrospective Review – In-Network, Outpatient
Retrospective Review – Out-of-Network, Outpatient
Medical Necessity
Experimental/Investigational/Unproven Services
Network Management – Network Adequacy
Reimbursement – Emergency Care
Reimbursement – Inpatient and Outpatient
Pharmacy / Step Therapy
Geographic Restrictions

Fallon Community Health Plan, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization & Concurrent Review
Retrospective Review
Pharmacy-Quantity Limitations
Provider Reimbursement
Pharmacy/Step Therapy
Pharmacy/Formulary Tiers
Fraud, Waste and Abuse Management
Outlier Claims Review
Coding Edits
DRG Claims
Provider Contracting
Medical Necessity

Harvard Pilgrim Health Care, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Provider Admission – In-Network Inpatient & Outpatient
Utilization Review – Inpatient & Outpatient
Pharmacy / Formulary Design
Provider Reimbursement – In-Network
Provider Reimbursement – Out-of-Network

Health New England, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization
Concurrent Review
Retrospective Review
Fail First/Step Therapy
Provider Credentialing
Board Certification Requirement
Facility-type Exclusions
Unlicensed Provider Requirement
Provider-type Exclusions
Provider Reimbursement
Geographic Restrictions
Medical Necessity Criteria

HPHC Insurance Company, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Provider Admission – In-Network Inpatient & Outpatient
Utilization Review – Inpatient & Outpatient
Pharmacy / Formulary Design
Provider Reimbursement – In-Network
Provider Reimbursement – Out-of-Network

Mass General Brigham Health Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization – In-Network, Inpatient
Prior Authorization – Out-of-Network, Inpatient
Prior Authorization – In-Network, Outpatient
Prior Authorization – Out-of-Network, Outpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – Out-of-Network, Inpatient
Concurrent Review – Out-of-Network, Outpatient
Retrospective Review – In-Network, Inpatient
Retrospective Review – Out-of-Network, Inpatient
Retrospective Review – In-Network, Outpatient
Retrospective Review – Out-of-Network, Outpatient
Pharmacy/Fail First/Step Therapy
Credentialing
Provider Reimbursement – In-Network / Facility
Provider Reimbursement – In-Network / Professional Services
Provider Reimbursement – Emergency Care
Provider Reimbursement – Inpatient/Outpatient
Geographic Restrictions

Mass General Brigham Health Plan, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization – In-Network, Inpatient
Prior Authorization – Out-of-Network, Inpatient
Prior Authorization – In-Network, Outpatient
Prior Authorization – Out-of-Network, Outpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – Out-of-Network, Inpatient
Concurrent Review – Out-of-Network, Outpatient
Retrospective Review – In-Network, Inpatient
Retrospective Review – Out-of-Network, Inpatient
Retrospective Review – In-Network, Outpatient
Retrospective Review – Out-of-Network, Outpatient
Pharmacy/Fail First/Step Therapy
Credentialing
Provider Reimbursement – In-Network / Facility
Provider Reimbursement – In-Network / Professional Services
Provider Reimbursement – Emergency Care
Provider Reimbursement – Inpatient/Outpatient
Geographic Restrictions

Tufts Associated Health Maintenance Organization, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Utilization Review – Inpatient
Utilization Review – Outpatient
Pharmacy / Formulary Design
Provider Admission
Provider Reimbursement
In-Network Reimbursement

Tufts Health Public Plans, Inc.

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Utilization Review – Inpatient
Utilization Review – Outpatient
Pharmacy / Formulary Design
Provider Admission
Provider Reimbursement
In-Network Reimbursement

Tufts Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Utilization Review – Inpatient
Utilization Review – Outpatient
Pharmacy / Formulary Design
Provider Admission
Provider Reimbursement
In-Network Reimbursement

United States Fire Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Medical Management Standards
Concurrent Review
Retrospective Review
Ongoing Case Management
Provider Credentialing
Network Reimbursement
Network Adequacy
Out-of-Network Reimbursement
Exclusions
Experimental/Investigational Determinations
Facility Restrictions
Provider Restrictions
Coverage Scope Limitations
Formulary Adequacy
Formulary Structure
Approval of Prescription Coverage
Step Therapy
Pharmacy Limitations

UnitedHealthcare Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Prior Authorization – In-Network, Inpatient
Prior Authorization – Out-of-Network, Inpatient
Prior Authorization – In-Network, Outpatient
Prior Authorization – Out-of-Network, Outpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – In-Network, Inpatient
Concurrent Review – Out-of-Network, Inpatient
Concurrent Review – Out-of-Network, Outpatient
Retrospective Review – In-Network, Inpatient
Retrospective Review – Out-of-Network, Inpatient
Retrospective Review – In-Network, Outpatient
Retrospective Review – Out-of-Network, Outpatient
Geographic Restrictions
In-Network Reimbursement / Professional Services
In-Network Reimbursement / Facility-Based
Out-of-Network Reimbursement / Professional Services and Facility-Based
Out-of-Network Reimbursement / Emergency Services
Pharmacy Benefit Programs Drug List
Prescription Drug Prior Authorization / Step Therapy
Network Management
Credentialing

Wellfleet Insurance Company

Within the comparative analysis materials, the carrier submitted an analysis of the following areas:

Medical Necessity Criteria Development
Prior Authorization
Concurrent Review
Retrospective Review
Quantity Limits
Step Therapy
Experimental and Investigational Determinations
Provider Access / Credentialing and Reimbursement
Formulary Design
Prior Authorization – Prescription Drug Benefit
Quantity Limits – Prescription Drug Benefit
Out-of-Network Reimbursement

2. Methodology to Check for Compliance with section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and section 4M of chapter 176G

Section 47B of chapter 175, section 8A of chapter 176A, section 4A of chapter 176B and section 4M of chapter 176G requires health insurance carriers to cover mental health benefits on a nondiscriminatory basis "for the diagnosis and treatment of the following biologically-based mental disorders, as described in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association, referred to in this section as the DSM: (1) schizophrenia; (2) schizoaffective disorder; (3) major depressive disorder; (4) bipolar disorder; (5) paranoia and other psychotic disorders; (6) obsessive-compulsive disorder; (7) panic disorder; (8) delirium and dementia; (9) affective disorders; (10) eating disorders; (11) post traumatic stress disorder; (12) substance abuse disorders; and (13) autism."

The Division reviewed carriers' evidences of coverage to ensure that all required mental health benefits are included. The Division reviews carriers' evidences of coverage to ensure that there are no exclusions that may provide limitations of the required mental health benefits that result in these benefits being less favorable than medical/surgical benefits. The Division reviews carriers' schedules of benefit which describe any cost-sharing features part of each plan in order to identify whether any cost-sharing is less favorable for mental health/substance use services than for medical/surgical services.

Appendix C includes a detailed summary of the review of the comparison of the behavioral health and non-behavioral health benefits of the insurance carriers' plans. None of the carriers' plans were found to be noncompliant regarding the benefits between behavioral health and non-behavioral health plans.

3. Market Conduct Examinations

There were not any market conduct examinations conducted in calendar year 2022.

On August 10, 2023, the Massachusetts Division of Insurance ("Division") commenced behavioral health parity market conduct examinations of twenty-one (21) health insurance companies to determine the companies' compliance with behavioral health parity requirements under section 8K of Chapter 26 of the Massachusetts General Laws as amended by Chapter 177 of the Acts of 2022 (An Act Addressing Barriers to Care for Mental Health), section 4 of Chapter 175, section 10 of Chapter 176G and all other applicable statutes. To assist in this regard the Division retained the services of the INS Companies, an approved vendor under RFR-2018-DOI-002 – Market Conduct Examination Services. The scope of the examinations shall include an insurers' compliance with the relevant provisions of the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 ("MPHEA"), as amended, any federal guidance or regulations relevant to the act, including 45 CFR Part 146.136, 45 CFR Part 147.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a) (3), and applicable state mental health parity laws, including, but not limited to, section 47B of Chapter 175, section 8A of Chapter 176A, section 4A of Chapter 176B and sections 4, 4B and 4M of Chapter 176G.

The examinations initiated in 2023 shall follow the directives outlined in the federal and state legislative mandate and employ a tailored methodology using standards included in the *2022 NAIC Market Regulation Handbook* (the "Handbook"), the applicable Commonwealth of Massachusetts' insurance laws, regulations, and relevant federal legislation. The Division initiated phase one of the examination process with an Interrogatory, one of the review methods under the Continuum of Regulatory Options ("Continuum") for Market Conduct Examinations as provided in the Handbook. Examiners will focus on high-level aggregate data requests for areas such as utilization review, including prior authorization data, concurrent review, retrospective review, denials of authorization, step-therapy, network admission standards/reimbursement rates, network adequacy, geographic restrictions, complaint/grievance data, information verifying compliance with MPHEA and denials of payment and coverage. Additionally, the examiners will review any corrective actions implemented as a result of previous examinations or reviews by other regulators or law enforcement agencies.

The Division's behavioral health parity market conduct examinations are ongoing as of the date of this Report. The Division expects to complete the examinations in 2024.

4. Authorizations

According to M.G.L. c. 176O, carriers may establish utilization review systems that evaluate the medical necessity of a requested service. If a carrier denies or modifies a request, the carrier is required to notify the covered member about this adverse determination within 2 days and provide information about how to appeal any such adverse determination both within the member's carrier's internal appeal system and if still denied through that appeal through an external review by an independent review board coordinated through the Office of Patient Protection.

Each carrier submitted a report of services requested, authorized or denied and of appeals that were conducted that were either overturned or upheld. A report presenting information on a company-by-company level is included in Appendix D. The following chart presents a summary of all the company authorizations for calendar year 2022.

No. of Requests Made (5a)	No. of Services Requested (5b)			No. of Requests Authorized[2] (5c)	No. of Requests Modified[2] (5d)	No. of Requests Denied (5e)	No. of Internal Appeals Filed (5f)	No. of Appeals Approved (5g)	No. of Appeals Denied (5h)	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
850,462	539,186	32,754,589	32,846,653	752,313	13,854	83,200	3,630	2,105	1,525	77	32	45
	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
44,593	183,289	6,607,979	6,791,268	41,951	1,477	1,155	120	41	79	11	7	4

1Reported information is for all 2022 non-governmental insured coverage issued in Massachusetts for requests made and appeals heard during calendar year 2021.

[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.

In 2022, for medical services, 752,313 (88.5%) of the 850,462 requests were approved for care. For behavioral health services, 41,951 (94.1%) of the 44,593 requests were approved for care. For medical services, of the 13,854 requests that were modified and the 83,200 requests that were denied, a total of 3,630 (0.4%) were appealed within the insurance carrier. For behavioral health services, of the 1,477 that were modified and the 1,155 that were denied, a total of 120 (0.5%) were appealed within the carrier.

When appealed within the carrier, 2,105 (56.0%) of 3,630 medical service denials were overturned and 79 (65.0%) of 120 behavioral service denials were overturned. When appealed with the external review, 32 (41.5%) of 77 medical service denials were overturned and 7 (63.3%) of 11 behavioral service denials were overturned.

5. Consumer Complaint Information

The Consumer Services Unit ("CSU") responds to inquiries and assists consumers in resolving insurance complaints or disputes against insurers, producers and other licensees. The Unit works to ensure that consumers are being treated in a fair and consistent manner by licensees and helps consumers resolve various issues including claims, billing, benefits, underwriting and misrepresentation of policies, premium refunds, and cancellation concerns.

The CSU works closely with the Bureau of Managed Care ("BMC") to review consumer complaints that are pertinent to health carriers' managed care practices. The BMC is responsible according to the provisions of section 3 of M.G.L. c. 176O and 211 CMR 52.18 to investigate any managed care practices that are not compliant with statutory and regulatory standards, including whether health plan benefits may inappropriately differ between covered benefits for behavioral health and non-behavioral health services.

The Division is also charged under section 8K(a)(i) of M.G.L. c. 26 with "evaluating and resolving all consumer complaints alleging a carrier's non-compliance with state or federal laws related to mental health and substance use disorder parity." This includes any "consumer complaints alleging a carrier's non-compliance with a state or federal law related to mental health and substance use disorder parity, including any matters referred to the commissioner by the office of patient protection under subsection (g) of section 14 of chapter 176O."[1]

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1 According to section 8K(f) of M.G.L. c. 26, "The [Commissioner of Insurance] shall evaluate and resolve a consumer complaint alleging a carrier's non-compliance with a state or federal law related to mental health and substance use disorder parity, including any matters referred to the commissioner by the office of patient protection under subsection (g) of section 14 of chapter 176*O*. A consumer complaint may be submitted orally or in writing; provided, however, that an oral complaint shall be followed by a written submission to the commissioner that shall include, but not be limited to, the complainant's name and address, the nature of the complaint and the complainant's signature authorizing the release of any information regarding the complaint to help the commissioner with the review of the complaint; and provided further, that the commissioner shall create a process for a consumer to request the appointment of an authorized representative to act on the consumer's behalf.

The commissioner shall review consumer complaints under this subsection using the legal standards pertaining to quantitative treatment limitations and nonquantitative treatment limitations under applicable state and federal mental health and substance use disorder parity laws, regulations and guidance, including, but not limited to, 45 CFR Part 146.136 and 29 CFR Part 2590.712. When reviewing the complaint, the commissioner shall consider: (i) any related right to a treatment or service under any related state or federal law or regulation; (ii) written documents submitted by the complainant; (iii) medical records and medical opinions by the complainant's treating provider that requested or provided a disputed service, which shall be obtained by the complainant's carrier or by the commissioner if the carrier fails to do so; (iv) the relevant results of any behavioral health parity compliance market conduct examination conducted and completed under clause (ii) of subsection (a); (v) any relevant information included in a carrier's annual reporting requirements under section 8M; (vi) additional information from the involved parties or outside sources that the commissioner deems necessary or relevant; and (vii) information obtained from any informal meeting held by the commissioner with the parties. The commissioner shall send final written disposition of the complaint and the reasons for the commissioner's decision to the complainant and the carrier not more than 90 days after the receipt of the written complaint. If the commissioner determines that a violation of a state or federal mental health and substance use disorder parity law occurred, the commissioner shall exercise its enforcement authority under subsections (b) and (c).

The commissioner shall respond as soon as practicable to all questions or concerns from consumers about carrier compliance with state or federal laws related to mental health and substance use disorder parity that are referred to the commissioner from the office of patient protection under subsection (g) of section 14 of chapter 176*O*."

Process

The Division issued Bulletin 2013-06 and promulgated 211 CMR 154.00 to provide information about submitting complaints regarding alleged non-compliance with state and federal laws for mental health parity. The Bulletin explained how consumers and their representatives could file a complaint or make a call to present information about any alleged complaint. All calls and complaints[2] are made with the Consumer Services Unit so that they may be properly logged for further review. In addition to complaints that may be logged with the Consumer Services Unit, the Division holds monthly meetings with the Office of Patient Protection (OPP) in order to discuss complaints that may have been made with OPP including those made associated with Mental Health Parity concerns.

In order to review all filed Mental Health Parity complaints, the Division created an inter-agency team composed of representatives from the Consumer Services Unit, Bureau of Managed Care, Legal Unit, Health Care Access Bureau and Special Investigations Unit to review all Mental Health Parity complaints filed with the Consumer Services Unit. The inter-agency team meets at least monthly or more frequently when a complaint has been specifically filed as a Mental Health Parity complaint. Since many complaints are filed without being specifically identified as a Mental Health Parity complaint, each complaint made that pertains to behavioral health services are reviewed by the inter-agency team.

Within calendar year 2022, a total of 2,534 complaints were filed with the Division's Consumer Services Unit. A total of 145 (5.7%) of the total were complaints about behavioral health. Of the total filed complaints, only one was specifically associated as a mental health parity complaint.

Mental Health Parity-Addiction Equity	
	2022
Consumer Service Complaints	2,534
Mental Health - Behavioral Health	139
Substance Abuse	6
Mental Health Parity	0
Complaint Resolution	
Resolved in Favor of Consumer	48
Resolved in Favor of Carrier	61
No DOI Jurisdiction *	29

2 Over the past few years, the Division has held discussions with consumer advocates about the complaint forms because the consumer advocates believe that certain disclosure language discourages consumers from filing behavioral health complaints. On its complaint form, the Division discloses that "[t]he complaint file is public record pursuant to Massachusetts law once the complaint file is closed and may be released upon request. The Division of Insurance will maintain the confidentiality of any personally identifiable information and personal health information to the extent required by law." As the Division has noted in discussions with consumer advocates, it does not have the authority under section 10 of M.G.L. c. 66 (the Public Records Law) and 950 CMR 32.00 (Public Records Access) to exclude complaints from disclosure; therefore, the disclosure is appropriate because it makes the complainant aware that other than "personally identified information and personal health information," the complaint may become public under the provisions of Massachusetts Public Records law. The Division and the consumer advocates have not been able to develop alternate language that may address consumer advocates' concerns about the disclosure language that may discourage the filing of behavioral health complaints.

The inter-agency team reviewed the 145 complaints that were not identified as Mental Health Parity complaints and did not find that they were Mental Health Parity complaints. The majority of complaints were associated with reimbursement for provider services or access to out-of-network care.

Of the 145 behavioral health complaints, 48 were resolved in favor of the consumer, 61 were resolved in favor of the insurance carrier. A total of 29 were identified as not under the jurisdiction of the Division because the consumer was covered by an insured health plan issued in another state and subject to the jurisdiction of that other state or was covered under a self-funded employer health benefit plan that is preempted from state regulation under federal ERISA (Employee Retirement Income Security Act) rules. There were not any complaints that were identified as Mental Health Parity complaints in 2022.

6. Educational or Corrective Action Taken

While all of the responding carriers indicated that no corrective actions were required based on internal assessments that each carrier was in compliance with federal and state Mental Health Parity laws, the Division is looking to take a number of steps to monitor compliance going forward, as described in the next section of this report.

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NEXT STEPS

Annually, the Division performs a review of 21 carriers' evidences of coverage, schedules of benefit and related information for the individual, small group and large group markets to verify that carriers are including quantitative treatment limitations that are no more restrictive for mental health/substance use services than for medical/surgical services. Additionally, the Division collects a large number of documents as part of a bi-annual managed care accreditation process for these 21 carriers. The Division intends to expand on this bi-annual review process by delving further into these documents with a particular focus on verifying compliance with MHPAEA and state Mental Health Parity laws.

As part of this process, the Division aims to compare carriers' utilization review policies and procedures; carriers' processes to establish guidelines for Medical Necessity; and perform a review of the Carrier's network adequacy standards. One additional component of the review process going forward will focus on differences among carriers who perform mental health/substance use utilization review in-house compared to carriers who delegate those functions to an external entity.

The Division currently holds regular internal meetings to discuss consumer complaints related to possible Mental Health Parity violations. The Division intends to continue to hold these regular meetings and further plans to have training sessions with staff from the Divisions Consumer Services Unit to help staff identify potential Mental Health Parity trends and concerns.

The Division created a new process for the review of Mental Health Parity compliance as a result of the creation of M.G.L. c. 26, section 8M. Because this first year created new requirements for the carriers, the Division intends to update the instructions filing guidance and the file submission process to further clarify submission requirements and to streamline the review process going forward.

While for this report we reviewed only those materials that were required as part of the new statute. However, for future reports we may look at previously filed information from the carriers to help identify areas where improvements may be suggested.

APPENDIX A

LIST OF RESPONDING CARRIERS

4 Ever Life Insurance Company
Aetna Health, Inc. (a Pennsylvania Corporation)
Aetna Health Insurance Company
Aetna Life Insurance Company
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.
Blue Cross and Blue Shield of Massachusetts, Inc.
Boston Medical Center Health Plan, Inc. (d/b/a WellSense Health Plan)
Cigna Health and Life Insurance Company
ConnectiCare of Massachusetts, Inc.
Fallon Community Health Plan, Inc.
Harvard Pilgrim Health Care, Inc.
Health New England, Inc.
HPHC Insurance Company, Inc.
Mass General Brigham Health Insurance Company
Mass General Brigham Health Plan, Inc.
Tufts Associated Health Maintenance Organization, Inc.
Tufts Health Public Plans, Inc.
Tufts Insurance Company
United States Fire Insurance Company
UnitedHealthcare Insurance Company
Wellfleet Insurance Company

APPENDIX B

Filing Guidance 2023-E – Annual Mental Health Parity Compliance Certifications

I. GENERAL INSTRUCTIONS

Health Insurance Carriers (Carriers) are required to submit the information and documentation contained within this Filing Guidance via an Informational Filing within the System for Electronic Rate and Form Filings (SERFF). The SERFF submission is due **no later than July 1, 2023** and covers the reporting period of January 1, 2022 through December 31, 2022. No filing fee is required for the SERFF submission. The submission will be submitted within the "Supporting Documentations" tab within SERFF. Within this tab, carriers are asked to create separate entries for each of the different documents/templates described below.

A checklist will be distributed for carriers to use to ensure that all materials have been included and submitted in their SERFF filing. This checklist can be submitted in the Checklist entry within the Supporting Documentation tab.

Carriers are required to submit a Certification of Compliance, to be signed by the carrier's Chief Executive Officer and Chief Medical Officer. ***Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes this certification.***

Please note that for the following Section II items, it is NOT necessary to create separate entries for EACH separate NQTL category.

II. M.G.L. CHAPTER 26, SECTION 8M

Chapter 177 of the Acts of 2020 creates a new law - M.G.L. c. 26, section 8M. This section 8M requires carriers to submit to the Division the following information:

(i) the specific plan or coverage terms or other relevant terms regarding the nonquantitative treatment limitations and a description of all mental health and substance use disorder benefits and medical and surgical benefits to which each term applies in each respective benefits classification; provided, however, that the nonquantitative treatment limitations shall include the processes, strategies, evidentiary standards or other factors used to develop and apply the carrier's reimbursement rates for mental health and substance use disorder benefits and medical and surgical benefits in each respective benefits classification;

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

(ii) the factors used to determine that the nonquantitative treatment limitations will apply to mental health and substance use disorder benefits and medical and surgical benefits;

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

(iii) the evidentiary standards used for the factors identified in clause (ii), when applicable, and any other source or evidence relied upon to design and apply the nonquantitative treatment limitations to mental health and substance use disorder benefits and medical and surgical benefits; provided, however, that every factor shall be defined;

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

(iv) a comparative analysis demonstrating that the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to mental health and substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards and other factors used to apply the nonquantitative treatment limitations to medical and surgical benefits in the benefits classification;

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

Please note that the above comparative analysis is required for the following nonquantitative treatment limitation categories:

Prior authorization, concurrent review, retrospective review, step-therapy, network admission standards, reimbursement rates and geographic restrictions

(v) the specific findings and conclusions reached by the carrier with respect to health insurance coverage, including any results of the analysis described in clause (iv) that indicate whether the carrier is in compliance with this section and the federal Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, as amended, and any federal guidance or regulations relevant to the act, including, but not limited to, 45 CFR Part 146.136, 45 CFR Part 147.160 and 45 CFR Part 156.115(a)(3);

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

(vi) the number of requests for parity documents received under 29 CFR 2590.712(d)(3) or 45 CFR 146.136(d)(3) and the number of any such requests for which the plan refused, declined or was unable to provide documents;

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

(vii) the additional information, if any, that a carrier is required to provide under 42 U.S.C. 300gg-26(a)(8)(B)(ii);

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

(viii) any other data or information the commissioner deems necessary to assess a carrier's compliance with mental health parity requirements.

For this section (viii), please submit the information as follows: M.G.L. c. 26, Section 8M requires certain data to be collected on an annual basis. The Division will work with carriers to ensure that carriers' IT systems will be able to produce the information starting with Calendar Year 2023, due July 1, 2024. For CY 2022, please submit data as follows:

1. Please use the Excel Template [MHP_Request Data_Template_07012022] to complete the data for calendar year 2022.

2. Please ensure that:

a. The reported information is only for requests for services for fully insured members.
b. The reported information is only for requests for services for persons covered under insured health plans that were issued or renewed within Massachusetts.
c. The reported information does not include requests for prescription medications.

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

III. *RESPONSES TO CHAPTER 110 OF THE ACTS OF 2017*

Chapter 110 of the Acts of 2017 requires that Carriers certify whether their coverage includes the following mental health home-based and community-based services for a child. Each Carrier must include a certification using the Excel template ***[MHP Template 2022_Chapter 110].***

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

(i) Intensive care coordination for a child with a serious emotional disturbance;[3] service that facilitates care planning and coordination that provides a single point of accountability for assessment, and developing and implementing a plan of care ensuring that medically necessary services are accessed, coordinated, and delivered in a strength-based, individualized, family/youth-driven, and ethnically, culturally, and linguistically relevant manner, and includes, but is not limited to, the following services[4]:

- Comprehensive home-based assessment
- Care Planning Team (CPT) meetings
- Individual Care Plans (ICP)
- Risk management/safety plan(s)
- Care coordination, including:
    - Links and referrals for supports and services
    - Assistance with systems navigation
    - Collateral contacts (phone and face-to-face)
    - Direct time with providers (e.g., attendance at IEP, hospital discharge, and other meetings)
    - Aftercare planning
- Education, advocacy and support to youth and parent(s)/caregiver(s)
- Individualized and family-driven interventions and/or supports for the youth and parent/caregiver
- Regular contact with youth and parent/caregiver
- Telephone support for youth and parent/caregiver
- 24/7 crisis monitoring and assistance in accessing ESP/MCI services
- Member transportation provided by staff
- Member outreach (up to 30 minutes)
- Documentation (time spent completing required paperwork as outlined in the Performance Specifications)

Please certify whether your organization covers these services. If your organization does not cover these services as described above, please identify what services are covered and what is not covered.

(ii) Mobile crisis intervention;

1 For further reference, please see Massachusetts Behavioral Health Partnership at: https://www.mass.gov/files/documents/2016/07/nh/ps-tcm-icc-ps.pdf

2 For further reference, please see Massachusetts Behavioral Health Partnership at: https://www.masspartnership.com/pdf/TCM-ICC%20service%20definition12-23-08.pdf

"Mobile crisis intervention", a short-term, mobile, on-site, face-to-face therapeutic response service that is available 24 hours a day, 7 days a week to a child experiencing a behavioral health crisis to identify, assess, treat and stabilize a situation and reduce the immediate risk of danger to the child or others; provided, however, that the intervention shall be consistent with the child's risk management or safety plan, if any.

Please certify whether your organization covers this service. If your organization does not cover this service as defined, please identify what services are covered and what is not covered.

(iii) Family support and training;

"Family support and training", a service provided to a parent or other caregiver of a child to improve the capacity of the parent or caregiver to ameliorate or resolve the child's emotional or behavioral needs and to parent; provided, however, that such service shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home or another community setting.

Please certify whether your organization covers this service. If your organization does not cover this service as defined, please identify what services are covered and what is not covered.

(iv) In-home therapy;

"In-home therapy", therapeutic clinical intervention or ongoing training and therapeutic support; provided however, that the intervention or support shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home or another community setting.

Please certify whether your organization covers this service. If your organization does not cover this service as defined, please identify what services are covered and what is not covered.

(v) Therapeutic mentoring services; and

"Therapeutic mentoring services", services provided to a child designed to support age-appropriate social functioning or to ameliorate deficits in the child's age-appropriate social functioning; provided, however, that such services may include supporting, coaching and training the child in age-appropriate behaviors, interpersonal communication, problem solving, conflict resolution and relating appropriately to other children and adolescents and to adults in recreational and social activities; and provided further, that such services shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home or another community setting.

Please certify whether your organization covers this service. If your organization does not cover this service as defined, please identify what services are covered and what is not covered.

(vi) In-home behavioral services.

"In-home behavioral services", a combination of behavior management therapy and behavior management monitoring; provided, however, that such services shall be provided where the child resides, including in the child's home, a foster home, a therapeutic foster home or another community setting.

Please certify whether your organization covers this service. If your organization does not cover this service as defined, please identify what services are covered and what is not covered.

In addition, please note that the following terms are also defined in Section 23 of Chapter 110 of the Acts of 2017 and are restated below.

"Child", a person under the age of 21.

"Behavior management monitoring", monitoring of a child's behavior, the implementation of a behavior plan and reinforcing implementation of a behavior plan by the child's parent or other caregiver.

"Behavior management therapy", therapy that addresses challenging behaviors that interfere with a child's successful functioning; provided, however, that "behavior management therapy" shall include assessment, development of a behavior plan and supervision and coordination of interventions to address specific behavioral objectives or performance, including the development of a crisis-response strategy; and provided further, that "behavior management therapy" may include short-term counseling and assistance.

"Ongoing therapeutic training and support", services that support implementation of a treatment plan pursuant to therapeutic clinical intervention that shall include, but not be limited to, teaching the child to understand, direct, interpret, manage and control feelings and emotional responses to situations and assisting the family in supporting the child and addressing the child's emotional and mental health needs.

"Therapeutic clinical intervention", intervention that shall include: (i) a structured and consistent therapeutic relationship between a licensed clinician and a child and the child's family to treat the child's mental health needs, including improvement of the family's ability to provide effective support for the child and promotion of healthy functioning of the child within the family; (ii) the development of a treatment plan; and (iii) using established psychotherapeutic techniques, working with the family or a subset of the family to enhance problem solving, limit setting, communication, emotional support or other family or individual functions.

IV. FEDERAL SELF-COMPLIANCE TOOL FOR THE MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

Please review the Federal Self-Compliance Tool for the Mental Health Parity and Addiction Equity Act (MHPAEA). All carriers are required to respond to each of the 8 listed questions using the Federal Self-Compliance Tool document. In doing so, carriers are required to follow each of the analyses indicated for each question. Carriers will be required to certify that all analyses in the tool were used in determining the answer to each question.

Please create a separate entry within the Supporting Documentation tab of your SERFF filing that includes the information requested above.

Please note that any documents that are referenced within this Filing Guidance Notice as needing to be completed and/or filled out will be distributed separately to each carrier.

If you have any questions, please contact Niels Puetthoff at niels.puetthoff@mass.gov.

APPENDIX C
Review of Plan Benefits

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical Inpatient	**Medical Outpatient**	**Mental Health Inpatient**	**Mental Health Outpatient**
4 Ever Life Insurance Company	Inpatient Care: • Acute Inpatient • Subacute Inpatient (i.e., skilled nursing care) • Inpatient Hospital Physician Consultation • Inpatient Professional Services • Inpatient Hospice Maternity Care	Office visits: • Preventive Wellness Exams • Outpatient PCP Office Visits • Outpatient Specialist Office Visits • Telehealth/ Telemedicine Services Med/Surg All Other Outpatient Services Include: • Outpatient Facility • Outpatient Surgery • Outpatient Professional Services • Outpatient non-office preventive services/ screenings (i.e., mammograms, colonoscopies, etc.) • Radiology • Advanced Radiology (i.e., MRI, CY, PET) • Home Health Care • Outpatient Hospice • Speech Therapy Ambulatory Care Emergency Care Rehabilitative and Habilitative Care Maternity Care Pharmacy	Inpatient Care: • Acute Inpatient • Subacute Inpatient (i.e., skilled nursing care) • Inpatient Hospital Physician Consultation • Inpatient Professional Services	Office visits: • Individual, family and group psychotherapy • Medication Management Services • Telepsychiatry Services MH/SUD All Other Outpatient Services Include: • Partial Hospitalization • Intensive Outpatient Programs • Applied Behavioral Analysis • Repetitive Transcranial Magnetic Stimulation • Ambulatory Detoxification • Outpatient Electroconvulsive Therapy (ECT) • Psychological Testing • Ambulance Ambulatory Care Emergency Care Rehabilitative and Habilitative Care Pharmacy
Aetna Health Inc. (PA)	-Medical Inpatient Confinements (surgical and non-surgical stays) -Inpatient Maternity stays -Skilled nursing facility (SNF) stays -Hospice care, inpatient -Inpatient Female Sterilization	-PCP office visits -Specialist office visits -Condition specific specialty care -Pre-natal maternity -Walk-in clinics -Routine adult physical exams/immunizations	-Psychiatric inpatient admissions -Substance use disorder (SUD) -inpatient admissions -Psychiatric Residential Treatment Center (RTC) –	-MH/SUD office visits to MH/SUD practitioner -Routine psychiatric office visits -Telemedicine -Urgent care

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical Inpatient	**Medical Outpatient**	**Mental Health Inpatient**	**Mental Health Outpatient**
		-Routine well child exams/immunizations -Routine gynecological care exams -Women's health -Routine eye exams -Routine hearing exams -Routine hearing screening -Telemedicine (where available) -Urgent care -Lab – Physician Office -X-Ray – Physician Office -Complex Imaging – Physician Office -Office Based Surgery -Infusion Therapy – Home/Physician Office -Acupuncture	SUD Residential Treatment Center (RTC)	
Aetna Health Insurance Company	-Medical Inpatient Confinements (surgical and non-surgical stays) -Inpatient Maternity stays -Skilled nursing facility (SNF) stays -Hospice care, inpatient -Inpatient Female Sterilization	-PCP office visits -Specialist office visits -Condition specific specialty care -Pre-natal maternity -Walk-in clinics -Routine adult physical exams/immunizations -Routine well child exams/immunizations -Routine gynecological care exams -Women's health -Routine eye exams -Routine hearing exams	-Psychiatric inpatient admissions -Substance use disorder (SUD) -inpatient admissions -Psychiatric Residential Treatment Center (RTC) – SUD Residential Treatment Center (RTC)	-MH/SUD office visits to MH/SUD practitioner -Routine psychiatric office visits -Telemedicine -Urgent care

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical Inpatient	**Medical Outpatient**	**Mental Health Inpatient**	**Mental Health Outpatient**
		-Routine hearing screening -Telemedicine (where available) -Urgent care -Lab – Physician Office -X-Ray – Physician Office -Complex Imaging – Physician Office -Office Based Surgery -Infusion Therapy – Home/Physician Office -Acupuncture		
Aetna Life Insurance Company	-Medical Inpatient Confinements (surgical and non-surgical stays) -Inpatient Maternity stays -Skilled nursing facility (SNF) stays -Hospice care, inpatient -Inpatient Female Sterilization	-PCP office visits -Specialist office visits -Condition specific specialty care -Pre-natal maternity -Walk-in clinics -Routine adult physical exams/immunizations -Routine well child exams/immunizations -Routine gynecological care exams -Women's health -Routine eye exams -Routine hearing exams -Routine hearing screening -Telemedicine (where available) -Urgent care -Lab – Physician Office	-Psychiatric inpatient admissions -Substance use disorder (SUD) -inpatient admissions -Psychiatric Residential Treatment Center (RTC) – SUD Residential Treatment Center (RTC)	-MH/SUD office visits to MH/SUD practitioner -Routine psychiatric office visits -Telemedicine -Urgent care

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical Inpatient	**Medical Outpatient**	**Mental Health Inpatient**	**Mental Health Outpatient**
		-X-Ray – Physician Office -Complex Imaging – Physician Office -Office Based Surgery -Infusion Therapy – Home/Physician Office -Acupuncture		
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	Emergent Inpatient-Notification only • Non-Emergent Inpatient Hospital services • Long Term Acute Care (LTAC) services • Rehabilitation Facility Services • Skilled Nursing Facility (SNF) services • Ambulance Services • Gene Therapy/Orphan Drugs • Inpatient Surgeries • Organ Transplants	Ambulance Services • Assisted Reproductive Technologies (IVF) • Chiropractic Therapy • Gene Therapy/Orphan Drugs • Genetic Testing • Neuropsychological testing • Outpatient non-surgical Procedures • Outpatient Surgical Procedures • Short term rehabilitation (STR) Home Health Services/Occupational Therapy/Physical Therapy • Radiation Therapy • Radiology Imaging • Sleep Management • Urine Drug Testing (UDT)	Emergent Inpatient-notification only • Non-Emergent Inpatient Hospital Services • Crisis Stabilization Bed (CSB) • Residential Treatment Center Services (RTC/ART) • Zulresso Infusions	• Applied Behavior Analysis • Genetic Testing • Intensive Community-Based Treatment (ICBT)-Children & Adolescent • Intermediate levels of care (ILOC) – Partial Hospital Program (PHP)/Intensive Outpatient Program (IOP)/Family Stabilization Team (FST) • Ketamine/ Esketamine • Psychological Testing • Transcranial Magnetic Stimulation (TMS) • Urine Drug Testing (UDT)
Blue Cross and Blue Shield of Massachusetts, Inc.	Emergent Inpatient-Notification only • Non-Emergent Inpatient Hospital services • Long Term Acute Care (LTAC) services	Ambulance Services • Assisted Reproductive Technologies (IVF) • Chiropractic Therapy • Gene Therapy/Orphan Drugs	Emergent Inpatient-notification only • Non-Emergent Inpatient Hospital Services • Crisis Stabilization Bed (CSB)	• Applied Behavior Analysis • Genetic Testing • Intensive Community-Based Treatment (ICBT)-Children & Adolescent

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical Inpatient	**Medical Outpatient**	**Mental Health Inpatient**	**Mental Health Outpatient**
	• Rehabilitation Facility Services • Skilled Nursing Facility (SNF) services • Ambulance Services • Gene Therapy/Orphan Drugs • Inpatient Surgeries • Organ Transplants	• Genetic Testing • Neuropsychological testing • Outpatient non-surgical Procedures • Outpatient Surgical Procedures • Short term rehabilitation (STR) Home Health Services/Occupational Therapy/Physical Therapy • Radiation Therapy • Radiology Imaging • Sleep Management • Urine Drug Testing (UDT)	• Residential Treatment Center Services (RTC/ART) • Zulresso Infusions	• Intermediate levels of care (ILOC) – Partial Hospital Program (PHP)/Intensive Outpatient Program (IOP)/Family Stabilization Team (FST) • Ketamine/ Esketamine • Psychological Testing • Transcranial Magnetic Stimulation (TMS) • Urine Drug Testing (UDT)
Boston Medical Center HealthNet Plan, d/b/a WellSense Health Plan	The Plan requires prior authorization for elective admissions to acute care, post-acute care, or custodial level of care.	Prior Authorization is performed for the following: • All home health care services • Outpatient rehabilitation services (PT, OT, ST) • Select outpatient procedures • Select outpatient services • Durable Medical Equipment • High Tech Radiology (non-emergent outpatient, excluding those associated with observation or emergency department visits) • Most genetic testing	Prior authorization applies to: Community Based Acute Treatment (CBAT)/Intensive Community Based Acute Treatment (ICBAT), Inpatient Mental Health, Inpatient ECT. After 11/8/22 Prior authorization no longer required for these inpatient services but subject to Concurrent review after 72 hours of admission.	Prior Authorization applies to the following Behavioral Health outpatient services/benefits: ABA, TMS, CBHI services

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical Inpatient	**Medical Outpatient**	**Mental Health Inpatient**	**Mental Health Outpatient**
Cigna Health and Life Insurance Company	Acute Inpatient Services; Subacute Inpatient Services, i.e. Skilled Nursing Care, physical rehabilitation hospitals, etc.; Inpatient Professional Services.	Advanced imaging services (e.g., CT scans, PET scans, MRIs, diagnostic cardiology) Certain outpatient surgical procedures Certain cardiology procedures Clinical trials Procedures that may be considered cosmetic in nature Durable Medical Equipment (DME) Experimental / Investigational / Unproven (EIU) Procedures Genetic testing Home Health Care (HHC) / home infusion therapy Hormone Implant Hyperbaric Oxygen Therapy Infertility services Infused / injectable medications Medical oncology Musculoskeletal services (major joint surgery and pain management services) Negative Pressure Wound Therapy Confidential Outpatient Therapy Services (Outpatient Acute Rehabilitation, Cardiac Rehabilitation, Cognitive Rehabilitation, Speech Therapy, Hearing Therapy, Occupational Therapy, Physical Therapy, Chiropractic, Acupuncture) Outpatient radiation therapy services Sleep testing Speech Therapy Therapeutic apheresis (aka Extracorporeal photopheresis (ECP) External Counterpulsation Unlisted procedures or services (note: the phrase “unlisted procedure or service” refers to an instance where a procedure or service is	Mental Health Acute Inpatient Services; Mental Health Subacute Residential Treatment; Mental Health Inpatient Professional Services; SUD Acute Inpatient Services; SUD Acute Inpatient Detoxification; SUD Subacute Residential Treatment; SUD Inpatient Professional Services.	Partial Hospitalization Applied Behavior Analysis (ABA) Transcranial Magnetic Stimulation

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical Inpatient	**Medical Outpatient**	**Mental Health Inpatient**	**Mental Health Outpatient**
		billed as "unlisted," meaning that no existing CPT code exists for the procedure or service)		
ConnectiCare of Massachusetts, Inc.	• All POS 21 acute care hospital facility admissions • Skilled nursing facility care (SNF) • Acute inpatient rehabilitation facility (IRF) • Long term acute care hospitalizations (LTAC)	• Radiology delegated to NIA • Cardiology • Muscular skeletal surgery and interventional pain management delegated to NIA	• MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment	• Partial Hospitalization (PHP)/Day Treatment • Intensive Outpatient (IOP)
Fallon Community Health Plan, Inc.	• Acute Inpatient Hospital • Elective Procedures • Chronic or Rehabilitation Inpatient Hospital Services • Hospice (24 hour) • Skilled Nursing Facility	• Acupuncture (administered w/o PA up to certain visit number-Medicaid) • Ambulatory Surgery/Outpatient Hospital Care • Breast Pumps (hospital-grade) • Dialysis • DME (< $300 does not require PA) • EPSDT • Early Intervention • Genetic Testing • Hearing Aids 6 • Home Health Services • Hospice (less than 24 hour) • Infertility o Not a covered benefit for Medicaid • Laboratory (out-of-network only) • Medical Nutritional Therapy • Orthotics • Oxygen and Respiratory Therapy Equipment • Physician – does not require PA except for out-of-network services o Note: a visit to a physician for diagnosis and planning purposes are not subject to PA. However, procedures on this list performed by physicians are subject to PA. • Podiatry • Prosthetic Services and Devices • Radiology and	• Acute Inpatient Hospital • Elective Procedures • Chronic or Rehabilitation Inpatient Hospital Services • Hospice (24 hour) • Skilled Nursing Facility Prior Authorization not required for inpatient services after 11/8/2022	• Partial Hospitalization Program (Based on performance metrics, some Partial Hospital Programs have the ability to submit a notification of admission without clinical review on web-based portal) • Applied Behavioral Analysis • Psychological and Neuropsychological Testing • Transcranial Magnetic Stimulation • Family Support & Training • Intensive Care Coordination (Commercial Only) • In-Home Behavioral Services • Therapeutic Mentor (Commercial Only) • Family Stabilization Team/In-Home Therapy (Commercial Only)

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical Inpatient	**Medical Outpatient**	**Mental Health Inpatient**	**Mental Health Outpatient**
		Diagnostic Tests • Therapy (PT/OT/ST) • Tobacco Cessation Services • Non-emergency Transportation • Vision Care (medical) • Vision (non-medical) • Wigs		
Harvard Pilgrim Health Care, Inc.	Select non-emergent hospital inpatient admissions • Admissions to Skilled Nursing Facilities ("SNF") • Inpatient rehabilitation admissions	Infusion and injectable medications • High end radiology • Speech therapy • Physical therapy and occupational therapy if services are expected to exceed the member's benefit limit • Molecular testing • Durable medical equipment (DME) • Sleep testing • Outpatient day surgery • Home health services (e.g., skilled nursing, physical therapy) • Interventional pain management for back pain • In vitro fertilization (IVF) • Hospice services	Non-emergent inpatient MH/SUD admissions • MH/SUD residential treatment	Electroconvulsive therapy (ECT) • Partial hospital programs • Intensive outpatient programs • Psychological testing • Transcranial Magnetic Stimulation (rTMS) Applied Behavioral Analysis (ABA)
Health New England, Inc.	Acute inpatient, skilled nursing facilities and inpatient rehabilitation facilities	Number of outpatient medical/surgical services	Residential Treatment Centers	Applied Behavioral Analysis (ABA), Repetitive Transcranial Magnetic Services (rTMS), Partial Hospitalization, psychiatric and neuro-psychiatric testing, mental health day treatment and Family Stabilization Treatment.
HPHC Insurance Company, Inc.	Select non-emergent hospital inpatient admissions • Admissions to Skilled Nursing Facilities ("SNF") • Inpatient rehabilitation admissions	Infusion and injectable medications • High end radiology • Speech therapy • Physical therapy and occupational therapy if services are expected to exceed the member's benefit limit • Molecular testing • Durable medical equipment (DME) • Sleep testing • Outpatient day surgery •	Non-emergent inpatient MH/SUD admissions • MH/SUD residential treatment	Electroconvulsive therapy (ECT) • Partial hospital programs • Intensive outpatient programs • Psychological testing • Transcranial Magnetic Stimulation (rTMS) Applied Behavioral Analysis (ABA)

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical Inpatient	**Medical Outpatient**	**Mental Health Inpatient**	**Mental Health Outpatient**
		Home health services (e.g., skilled nursing, physical therapy) • Interventional pain management for back pain • In vitro fertilization (IVF) • Hospice services		
Mass General Brigham Health Insurance Company	• Acute inpatient hospital (elective admission) • Inpatient Rehabilitation • Long Term Acute Care • Skilled Nursing Facilities	• Assisted Reproductive Services/Infertility Services • Subset of ambulatory surgical day procedures • Subset of DME items • Subset of genetic testing • Bariatric surgery • Bone Growth Stimulation (ultrasound, noninvasive and invasive electric bone growth Stimulation) • Breast surgeries (Subset of procedures) • Cardiac imaging • Cardiac Outpatient Mobile Telemetry • Cochlear Implants and Hearing Aids • Cosmetic and Reconstructive procedures • Early Intensive Behavioral Intervention (EIBI) (Autism Specialty Services) • Enteral, Parenteral and Nutritional Formulas • Gender Affirming Procedures • HIV associated lipodystrophy syndrome • Hyperbaric Oxygen Chamber Treatment • Implantable Neuro-Electrodes • Home and outpatient infusion • Lens, Therapeutic • High tech radiology imaging • Medical Specialty Medications (a subset) • Neuropsychological Testing • Non-emergency medically necessary transportation • Orthotics & Prosthetics • Pain Management Therapy • Phototherapy and	• Acute Inpatient Hospitalization: In Massachusetts prior authorization is not required for emergent admissions, but providers are required to notify OHBS of the member's admission within 72 hours or the next business day. • MH Subacute Residential Treatment (a.k.a CBAT and ICBAT): facility must notify OHBS of admission and initial treatment plan within 72 hours of admission. • Acute Residential Treatment (ART) for adults.	• Partial Hospitalization Program (PHP) • Day Treatment • Intensive Outpatient Program (IOP) • Transcranial Magnetic Stimulation (TMS) • Applied Behavior Analysis (ABA) • Psychological Testing over 5 hours • Outpatient Electroconvulsive-Therapy (ECT) • Specialing

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical Inpatient	**Medical Outpatient**	**Mental Health Inpatient**	**Mental Health Outpatient**
		Photochemotherapy for Dermatologic Conditions • Sleep studies /sleep DME • Transplant evals/ transplant		
Mass General Brigham Health Plan, Inc.	• Acute inpatient hospital (elective admission) • Inpatient Rehabilitation • Long Term Acute Care • Skilled Nursing Facilities	• Assisted Reproductive Services/Infertility Services • Subset of ambulatory surgical day procedures • Subset of DME items • Subset of genetic testing • Bariatric surgery • Bone Growth Stimulation (ultrasound, noninvasive and invasive electric bone growth Stimulation) • Breast surgeries (Subset of procedures) • Cardiac imaging • Cardiac Outpatient Mobile Telemetry • Cochlear Implants and Hearing Aids • Cosmetic and Reconstructive procedures • Early Intensive Behavioral Intervention (EIBI) (Autism Specialty Services) • Enteral, Parenteral and Nutritional Formulas • Gender Affirming Procedures • HIV associated lipodystrophy syndrome • Hyperbaric Oxygen Chamber Treatment • Implantable Neuro-Electrodes • Home and outpatient infusion • Lens, Therapeutic • High tech radiology imaging • Medical Specialty Medications (a subset) • Neuropsychological Testing • Non-emergency medically necessary transportation • Orthotics & Prosthetics • Pain Management Therapy • Phototherapy and Photochemotherapy for Dermatologic Conditions • Sleep studies /sleep	• Acute Inpatient Hospitalization: In Massachusetts prior authorization is not required for emergent admissions, but providers are required to notify OHBS of the member's admission within 72 hours or the next business day. • MH Subacute Residential Treatment (a.k.a CBAT and ICBAT): facility must notify OHBS of admission and initial treatment plan within 72 hours of admission. • Acute Residential Treatment (ART) for adults.	• Partial Hospitalization Program (PHP) • Day Treatment • Intensive Outpatient Program (IOP) • Transcranial Magnetic Stimulation (TMS) • Applied Behavior Analysis (ABA) • Psychological Testing over 5 hours • Outpatient Electroconvulsive-Therapy (ECT) • Specialing

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical Inpatient	**Medical Outpatient**	**Mental Health Inpatient**	**Mental Health Outpatient**
		DME • Transplant evals/ transplant		
Tufts Associated Health Maintenance Organization, Inc.	• Acute inpatient hospital admissions • Sub-acute skilled nursing facility (SNF) admissions • Acute inpatient rehabilitation admissions	• High tech imaging • Home health care • Hospice services • Hyperbaric Oxygen Therapy • Osteogenesis stimulators, non-invasive • Proton beam therapy • Elective surgery • IVF/infertility services • Devices for the management of diabetes (e.g., Continuous Glucose Monitor and Artificial Pancreas) • Sleep studies • Upper GI endoscopy • Selective diagnostic procedures including mobile cardiac outpatient telemetry, video capsule endoscopy, and upper endoscopy • Genetic testing • Gene therapy • Dental procedures • Hematopoietic Stem-Cell Transplantation (HSCT) • Oral formula • Physical therapy/occupational therapy/speech therapy	Prior Authorization is not required for inpatient mental health/substance use services. Concurrent review is applied for: • Inpatient BH hospital admissions • Admissions to BH residential treatment • Crisis stabilization	•Psychological/Neuropsychological testing • Transcranial Magnetic Stimulation (rTMS) • Applied Behavioral Analysis (ABA) skilled services • In-Home Behavioral Services (IHBS) • In-Home Therapy Services (IHT)
Tufts Health Public Plans, Inc.	• Acute inpatient hospital admissions • Sub-acute skilled nursing facility (SNF) admissions • Acute inpatient rehabilitation admissions	• High tech imaging • Home health care • Hospice services • Hyperbaric Oxygen Therapy • Osteogenesis stimulators, non-invasive • Proton beam therapy • Elective surgery • IVF/infertility services • Devices for the management of diabetes (e.g., Continuous Glucose Monitor and Artificial Pancreas) • Sleep studies • Upper GI endoscopy • Selective diagnostic procedures including mobile cardiac outpatient telemetry, video capsule endoscopy, and upper endoscopy • Genetic testing • Gene therapy • Dental	Prior Authorization is not required for inpatient mental health/substance use services. Concurrent review is applied for: • Inpatient BH hospital admissions • Admissions to BH residential treatment • Crisis stabilization	•Psychological/Neuropsychological testing • Transcranial Magnetic Stimulation (rTMS) • Applied Behavioral Analysis (ABA) skilled services • In-Home Behavioral Services (IHBS) • In-Home Therapy Services (IHT)

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical Inpatient	**Medical Outpatient**	**Mental Health Inpatient**	**Mental Health Outpatient**
		procedures • Hematopoietic Stem-Cell Transplantation (HSCT) • Oral formula • Physical therapy/occupational therapy/speech therapy		
Tufts Insurance Company	• Acute inpatient hospital admissions • Sub-acute skilled nursing facility (SNF) admissions • Acute inpatient rehabilitation admissions	• High tech imaging • Home health care • Hospice services • Hyperbaric Oxygen Therapy • Osteogenesis stimulators, non-invasive • Proton beam therapy • Elective surgery • IVF/infertility services • Devices for the management of diabetes (e.g., Continuous Glucose Monitor and Artificial Pancreas) • Sleep studies • Upper GI endoscopy • Selective diagnostic procedures including mobile cardiac outpatient telemetry, video capsule endoscopy, and upper endoscopy • Genetic testing • Gene therapy • Dental procedures • Hematopoietic Stem-Cell Transplantation (HSCT) • Oral formula • Physical therapy/occupational therapy/speech therapy	Prior Authorization is not required for inpatient mental health/substance use services. Concurrent review is applied for: • Inpatient BH hospital admissions • Admissions to BH residential treatment • Crisis stabilization	•Psychological/Neuropsychological testing • Transcranial Magnetic Stimulation (rTMS) • Applied Behavioral Analysis (ABA) skilled services • In-Home Behavioral Services (IHBS) • In-Home Therapy Services (IHT)
UnitedHealthcare Insurance Company	• Arthroplasty • Bariatric Surgery • Breast Reconstruction (non-mastectomy) • Cardiology • Cerebral Seizure Monitoring – Inpatient Video EEG • Chemotherapy Services • Clinical Trials • Congenital Heart Disease • Cosmetic and Reconstructive Procedures • End-stage renal disease (ESRD) dialysis services	• Arthroplasty • Arthroscopy • Bariatric • Bone Growth Stimulator • Breast Reconstruction (non-mastectomy) • *Cancer supportive care • *Cardiology • Cardiovascular • Cartilage Implants • *Chemotherapy Services • Clinical Trials • Cochlear Implants and Other Auditory Implants • Congenital Heart Disease	• MH Non-Emergent Acute Inpatient • MH Subacute Residential Treatment • SUD Acute Inpatient Detoxification • SUD Acute Inpatient Rehabilitation • SUD Subacute Residential Treatment	• *Partial Hospitalization (PHP)/Day Treatment • *Intensive Outpatient (IOP) • Electroconvulsive Therapy (ECT) • Psychological Testing • Applied Behavior Analysis (ABA) • Transcranial Magnetic Stimulation (TMS)

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical Inpatient	**Medical Outpatient**	**Mental Health Inpatient**	**Mental Health Outpatient**
	• Foot Surgery • Gender Dysphoria Treatment • Hysterectomy • Inpatient admissions – post-acute services • Orthognathic Surgery • Sleep Apnea Procedures and Surgeries • Spinal Surgery • Transplant • Ventricular Assist Devices	• *Continuous Glucose Monitoring • Cosmetic and reconstructive procedures • *Durable Medical Equipment (DME) over $1,000 • *End-stage renal disease (ESRD) dialysis services • Foot Surgery • Functional Endoscopic Sinus Surgery (FESS) • Gender Dysphoria Treatment • Genetic and molecular testing to include BRCA gene testing • *Home Health Care – Non-nutritional • Hysterectomy (abdominal and laparoscopic surgeries) • Infertility • *Injectable Medications • MR-guided focused ultrasound (MRgFUS) to treat uterine fibroid • Non-Emergency Air Transport • Orthognathic Surgery • Orthotics over $1,000 • *Pain Management and Injection • Physical Therapy/Occupational Therapy • Potentially unproven services (including experimental/investigational and/or linked services) • Prostate Procedures • Prosthetics over $1,000 • *Radiation Therapy • Radiology • Rhinoplasty • Sinuplasty • Site of Service – Office-based program • Site of Service – Outpatient hospital		

Summary of Responses - M.G.L. c. 26, s. 8M(a)(i)				
Carrier	**Coverage Terms/Benefit Categories**			
	Medical Inpatient	**Medical Outpatient**	**Mental Health Inpatient**	**Mental Health Outpatient**
		• Site of Service – Outpatient hospital expansion • Sleep Apnea Procedures & Surgeries • Sleep Studies • Spinal Cord Stimulators • Spinal Surgery • Stimulators – not related to spine • *Therapeutic Radiopharmaceuticals • Transplant • Vein Procedures		
United States Fire Insurance Company	• Acute Inpatient Services • Subacute Inpatient Services, i.e., Skilled Nursing Care, Physical Rehabilitation Hospitals, etc. • Inpatient Professional Services	• Physician Visit • Consultant Physician • Day Surgery Miscellaneous Expenses • Surgeon • Diagnostic X-Ray & Laboratory - CT Scan, PET Scan or MRI • Emergency Room • Urgent Care • Home Health Care • Wellness Medical Expense • Infertility • Pediatric Specialty Care • Ambulance • Telemedicine • Pharmacy	• Mental Health Acute Inpatient Services • Mental Health Subacute Residential Treatment • Mental Health Inpatient Professional Services • SUD Acute Inpatient Services • SUD Acute Inpatient Detoxification • SUD Subacute Residential Treatment • SUD Inpatient Professional Services	• Autism • Eating Disorder • Intensive Behavioral Case Management • Opioid and Pain Management • Substance Use • Coaching Support for Parents and Families
Wellfleet Insurance Company	• Hospital Care • Preadmission Testing • Physician's Visits while confined • Skilled Nursing Facility • Inpatient Rehabilitation Facility • Registered Nurse Services while confined • Physical Therapy while Confined	• Preventive Services • Chemotherapy and radiation therapy • Chiropractic care • Diagnostic imaging/testing • Durable Medical Equipment (DME) • Genetic testing • Home health care • Infertility Treatment • Infusion therapy • Outpatient surgery & procedures • Rehabilitation & habilitation therapies • Emergency Care • Pharmacy	• Inpatient Mental Health Care for a continuous confinement when in a Hospital • Residential Treatment • Inpatient Rehabilitation Services	Physician's Office Visits including, but not limited to: • Physician visits • Individual and group therapy • Medication Management • Emergency Care • Pharmacy

APPENDIX D
Factors Used for Comparative Analysis

Summary of Responses – M.G.L. c. 26, s. 8M(a)(ii)		
Carrier	**Factors Used**	
	Medical/Surgical	**Mental Health/Substance Use**
4 Ever Life Insurance Company	The Plan: Medical policies are available online at: https://medpolicy.ibx.com/ibc/Commercial/Pages/Policy-Bulletin-View.aspx Magellan: Magellan Care Guidelines are available online at: https://www.magellanprovider.com/media/45694/mcg.pdf	
Aetna Health, Inc. (PA)	• Frequency of services being administered on an OON basis ○ There is no fixed quantitative standard applied; rather frequency of services being administered on an OON basis is a quantitative evaluation of OON utilization rates relative to other Outpatient All Other services. • Duration of the typical course of treatment ○ There is no fixed quantitative standard applied; rather duration of the typical course of treatment is a quantitative evaluation of duration of treatment data relative to other Outpatient All Other services.	
Aetna Health Insurance Company	• Frequency of services being administered on an OON basis ○ There is no fixed quantitative standard applied; rather frequency of services being administered on an OON basis is a quantitative evaluation of OON utilization rates relative to other Outpatient All Other services. • Duration of the typical course of treatment ○ There is no fixed quantitative standard applied; rather duration of the typical course of treatment is a quantitative evaluation of duration of treatment data relative to other Outpatient All Other services.	
Aetna Life Insurance Company	• Frequency of services being administered on an OON basis ○ There is no fixed quantitative standard applied; rather frequency of services being administered on an OON basis is a quantitative evaluation of OON utilization rates relative to other Outpatient All Other services. • Duration of the typical course of treatment ○ There is no fixed quantitative standard applied; rather duration of the typical course of treatment is a quantitative evaluation of duration of treatment data relative to other Outpatient All Other services.	
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	Cost of treatment/procedure, Medical cost escalation, Fraud Waste and Abuse, Return on Investment	
Blue Cross and Blue Shield of Massachusetts, Inc.	Cost of treatment/procedure, Medical cost escalation, Fraud Waste and Abuse, Return on Investment	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(ii)		
Carrier	**Factors Used**	
	Medical/Surgical	**Mental Health/Substance Use**
Boston Medical Center Health Plan, Inc. d/b/a WellSense Health Plan	Examples of factors include but are not limited to the following: o Excessive utilization; o Recent medical cost escalation; o Provider discretion in determining diagnosis; o Lack of clinical efficiency of treatment or service; o High variability in cost per episode of care; o High levels of variation in length of stay; o Lack of adherence to quality standards; o Claim types with high percentage of fraud; and o Current and projected demand for services.	
Cigna Health and Life Insurance Company	Medical Necessity Medical Cost Return on Investment	
ConnectiCare of Massachusetts, Inc.	Clinical Appropriateness Value	
Fallon Community Health Plan, Inc.	- Excessive utilization - Recent medical cost escalation - Lack of adherence to quality standards - High levels of variation in length of stay - High variability in cost per episode of care - Clinical efficacy of the proposed treatment or service - Provider discretion in determining diagnoses - Claims associated with a high percentage of fraud - Severity or chronicity of the MH/SUD condition	
Harvard Pilgrim Health Care, Inc.	The Plan uses the following factors in determining what services are subject to utilization management: • Clinical appropriateness/clinical efficacy, i.e., the application of utilization management promotes optimal clinical outcomes, whether the service or procedure works for treating a certain condition • Variation: whether there is variation in utilization patterns, including underutilization or overutilization relative to clinical benchmarks • Value: Potential for meaningful results from utilization management activity relative to the administrative cost	
Health New England, Inc.	Inpatient and outpatient: Clinical Efficacy, efficacy of treatment or service, level of care Prescription Drugs: cost efficacy and safety, prevention of substance abuse, patient outcomes, minimization of errors.	
HPHC Insurance Company, Inc.	The Plan uses the following factors in determining what services are subject to utilization management: • Clinical appropriateness/clinical efficacy, i.e., the application of utilization management promotes optimal clinical outcomes, whether the service or procedure works for treating a certain condition • Variation: whether there is variation in utilization patterns, including underutilization or overutilization relative to clinical benchmarks	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(ii)		
Carrier	**Factors Used**	
	Medical/Surgical	**Mental Health/Substance Use**
	• Value: Potential for meaningful results from utilization management activity relative to the administrative cost	
Mass General Brigham Health Insurance Company	Clinical Appropriateness o Whether the application of prior authorization promotes optimal clinical outcomes Value o The process and cost of conducting clinical review results in measurable impact and improved adherence to evidence-based practice and, more effective allocation of clinical resources	Clinical Appropriateness o Whether the application of prior authorization promotes optimal clinical outcomes Value o The cost of the service exceeds the associated costs of conducting a prior authorization review
Mass General Brigham Health Plan, Inc.	Clinical Appropriateness o Whether the application of prior authorization promotes optimal clinical outcomes Value o The process and cost of conducting clinical review results in measurable impact and improved adherence to evidence-based practice and, more effective allocation of clinical resources	Clinical Appropriateness o Whether the application of prior authorization promotes optimal clinical outcomes Value o The cost of the service exceeds the associated costs of conducting a prior authorization review
Tufts Associated Health Maintenance Organization, Inc.	The Plan uses the following factors in determining what services are subject to utilization management: • Clinical appropriateness/clinical efficacy, i.e., the application of utilization management promotes optimal clinical outcomes, whether the service or procedure works for treating a certain condition • Variation: whether there is variation in utilization patterns, including underutilization or overutilization relative to clinical benchmarks • Value: Potential for meaningful results from utilization management activity relative to the administrative cost	
Tufts Health Public Plans, Inc.	The Plan uses the following factors in determining what services are subject to utilization management: • Clinical appropriateness/clinical efficacy, i.e., the application of utilization management promotes optimal clinical outcomes, whether the service or procedure works for treating a certain condition • Variation: whether there is variation in utilization patterns, including underutilization or overutilization relative to clinical benchmarks	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(ii)		
Carrier	**Factors Used**	
	Medical/Surgical	**Mental Health/Substance Use**
	• Value: Potential for meaningful results from utilization management activity relative to the administrative cost	
Tufts Insurance Company	The Plan uses the following factors in determining what services are subject to utilization management: • Clinical appropriateness/clinical efficacy, i.e., the application of utilization management promotes optimal clinical outcomes, whether the service or procedure works for treating a certain condition • Variation: whether there is variation in utilization patterns, including underutilization or overutilization relative to clinical benchmarks • Value: Potential for meaningful results from utilization management activity relative to the administrative cost	
UnitedHealthcare Insurance Company	**• Clinical Appropriateness** o Whether the application of prior authorization promotes optimal clinical outcomes **• Value** o The cost of the service exceeds the associated costs of conducting a prior authorization review	
United States Fire Insurance Company	US Fire delegates health plan administration to the following vendors: • Cigna: network maintenance, including provider credentialing and negotiating appropriate reimbursement rates; • Cigna and HealthSmart: claims administration, utilization management and case management; and • Express Scripts prescription drugs, including formulary development. US Fire conducted NQTL analysis utilizing plan coverage provisions and vendor NQTLs and policies and procedures. Factors included goals and objectives of vendor materials including accessibility, appropriateness, timeliness and efficacy of care.	
Wellfleet Insurance Company	• Wellfleet delegates network maintenance (including Provider Access, Credentialing and Reimbursement and Provider Questions), non-pharmacy utilization management (including Medical Necessity Criteria Development, Prior Authorization, Concurrent Review, Retrospective Review, and Experimental and Investigational Determinations) to CIGNA and performs reviews only for Gender-affirming procedures for all members in-house at Wellfleet. Wellfleet's "Utilization Review Guideline: Gender-affirming Services" is available at: http://wellfleetstudent.com/wp-content/uploads/2023/03/Gender-Affirming-Services-v4.1.pdf. • Wellfleet reimburses out-of-network providers through Reasonable and Customary (R&C) methodology and also maintains guidelines for reimbursing out-of-network providers at an in-network benefit level in specific circumstances. Wellfleet maintains pharmacy guidelines for Medical Necessity Criteria Development, Formulary Design, Step Therapy and Prior Authorization. Wellfleet delegates pharmacy utilization management to Express Scripts (ESI); however, the application of Wellfleet's pharmacy guidelines that drive	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(ii)		
Carrier	**Factors Used**	
	Medical/Surgical	**Mental Health/Substance Use**
	ESI's decisions are approved by Wellfleet's internal Pharmacy and Therapeutics Committee (P&T) and Value Assessment Committee (VAC). Wellfleet's student health formulary, prior authorization guidelines and formulary drug exception procedure are available at: www.wellfleetrx.com/students/formularies.	

APPENDIX E
Evidentiary Standards for Comparative Analysis

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
4 Ever Life Insurance Company	The Plan (NCQA Accredited): In creating medical policies, evidence relied upon includes credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community, physician specialty recommendations, and the views of the physicians practicing in relevant clinical areas. The Plan also relies on InterQual Clinical Decision Support Criteria, CMS guidelines, and extensive literature searches.	Magellan (NCQA Accredited): In creating medical policies, Magellan relies on credible scientific evidence published in peer-reviewed, medical literature generally recognized by the relevant medical community, physician specialty recommendations, and the views of the physicians practicing in relevant clinical areas. Magellan also relies on CMS guidelines, MCG (formerly Milliman Care Guidelines), and American Society of Addiction Medicine (ASAM) criteria for substance use disorder services. Additional external sources include InterQual Criteria (an externally validated, computer-based system).
Aetna Health, Inc.	• Review of Medicare rates • Internal claims database analysis • Review of generally accepted national evidence-based guidelines from national medical professional organizations, evidence-based evaluations by consensus panels, and technology evaluation bodies or criteria from professional associations such as: • Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and Medicare Benefit Policy Manual • MCG guidelines • National Comprehensive Cancer Network NCCN) guidelines (Category 1 and 2A recommendations) • American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions, most recent version • Applied Behavior Analysis Medical Necessity Guide • InterQual guidelines (as required by contractual provisions) • The Level of Care Utilization System (LOCUS) & Children and Adolescent Level of Care Utilization System (CALOCUS) • Review of generally accepted national quality standards, i.e.) National Committee for Quality Assurance, NCQA • Internal claims system review. Review of claims systems capabilities with Head of Operations to validate system functionality.	
Aetna Health Insurance Company	• Review of Medicare rates • Internal claims database analysis • Review of generally accepted national evidence-based guidelines from national medical professional organizations, evidence-based evaluations by consensus panels, and technology evaluation bodies or criteria from professional associations such as: • Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and Medicare Benefit Policy Manual • MCG guidelines • National Comprehensive Cancer Network NCCN) guidelines (Category 1 and 2A recommendations) • American Society of Addiction Medicine	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	(ASAM) Criteria; Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions, most recent version • Applied Behavior Analysis Medical Necessity Guide • InterQual guidelines (as required by contractual provisions) • The Level of Care Utilization System (LOCUS) & Children and Adolescent Level of Care Utilization System (CALOCUS) • Review of generally accepted national quality standards, i.e.) National Committee for Quality Assurance, NCQA • Internal claims system review. Review of claims systems capabilities with Head of Operations to validate system functionality.	
Aetna Life Insurance Company	• Review of Medicare rates • Internal claims database analysis • Review of generally accepted national evidence-based guidelines from national medical professional organizations, evidence-based evaluations by consensus panels, and technology evaluation bodies or criteria from professional associations such as: • Centers for Medicare & Medicaid Services (CMS) National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs) and Medicare Benefit Policy Manual • MCG guidelines • National Comprehensive Cancer Network NCCN) guidelines (Category 1 and 2A recommendations) • American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance Related, and Co-Occurring Conditions, most recent version • Applied Behavior Analysis Medical Necessity Guide • InterQual guidelines (as required by contractual provisions) • The Level of Care Utilization System (LOCUS) & Children and Adolescent Level of Care Utilization System (CALOCUS) • Review of generally accepted national quality standards, i.e.) National Committee for Quality Assurance, NCQA • Internal claims system review. Review of claims systems capabilities with Head of Operations to validate system functionality.	
Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	Inpatient: -Classification system (referred to as DRGs) for inpatient discharges established under Section 1886(d) of the Social Security Act; -InterQual Criteria Outpatient: -Factors vary based on the outpatient service	
Blue Cross and Blue Shield of Massachusetts, Inc.	Inpatient: -Classification system (referred to as DRGs) for inpatient discharges established under Section 1886(d) of the Social Security Act; -InterQual Criteria Outpatient: -Factors vary based on the outpatient service	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
Boston Medical Center Health Plan, Inc. d/b/a WellSense Health Plan	Examples of **sources of factors** include, but are not limited to, the following: o Internal claims analysis; o Medical expert reviews; o State and federal requirements; o National accreditation standards; o Internal market and competitive analysis; o Medicare physician fee schedules; and o Evidentiary standards, including any published standards as well as internal plan or issuer standards, relied upon to define the factors triggering the application of an NQTL to benefits. If these factors are utilized, they must be applied comparably to MH/SUD and medical/surgical benefits.	
Cigna Health and Life Insurance Company	Medical Necessity Criteria Internally developed coverage guidelines ASAM Criteria	
ConnectiCare of Massachusetts, Inc.	**Evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor:** o Expert Medical Review o Objective, evidence-based clinical criteria, and nationally recognized guidelines o Internal claims data o UM program operating costs o UM authorization data	**Evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor:** o Clinical criteria from nationally recognized third-party sources (e.g., ASAM®, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) review o Evidence-based policies, and publications and guidelines by nationally recognized authorities, such as government sources and/or professional societies
	The Evidentiary standard that defines and/or triggers the Value factor: o Value is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the service to prior authorization by at least 1:1 • **The sources used to define the Value factor:** o National internal claims data o National UM program operating costs o National UM authorization data	
Fallon Community Health Plan, Inc.	CMS Guidelines MassHealth Guidelines InterQual Criteria Internally developed criteria	ASAM Criteria InterQual Criteria Criteria from AMA, APA, AACAP, SMHSA

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
Harvard Pilgrim Health Care, Inc.	The Plan uses the following sources to define the factors identified above: • **Factor**: Clinical appropriateness/clinical efficacy o Recognized medical literature, evidence-based empirical data and published research studies o Quality and clinical efficacy data o Internal and external subject matter expert feedback o State and federal requirements o Publications by government sources and/or professional societies **• Factor: Variation** o Utilization data o Cost and trend data o Quality and clinical efficacy data o Internal and external subject matter expert feedback o Publications by government sources and/or professional societies **Factor: Value** o Utilization data o Cost and trend data o Internal and external subject matter expert feedback	
Health New England, Inc.	Review of internal sources; external sources include AMA, CMS, American Psychiatric Association, Journal of Addiction Medicine; Pharmacy: FDA labeling; medical literature; internal claims data; accreditation standards of NCQA; Clinical Care Assessment Committee.	
HPHC Insurance Company, Inc.	The Plan uses the following sources to define the factors identified above: • **Factor**: Clinical appropriateness/clinical efficacy o Recognized medical literature, evidence-based empirical data and published research studies o Quality and clinical efficacy data o Internal and external subject matter expert feedback o State and federal requirements o Publications by government sources and/or professional societies **• Factor: Variation** o Utilization data o Cost and trend data o Quality and clinical efficacy data o Internal and external subject matter expert feedback o Publications by government sources and/or professional societies **Factor: Value** o Utilization data o Cost and trend data o Internal and external subject matter expert feedback	
Mass General Brigham Health Insurance Company	**Factor – Clinical Appropriateness** is defined as the existence of evidence-	**Factor – Clinical Appropriateness** is defined as the existence of evidence-based medical necessity

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	based medical necessity criteria for inpatient services in accordance with nationally recognized clinical criteria and evidence-based policies. • Evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor: o Clinical criteria from a nationally recognized third-party source, InterQual® o Medical Technology Assessment Committee (MTAC) review o Evidence-based policies, publications and guidelines by nationally recognized authorities, such as government sources and/or professional societies. These include, but are not limited to: o Published articles and reports in credible, peer-reviewed English language medical and scientific journals; o Cochrane Library; o Professional organizations' clinical practice guidelines o Hayes Inc., an independent health technology assessment organization; providing assessment of the safety and efficacy of technologies **Factor – Value** is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to prior authorization review. Consideration of this factor includes a review of inpatient utilization denial rates or claims data to identify if there	criteria for inpatient services in accordance with nationally recognized clinical criteria and evidence-based policies. • Evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor: o Clinical criteria from nationally recognized third-party sources (e.g., ASAM®, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) review o Evidence-based policies, publications and guidelines by nationally recognized authorities, such as government sources and/or professional societies. **Factor – Value** is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to prior authorization review by at least 1:1. Consideration of this factor includes a review of national inpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when prior authorization is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering prior authorization to determine value. • The sources used to define the Value factor: o National internal claims data o National UM program operating costs o National UM authorization data

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	is opportunity to improve quality and reduce unnecessary costs when prior authorization is applied. • The Evidentiary standard that defines and/or triggers the Value factor: o The process and cost of conducting clinical review results in improved adherence to evidence-based practice and more effective allocation of clinical resources • The sources used to define the Value factor: o Internal claims data	
Mass General Brigham Health Plan, Inc.	**Factor – Clinical Appropriateness** is defined as the existence of evidence-based medical necessity criteria for inpatient services in accordance with nationally recognized clinical criteria and evidence-based policies. • Evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor: o Clinical criteria from a nationally recognized third-party source, InterQual® o Medical Technology Assessment Committee (MTAC) review o Evidence-based policies, publications and guidelines by nationally recognized authorities, such as government sources and/or professional societies. These include, but are not limited to: o Published articles and reports in credible, peer-reviewed English language	**Factor – Clinical Appropriateness** is defined as the existence of evidence-based medical necessity criteria for inpatient services in accordance with nationally recognized clinical criteria and evidence-based policies. • Evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor: o Clinical criteria from nationally recognized third-party sources (e.g., ASAM®, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) review o Evidence-based policies, publications and guidelines by nationally recognized authorities, such as government sources and/or professional societies. **Factor – Value** is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to prior authorization review by at least 1:1.

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	medical and scientific journals; o Cochrane Library; o Professional organizations' clinical practice guidelines o Hayes Inc., an independent health technology assessment organization; providing assessment of the safety and efficacy of technologies **Factor – Value** is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to prior authorization review. Consideration of this factor includes a review of inpatient utilization denial rates or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when prior authorization is applied. • The Evidentiary standard that defines and/or triggers the Value factor: o The process and cost of conducting clinical review results in improved adherence to evidence-based practice and more effective allocation of clinical resources • The sources used to define the Value factor: o Internal claims data	Consideration of this factor includes a review of national inpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when prior authorization is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering prior authorization to determine value. • The sources used to define the Value factor: o National internal claims data o National UM program operating costs o National UM authorization data
Tufts Associated Health Maintenance Organization	The Plan uses the following sources to define the factors identified above: • **Factor**: Clinical appropriateness/clinical efficacy o Recognized medical literature, evidence-based empirical data and published research studies o Quality and clinical efficacy data o Internal and external subject matter expert feedback o State and federal requirements	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	o Publications by government sources and/or professional societies **• Factor: Variation** o Utilization data o Cost and trend data o Quality and clinical efficacy data o Internal and external subject matter expert feedback o Publications by government sources and/or professional societies **Factor: Value** o Utilization data o Cost and trend data o Internal and external subject matter expert feedback	
Tufts Health Public Plans, Inc.	The Plan uses the following sources to define the factors identified above: **• Factor**: Clinical appropriateness/clinical efficacy o Recognized medical literature, evidence-based empirical data and published research studies o Quality and clinical efficacy data o Internal and external subject matter expert feedback o State and federal requirements o Publications by government sources and/or professional societies **• Factor: Variation** o Utilization data o Cost and trend data o Quality and clinical efficacy data o Internal and external subject matter expert feedback o Publications by government sources and/or professional societies **Factor: Value** o Utilization data o Cost and trend data o Internal and external subject matter expert feedback	
Tufts Insurance Company	The Plan uses the following sources to define the factors identified above: **• Factor**: Clinical appropriateness/clinical efficacy o Recognized medical literature, evidence-based empirical data and published research studies o Quality and clinical efficacy data o Internal and external subject matter expert feedback o State and federal requirements o Publications by government sources and/or professional societies **• Factor: Variation** o Utilization data o Cost and trend data o Quality and clinical efficacy data o Internal and external subject matter expert feedback o Publications by government sources and/or professional societies **Factor: Value**	

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	o Utilization data o Cost and trend data o Internal and external subject matter expert feedback	
UnitedHealthcare Insurance Company	**Factor – Clinical Appropriateness** is defined as those inpatient services that are determined by internal medical experts to be in accordance with objective, evidence-based clinical criteria, and nationally recognized guidelines. The Plan's evidentiary standards and sources that define and/or trigger the Clinical Appropriateness factor: o Clinical criteria from nationally recognized third-party sources (e.g., InterQual® for M/S services, and ASAM, LOCUS, CALOCUS-CASII and ECSII guidelines for MH/SUD services) o Clinical Technology Assessment Committee (CTAC) and Medical Technology and Assessment Committee (MTAC) review o Objective, evidence-based clinical policies and nationally recognized guidelines **Factor – Value** is defined as the cost of the inpatient service exceeding the administrative costs of subjecting the inpatient service to prior authorization review by at least 1:1. Consideration of this factor includes a review of national inpatient utilization or claims data to identify if there is opportunity to improve quality and reduce unnecessary costs when prior authorization is applied. The projected benefit cost savings is reviewed relative to the operating cost of administering prior authorization to determine value. Sources: National internal claims data National UM program operating costs National UM authorization data	
United States Fire Insurance Company	In addition to vendor policies and procedures, US Fire utilized objective medical information including ASAM Criteria, MCG Criteria, InterQual, National Comprehensive Cancer Network (NCCN), Official Disability Guidelines (ODG), American Medical Association (AMA) Publication of the Current Procedural Terminology (CPT) Book, American Hospital Association (AHA) Publication of Revenue Codes, American Formulary Association (AFA) Publication of Codes, FDA Labeling and Office of Clinical	In addition to vendor policies and procedures, US Fire utilized objective medical information including ASAM Criteria, MCG Criteria, InterQual, National Comprehensive Cancer Network (NCCN), Official Disability Guidelines (ODG), American Medical Association (AMA) Publication of the Current Procedural Terminology (CPT) Book, American Hospital Association (AHA) Publication of Revenue Codes, American Formulary Association (AFA) Publication of Codes, FDA Labeling and Office of Clinical Evaluation & Policy (OCEP) Review.

Summary of Responses – M.G.L. c. 26, s. 8M(a)(iii)		
Carrier	**Evidentiary Standards**	
	Medical/Surgical	**Mental Health/Substance Use**
	Evaluation & Policy (OCEP) Review.	
Wellfleet Insurance Company	• Pharmacy: FDA Prescribing Information, professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines, nationally recognized Compendia - Truven Health Analytics Micromedex DrugDEX (DrugDEX), and peer-reviewed medical literature, as well as First Databank (FDB) and Wellfleet internal market and competitive analysis, and therapeutic class total net cost analysis. • Out-of-Network Reimbursement: Fair Health data, provider type, services and/or procedures provided, geographic location, and industry benchmark rates/methodology. See also, CIGNA information above regarding non-pharmacy, non-gender-affirming evidentiary standards.	• Gender-Affirming Care: WPATH Standards of Care. See also, CIGNA information above regarding non-pharmacy, non-gender-affirming evidentiary standards.

APPENDIX F
Company-Specific Authorization Information

	MASSACHUSETTS CARRIERS 2022	No. of Requests Made (5a)	No. of Services Requested (5b)			No. of Requests Authorized[2] (5c)	No. of Requests Modified[2] (5d)	No. of Requests Denied (5e)	No. of Internal Appeals Filed (5f)	No. of Appeals Approved (5g)	No. of Appeals Denied (5h)	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
1	Aetna Health Inc./ Aetna Health Insurance Company	142	64	244	308	108	5	29	0	0	0	0	0	0
2	Aetna Life Insurance Company	3,028	2,218	14,271	16,489	2,351	133	544	33	14	19	2	1	1
3	Blue Cross and Blue Shield of Massachusetts, Inc.	37,901	26,019	2,627,608	2,653,627	35,909	28	1,964	65	45	20	2	0	2
4	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	289,664	308,134	20,527,200	20,835,334	275,919	361	13,384	1,198	722	476	15	5	10
5	Boston Medical Center Health Plan, Inc.[2]	21,634	15,327	4,854,740	4,870,067	19,367	180	2,087	189	56	133	3	2	1
6	CIGNA Health and Life Insurance Company^	151,881	2,873	149,008	151,881	124,882	0	26,999	202	106	96	3	1	2
7	ConnectiCare of Massachusetts, Inc.	76	6	97	103	57	0	19	11	5	6	0	0	0
8	Fallon Community Health Plan, Inc.	3,751	4,306	24,885	29,191	3,321	36	394	108	70	38	0	0	0
9	Fallon Health & Life Assurance Company, Inc.[2]	0	0	0	0	0	0	0	0	0	0	0	0	0
10	4 Ever Life Insurance Company	0	0	0	0	0	0	0	0	0	0	0	0	0
11	Harvard Pilgrim Health Care, Inc.	95,919	12,435	1,057,514	1,069,949	83,686	1,158	11,075	436	267	169	13	6	7
12	HPHC Insurance Company, Inc.	24,738	1,800	269,996	271,796	20,974	269	3,495	76	46	30	4	1	3
13	Health New England, Inc.	7,981	14,442	295,948	310,390	7,185	23	773	528	399	129	5	2	3
14	Mass General Brigham Health Plan, Inc. and Mass General Brigham Health Insurance Company (collectively, Mass General Brigham Health Plan)	38,376	20,122	427,000	447, 122	24,045	11,659	2,672	111	39	72	2	0	2
15	Tufts Associated Health Maintenance Organization, Inc.**	62,199	24,644	1,094,625	1,119,269	54,890	0	7,309	142	63	79	5	2	3
16	Tufts Health Public Plans, Inc.[2]	66,658	101,396	989,855	1,091,251	59,521	0	7,137	282	121	161	13	6	7
17	Tufts Insurance Company	7,832	4,255	384,055	388,310	7,056	0	776	22	10	12	2	2	0
18	UnitedHealthcare Insurance Company	38,179	1,135	37,044	38,179	32,641	0	4,448	227	142	85	8	4	4
19	United State Fire Insurance Company	436	1	438	439	365	2	69	0	0	0	0	0	0
20	Wellfleet Insurance Company	67	9	61	70	36	0	26	0	0	0	0	0	0
	TOTALS:	**850,462**	**539,186**	**32,754,589**	**32,846,653**	**752,313**	**13,854**	**83,200**	**3,630**	**2,105**	**1,525**	**77**	**32**	**45**

			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
1	Aetna Health Inc. / Aetna Health Insurance Company	10	27	6,535	6,562	10	0	0	0	0	0	0	0	0
2	Aetna Life Insurance Company	248	1,683	48,261	49,944	240	3	5	1	1	0	2	0	2
3	Blue Cross and Blue Shield of Massachusetts, Inc.	1,987	19,597	500,743	520,340	1,985	1	1	0	0	0	0	0	0
4	Blue Cross and Blue Shield of Massachusetts HMO Blue, Inc.	12,648	102,402	2,796,100	2,898,502	12,595	7	46	19	8	11	1	1	0
5	Boston Medical Center Health Plan, Inc.	1,319	5,207	51,088	56,295	1,309	0	10	1	1	0	0	0	0
6	CIGNA Health and Life Insurance Company	1,429	748	681	1,429	1,357	0	72	12	5	7	1	1	0
7	ConnectiCare of Massachusetts, Inc.	0	0	0	0	0	0	0	0	0	0	0	0	0
8	Fallon Community Health Plan, Inc.	901	2,291	50,891	53,182	876	0	25	1	0	1	0	0	0
9	Fallon Health & Life Assurance Company, Inc.	0	0	0	0	0	0	0	0	0	0	0	0	0
10	4 Ever Life Insurance Company	0	0	0	0	0	0	0	0	0	0	0	0	0
11	Harvard Pilgrim Health Care, Inc.	10,180	15,157	818,551	833,708	8,804	981	395	31	7	24	3	3	0
12	HPHC Insurance Company, Inc.	1,584	2,137	168,998	171,135	1,358	165	61	5	2	3	0	0	0
13	Health New England, Inc.	1,430	4,502	317,883	322,385	1,248	18	164	23	7	16	1	0	1
14	Mass General Brigham Health Plan, Inc. and Mass General Brigham Health Insurance Company (collectively, Mass General Brigham Health Plan)	3,090	6,045	380,393	386,438	2,737	298	55	12	7	5	1	1	0
15	Tufts Associated Health Maintenance Organization, Inc.	3,137	9,125	888,239	897,364	3,006	0	131	5	2	3	1	1	0
16	Tufts Health Public Plans, Inc.	3,412	11,073	261,742	272,815	3,318	0	94	2	1	1	0	0	0
17	Tufts Insurance Company	825	2,833	315,892	318,725	802	0	23	4	0	4	0	0	0
18	UnitedHealthcare Insurance Company	2,168	398	1,770	2,168	2,106	0	52	4	0	4	1	0	1
19	United State Fire Insurance Company	225	64	212	276	200	4	21	0	0	0	0	0	0
20	Wellfleet Insurance Company	0	0	0	0	0	0	0	0	0	0	0	0	0
	TOTALS:	**44,593**	**183,289**	**6,607,979**	**6,791,268**	**41,951**	**1,477**	**1,155**	**120**	**41**	**79**	**11**	**7**	**4**

[1]Reported information is for all 2022 non-governmental insured coverage issued in Massachusetts for requests made and appeals heard during calendar year 2022.
[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.
Tufts Associated Health Maintenance Org., Inc.
Tufts Insurance Company
Tufts Health Public Plans, Inc.
UnitedHealthcare Insurance Company
Wellfleet Insurance Company