MHPAEA Summary Form Instructions

The below summary form is prepared to satisfy the requirements of §15-144 (m)(2), Insurance Article, Annotated Code of Maryland. The summary form must be made available to plan members and to the public on the carrier's website.

Confidential and proprietary information must be removed from the summary form. Confidential and proprietary information that is removed from the summary form must satisfy § 15-144(h)(1), Insurance Article, Annotated Code of Maryland.

The MHPAEA Summary Form includes the MHPAEA Data Report.

Carriers must use the terms defined in COMAR 31.10.51 and the *Instructions for MHPAEA NQTL Analysis Report and Data Report* to complete the summary form.

MHPAEA Summary Form

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), CareFirst must make sure that there is "parity" between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that financial requirements and treatment limitations applied to mental health or substance use disorder benefits cannot be more restrictive than the financial requirements and treatment limitations applied to medical and surgical benefits. The types of limits covered by parity protections include:

- Financial requirements—such as deductibles, copayments, coinsurance, and out-of-pocket limits; and
- Treatment limitations—such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization).

CareFirst has performed an analysis of mental health parity as required by Maryland law and has submitted the required report to the State of Maryland. Below is a summary of that report.

If you have any questions on this summary, please contact CareFirst MHPAEA NQTL Office at MHPAEA_NQTL@carefirst.com

If you have questions on your specific health plan, please contact Member Services at the phone number on the back of your member ID card

Overview:

We have identified the five health benefit plans with the highest enrollment for each product we offer in the individual, small, and large group markets, as applicable. These plans contain items called Non-Quantitative Treatment Limitations (NQTLs) that put limits on benefits paid. What these NQTL's are and how the health plans achieve parity are discussed below.

1. Definition of Medical Necessity

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

Medical Necessity means health care services or supplies that a health care provider, exercising prudent clinical judgment, renders to or recommends for a patient for the purpose of preventing, evaluating, diagnosing, or treating an illness, injury, disease or its symptoms. These health care services, or supplies are:

- In accordance with generally accepted standards of medical practice
- Clinically appropriate, in terms of type, frequency, extent, site, and duration, and considered effective for a patient's illness, injury or disease
- Not primarily for the convenience of a patient or health care provider
- Not more costly than an alternative service or sequence of services, at least as likely to produce equivalent therapeutic or diagnostic results in the diagnosis or treatment of that patient's illness, injury or disease

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, physician specialty society recommendations and views of health care providers practicing in relevant clinical areas, and any other relevant factors. ***(Source- Plan doc, Section 1 Definitions)***

Medical Necessity criteria are applicable to all Med/Surg and MH/SUD benefits, classifications, and sub-classifications.

B. Identify the factors used in the development of the limitation(s);
C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor 1	In accordance with general accepted standards of medical practice.
Definition	"Generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical

	community, physician specialty society recommendations and views of health care providers practicing in relevant clinical areas, and any other relevant factors.
Sources	• MCG • AEP • ACOG • AAP • US Preventive Services Task Force • CMS • Apollo Managed Care Physical Therapy • NIA/Magellan • American Society of Addiction Medicine (ASAM) for SUD services • Patient records and health history
Evidentiary Standards	• MCG care guidelines • ACOG recommendations • AAP recommendations • US Preventative Task Force evidence-based recommendations • CMS national and local coverage determinations • Apollo Managed Care guidelines • NIA Magellan recommendations • Peer-reviewed medical literature • ASAM criteria for SUD services
Factor 2	Clinically Appropriate
Definition	The service must be clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease. The service must be clinically appropriate and effective per the accepted guidelines based upon the patient's condition.
Sources	• MCG • AEP • ACOG • AAP • US Preventive Services Task Force

	• CMS • Apollo Managed Care Physical Therapy • NIA/Magellan • American Society of Addiction Medicine (ASAM) for SUD services • Patient records and health history
Evidentiary Standards	• MCG care guidelines • ACOG recommendations • AAP recommendations • US Preventative Task Force evidence-based recommendations • CMS national and local coverage determinations • Apollo Managed Care guidelines • NIA Magellan recommendations • Peer-reviewed medical literature • ASAM criteria for SUD services
Factor 3	Not primarily for the convenience of the patient, physician, or other health care provider.
Definition	The requested service cannot be determined to be primarily convenient for the patient, the physician, or other provider as opposed to the most cost-effective service for the best outcome based upon the patient's condition and medical history.
Sources	• Medical history of patients • Claims reports
Evidentiary Standards	• Patient history review • MCG care guidelines • ACOG recommendations • AAP recommendations • US Preventative Task Force evidence-based recommendations • CMS national and local coverage determinations • Apollo Managed Care guidelines • NIA Magellan recommendations • Peer-reviewed medical literature • ASAM criteria for SUD services

Factor 4	Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.
Definition	Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease. The service must be the most cost-effective option to achieve the desired outcome based upon the patient's condition. If there is a better cost-effective option available that is just or even more effective, it should be utilized.

Sources	• Claims analysis
	• Medical history of patients
	• CMS
	• NIH
	• NCI
	• CDC
	• AHRQ
	• Medical Associations
	  ○ AMA
	  ○ SAMHSA
	  ○ National Institute of Mental Health
	  ○ APA

Evidentiary Standards	• Peer-reviewed journals and medical literature • CMS guidelines • NIH guidelines • NCI recommendations • CDC recommendations • AHRQ research and recommendations • AMA recommendations • SAMHSA recommendations (MH/SUD) • National Institute for Mental Health recommendations (MH/SUD) • APA recommendations • Expert reviews and professional opinions

D. Identify the methods and analysis used in the development of the limitation(s); and

Medical Necessity eligibility criteria analyses relies on the expert opinion of CareFirst's Chief Medical Officer, senior medical directors, and the behavioral health medical director. All CareFirst M/S and MH/SUD policies in the CareFirst Medical Policy Reference Manual are developed based on the most recent peer review literature and are reviewed by CareFirst's chief medical officer, senior medical directors, and the behavioral health medical director. The criteria are not absolute but are designed to be used in conjunction with an assessment of the needs of the individual patient. All of CareFirst's medical and behavioral health policies are available on www.carefirst.com.

The criteria used for both M/S and MH/SUD are authorized by the CareFirst Criteria Review Committee. All criteria are reviewed annually and updated as needed to reflect current patterns of care. Input and suggestions are actively invited and sought from stakeholders, such as community physicians, primary care providers and behavioral health practitioners. CareFirst recognizes that standards of clinical practice may vary from region to region; therefore, criteria sets are adopted, reviewed, and modified as appropriate with the involvement and approval of practicing practitioners. Utilization Management criteria are not absolute; the CareFirst Medical Director may consider the individual needs and circumstances of a member and make coverage decisions based on those additional considerations. CareFirst follows the same model of care and utilization management processes for both medical and behavioral health and substance use disorder services.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

As written, CareFirst applies the Medical Necessity NQTL in parity to all benefit classifications. The same definition of medical necessity is utilized for M/S and MH/SUD benefits. CareFirst follows the same model of care and utilization management processes for both M/S and MH/SUD. Clinical policy, criteria utilized, and qualifications for utilization determinations among M/S and MH/SUD are comparable for their respective areas. The appropriate criteria for each service type is utilized when determining medical necessity. Medically Necessary health care services, supplies and medications provided for the purpose of preventing, evaluating, diagnosing or treating a sickness, injury, condition, disease or its symptoms, are all determined by specialty specific and appropriate UM Nurse Reviewers and the Chief Medical Director or Behavioral Health Medical Director, including the availability of Physician Reviews and specialists for escalated evaluations.

All CareFirst M/S and MH/SUD policies in the CareFirst Medical Policy Reference Manual are developed based on the most recent clinical evidence and peered review literature. Policies are reviewed by CareFirst's chief medical officer, senior medical directors, and the behavioral health medical director. The criteria are always used with an assessment of the individual patient's needs and circumstances. CareFirst's medical and behavioral health policies are available on web.carefirst.com.

The criteria used for both M/S and MH/SUD are authorized by the CareFirst Criteria Review Committee. All criteria are reviewed annually and updated as needed to reflect current patterns of care. Input and suggestions are actively invited and sought from stakeholders, such as community physicians, primary care providers and behavioral health practitioners. Specialists are consulted when specialist input is needed for both M/S and MH/SUD.

For M/S and MH/SUD benefits, appropriately qualified clinical staff make medical necessity determinations. Approvers require an active RN license in Maryland, Virginia, or the District of Columbia with a minimum of 7-10 years clinical experience or actively Licensed Clinical Social Worker (LCSW) or Licensed Certified Social Worker-Clinical (LCSW-C) or Licensed Certified Professional Counselor (LCPC) and must have a minimum of 7-10 years clinical experience. For both M/S and MH/SUD, denials may only be issued by Medical Directors, with an MD degree in addition to 5 years clinical experience; a psychiatric MD degree and 5 years clinical experience is required for MH/SUD clinical denials.

A review of CareFirst’s written policies and processes reveals the comparable application of Medical Necessity to M/S and MH/SUD services within the applicable benefit classification. The Plan’s Medical Necessity coverage policy development and application process is consistent between M/S and MH/SUD. CareFirst applies comparable evidence-based guidelines to define established standards of effective care for both M/S and MH/SUD benefits. Compliance is further demonstrated through the Plan’s uniform definition of Medical Necessity for M/S and MH/SUD benefits.

CareFirst conducts monthly Care Management audits to help ensure that medical necessity criteria are applied in a consistent and impartial manner. The Interrater Reliability Monitoring program is in place to evaluate the consistency with which Medical Director, Physician Reviewers apply Medical, Behavioral Health and Substance Use, Pharmacy, and Dental medical necessity criteria in decision making. Corrective action is initiated if an interrater score falls below 90%. A score of 90 – 100% is considered acceptable. If the results are below 90% the Senior Medical Director

will evaluate the scores and decide whether to convene a review process with the Medical Directors/Physician Reviewers.

In 2021, the Inter-rater Reliability Score (IRR) was 100% for M/S and 100% for MH/SUD. In 2021, the RN Inter-rate Reliability Score (IRR) was 97.275 for M/S and 98.25 for MH/SUD. Outcomes support the consistent application of clinical criteria is no more stringent for MH/SUD, than for M/S.

In 2023, IRR scores were collected bi-annually and reported as 96.1% and 99.2% for physician reviewers. Nurse reviewer IRR scores for 2023 are 96.6% and 97.3%. Outcomes support the consistent application of clinical criteria is no more stringent for MH/SUD, than for M/S.

Additionally, there are no disparate outcomes of concern, between M/S and MH/SUD when evaluating all phases of utilization management including prior authorization, concurrent review and retrospective review as detailed within the respective sections below. Accordingly, CareFirst concludes that the application of Medical Necessity is no more stringent for MH/SUD benefits, than it is for M/S benefits, in operation.

2. Prior Authorization Review Process

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

Prior authorization means the process that a carrier or any entity delegated by the carrier to manage mental health, substance use disorder, or medical/surgical benefits on behalf of the carrier requires a member or provider to follow prior to the rendering of services to determine if coverage will be provided based on considerations such as medical necessity, level of care, appropriateness of health care services, provider type, geographic location, or diagnosis exclusions. Prior authorization includes, but is not limited to, preauthorization, precertification, prospective review, preadmission review, pretreatment review, utilization review, and any requirement that a member or provider notify the carrier or organization prior to receiving or delivering a health care service. Prior authorization includes reauthorization of services or benefits that had received preauthorization, but for which the approval period has lapsed at the time the request is submitted. A request for prior authorization is one received during the reporting period, regardless of whether or when services are delivered or whether or when a claim is submitted. ***(Source- COMAR 31.10.51)***

CareFirst BlueChoice requires prior authorization for the services mentioned. When a member seeks services from a Contracting Provider, the Contracting Provider is responsible for obtaining prior authorization. If the provider fails to obtain prior authorization for Covered Services, the Member shall be held harmless. ***(Source- Plan doc, Prior Authorization Amendment)***

Please refer to your plan documents for services subject to prior authorization. A standard list is available online here. Prior authorization is applied to the following benefit classifications: In-network Inpatient, In-network Outpatient, Out-of-network Inpatient, Out-of-network Outpatient.

For details on Pharmacy Prior Authorization, please reference section on NQTL #7 (Prescription Drugs Formulary Design).

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor 1	Variations in length of stay
Definition	The proposed length of stay should be similar to other stays with the same or similar diagnosis in the same or similar place of service. High levels of variations in length of stay that show patients stayed longer than the average stay or stays over 30 days may for the same or similar diagnosis may impact the determination of this factor.
Sources	• CMS • ASAM (SUD)
Evidentiary Standards	• MCG guidelines • ASAM guidelines
Threshold or Explanation	More than 30 days, appropriate intervals based on industry standards.
Factor 2	Standards of Care
Definition	To determine if the quality standards for the proposed treatment or service will be met, or whether further research may need to be done to validate. Deviations from generally accepted national quality standards for a specific diagnosis or disease category may also impact the determination as to this factor.
Sources	• CMS • ASAM (SUD)
Evidentiary Standards	• MCG guidelines • ASAM guidelines
Factor 3	Clinical efficacy and appropriateness of a proposed treatment or service
Definition	Clinical efficacy refers to achieving a desired treatment effect. The proposed treatment or service must be safe and effective for the diagnosis based upon the information provided about the patient's condition and the proposed treatment or service will provide the optimal clinical outcome for the diagnosis based upon the information provided about the patient's condition.
Sources	• CMS • ASAM (SUD)

	• Claims analysis • Patient records and health history
Evidentiary Standards	• MCG guidelines • ASAM guidelines • Peer-reviewed medical literature

D. Identify the methods and analysis used in the development of the limitation(s); and

Prior authorization eligibility criteria analyses rely on the expert opinion of CareFirst's Chief Medical Officer, senior medical directors and the behavioral health medical director. All CareFirst M/S and MH/SUD policies in the CareFirst Medical Policy Reference Manual are developed based on the most recent peer review literature and are reviewed by CareFirst's chief medical officer, senior medical directors, and the behavioral health medical director. The criteria are not absolute but are designed to be used in conjunction with an assessment of the needs of the individual patient. All of CareFirst's medical and behavioral health policies are available on www.carefirst.com.

The criteria used for both M/S and MH/SUD are authorized by the CareFirst Criteria Review Committee. All criteria are reviewed annually and updated as needed to reflect current patterns of care. Input and suggestions are actively invited and sought from stakeholders, such as community physicians, primary care providers and behavioral health practitioners. CareFirst recognizes that standards of clinical practice may vary from region to region; therefore, criteria sets are adopted, reviewed, and modified as appropriate with the involvement and approval of practicing practitioners. Utilization Management criteria are not absolute; the CareFirst Medical Director may consider the individual needs and circumstances of a member and make coverage decisions based on those additional considerations. CareFirst follows the same model of care and utilization management processes for both medical and behavioral health and substance use disorder services.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

A review of CareFirst’s written policies and processes reveals the comparable application of the Prior Authorization NQTL to M/S and MH/SUD services within the applicable benefit classifications. The Plan’s Prior Authorization policy development and application process is consistent between M/S and MH/SUD. CareFirst applies comparable evidence-based guidelines to define established standards of effective care for both M/S and MH/SUD benefits.

Compliance is further demonstrated through the Plan's uniform application of factors and evidentiary standards among M/S and MH/SUD services.

CareFirst conducts monthly Care Management audits to help ensure that medical necessity criteria are applied in a consistent and impartial manner. The Interrater Reliability Monitoring program is in place to evaluate the consistency with which Medical Director, Physician Reviewers apply Medical, Behavioral Health and Substance Use, Pharmacy, and Dental medical necessity criteria in decision making. Corrective action is initiated if an interrater score falls below 90%. A score of 90 – 100% is considered acceptable. If the results are below 90% the Senior Medical Director will evaluate the scores and decide whether to convene a review process with the Medical Directors/Physician Reviewers.

In 2021, the Inter-rater Reliability Score (IRR) was 100% for M/S and 100% for MH/SUD. In 2021, the RN Inter-rate Reliability Score (IRR) was 97.275 for M/S and 98.25 for MH/SUD. Outcomes support the consistent application of clinical criteria is no more stringent for MH/SUD, than for M/S.

In 2023, IRR scores were collected bi-annually and reported as 96.1% and 99.2% for physician reviewers. Nurse reviewer IRR scores for 2023 are 96.6% and 97.3%. Outcomes support the consistent application of clinical criteria is no more stringent for MH/SUD, than for M/S.

Additionally, there are no disparate outcomes of concern, between M/S and MH/SUD when evaluating all phases of utilization management including prior authorization, concurrent review and retrospective review as detailed within the respective sections below. Accordingly, CareFirst concludes that the application of Medical Necessity is no more stringent for MH/SUD benefits, than it is for M/S benefits, in operation.

3. Concurrent Review Process

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

Concurrent Review means any process used by the carrier or its private review agent to conduct utilization review for ongoing health care or for an extension of treatment beyond previously approved health care. ***(Source- COMAR 31.10.51)***
Concurrent care decisions: If an ongoing course of treatment has been approved to be provided over a period or number of treatments:

- Any reduction or termination of such course of treatment (other than by Plan amendment or termination) before the end of such period or number of treatments shall constitute an Adverse Benefit Determination.
- Any request by a Member to extend the course of treatment beyond the period of time or number of treatments that is a Claim Involving Urgent Care shall be decided as soon as possible, considering the medical exigencies. ***(Source- Plan doc, Section 1 Definitions)***

Utilization Management Specialists perform medical and behavioral health utilization management activities, including but not limited to medical necessity of care determinations and eligibility for coverage. ***(Spreadsheet- MHP NQTL Self-Funded Account Standard Response)***
Principles of Process: The Utilization Management Specialists use the Organization's approved criteria assigned for the place of service to determine appropriateness of level of care, continued stay, and post-acute admission appropriateness.

Procedure:

- Utilization Management Specialists assign and manage all authorizations in assignment and review, and triage authorizations based on the available clinical information.
- Utilization Management Specialists request and/or review Clinical information for continued stay review within 24 hours of the last approved day and clinical information will be documented in the clinical auth notes.
- Initial notes include all clinical information supporting admission and the need for continued stay. The notes are documented by department standards. After Initial review Utilization Management Specialists approve up to 3 additional days based on medical necessity.

- Utilization Management Specialists review DRG admissions once the outlier status is reached, and every 3 days following based on medical necessity and follow the departmental process for review with a Medical Director.
- Non-clinical staff monitors Members that are Medicare Primary for continued stay or discharge date via communication with facility contact and/or Admission, Discharge, and Transfer Report and follow the outlined process for Medicare Primary Members refer to Medicare SOP.
- Utilization Management Specialists review cases initially leveled a 2 for potential change to level 1 based on available clinical information.
- Upon notification of discharge Utilization Management Specialists/Nonclinical staff update the Member's authorization to ensure all inpatient days are included in the authorization and close the auth.
- UM does not apply any penalties for late or no Utilization request. These penalties would be applied by services/claims.
- Concurrent review criteria are applicable to both Med/Surg and MH/SUD benefits, classifications, and sub-classifications.

The following services are subject to Concurrent Review: M/S services - (Non-emergency) Acute Inpatient, Hospital Stays (Sub-Acute), Inpatient Hospice, Hospice Respite Care, Inpatient Rehabilitation, Inpatient Cosmetic Procedures, Organ and Tissue Transplants (except Cornea and Kidney Transplants, Maternity Services and Newborn Care (after 48 hours of confinement for normal delivery or 96 hours of confinement for cesarean delivery). MH/SUD services - (Non-emergency) Acute Inpatient, Hospital Stays (Sub-Acute), Residential Treatment, Inpatient Rehabilitation

Concurrent Review is applied to the following benefit classifications: In-network Inpatient and Out-of-network Inpatient

B. Identify the factors used in the development of the limitation(s);
C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor 1	Variations in length of stay

Definition	The proposed length of stay should be similar to other stays with the same or similar diagnosis in the same or similar place of service. High levels of variations in length of stay that show patients stayed longer than the average stay or stays over 30 days may for the same or similar diagnosis may impact the determination of this factor.
Sources	• CMS • ASAM (SUD)
Evidentiary Standards	• MCG guidelines • ASAM guidelines
Threshold or Explanation	More than 30 days, appropriate intervals based on industry standards.
Factor 2	Standards of Care
Definition	To determine if the quality standards for the proposed treatment or service will be met, or whether further research may need to be done to validate. Deviations from generally accepted national quality standards for a specific diagnosis or disease category may also impact the determination as to this factor.
Sources	• CMS • ASAM (SUD)
Evidentiary Standards	• MCG guidelines • ASAM guidelines
Factor 3	Clinical efficacy and appropriateness of a proposed treatment or service
Definition	Clinical efficacy refers to achieving a desired treatment effect. The proposed treatment or service must be safe and effective for the diagnosis based upon the information provided about the patient's condition and the proposed treatment or service will provide the optimal clinical outcome for the diagnosis based upon the information provided about the patient's condition.
Sources	• CMS • ASAM (SUD) • Claims analysis • Patient records and health history
Evidentiary Standards	• MCG guidelines • ASAM guidelines

	• Peer-reviewed medical literature

D. Identify the methods and analysis used in the development of the limitation(s); and

Concurrent review eligibility criteria analyses rely on the expert opinion of CareFirst's Chief Medical Officer, senior medical directors and the behavioral health medical director. All CareFirst M/S and MH/SUD policies in the CareFirst Medical Policy Reference Manual are developed based on the most recent peer review literature and are reviewed by CareFirst's chief medical officer, senior medical directors, and the behavioral health medical director. The criteria are not absolute but are designed to be used in conjunction with an assessment of the needs of the individual patient. All of CareFirst's medical and behavioral health policies are available on www.carefirst.com.

The criteria used for both M/S and MH/SUD are authorized by the CareFirst Criteria Review Committee. All criteria are reviewed annually and updated as needed to reflect current patterns of care. Input and suggestions are actively invited and sought from stakeholders, such as community physicians, primary care providers and behavioral health practitioners. CareFirst recognizes that standards of clinical practice may vary from region to region; therefore, criteria sets are adopted, reviewed, and modified as appropriate with the involvement and approval of practitioners. Utilization Management criteria are not absolute; the CareFirst Medical Director may consider the individual needs and circumstances of a member and make coverage decisions based on those additional considerations. CareFirst follows the same model of care and utilization management processes for both medical and behavioral health and substance use disorder services.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

A review of CareFirst’s written policies and processes reveals the comparable application of the Concurrent Review NQTL to M/S and MH/SUD services within the applicable benefit classifications. The Plan’s Concurrent Review policy development and application process is consistent between M/S and MH/SUD. CareFirst applies comparable evidence-based guidelines to define established standards of effective care for both M/S and MH/SUD benefits. Compliance is further demonstrated through the Plan’s uniform application of factors and evidentiary standards among M/S and MH/SUD services.

CareFirst conducts monthly Care Management audits to help ensure that medical necessity criteria are applied in a consistent and impartial manner. The Interrater Reliability Monitoring program is in place to evaluate the consistency with which Medical Director, Physician Reviewers apply Medical, Behavioral Health and Substance Use, Pharmacy, and Dental medical necessity criteria in decision making. Corrective action is initiated if an interrater score falls below 90%. A score of 90 – 100% is considered acceptable. If the results are below 90% the Senior Medical Director will evaluate the scores and decide whether to convene a review process with the Medical Directors/Physician Reviewers.

In 2021, the Inter-rater Reliability Score (IRR) was 100% for M/S and 100% for MH/SUD. In 2021, the RN Inter-rate Reliability Score (IRR) was 97.275 for M/S and 98.25 for MH/SUD. Outcomes support the consistent application of clinical criteria is no more stringent for MH/SUD, than for M/S.

In 2023, IRR scores were collected bi-annually and reported as 96.1% and 99.2% for physician reviewers. Nurse reviewer IRR scores for 2023 are 96.6% and 97.3%. Outcomes support the consistent application of clinical criteria is no more stringent for MH/SUD, than for M/S.

Additionally, there are no disparate outcomes of concern, between M/S and MH/SUD when evaluating all phases of utilization management including prior authorization, concurrent review and retrospective review as detailed within the respective sections below. Accordingly, CareFirst concludes that the application of Medical Necessity is no more stringent for MH/SUD benefits, than it is for M/S benefits, in operation.

4. Retrospective Review Process

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

Retrospective Review means utilization review of health care that has been provided to an enrollee.
Utilization review criteria are determined by the type of service, drug or device a provider seeks to be reimbursed as no member receiving services for any condition at any setting will or can be treated identically. Utilization Management does not apply any penalties for late or no Utilization request. These penalties would be applied by services/claims.
Retrospective Review criteria is applicable to both Med/Surg and MH/SUD benefits, classifications, and sub-classifications.

Retrospective Review applies to services that are subject to utilization management. Retrospective Review is a second chance to obtain authorization in cases where authorization was not approved prior to service. Retrospective Review is applied to the following benefit classifications: In-network Inpatient, Out-of-network Inpatient, In-network Outpatient, Out-of-network Outpatient.

B. Identify the factors used in the development of the limitation(s);
C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor 1	Variations in length of stay
Definition	The proposed length of stay should be similar to other stays with the same or similar diagnosis in the same or similar place of service. High levels of variations in length of stay that show patients stayed longer than the average stay or stays over 30 days may for the same or similar diagnosis may impact the determination of this factor.
Sources	• CMS • ASAM (SUD)
Evidentiary Standards	• MCG guidelines • ASAM guidelines

Threshold or Explanation	More than 30 days, appropriate intervals based on industry standards.
Factor 2	Standards of Care
Definition	To determine if the quality standards for the proposed treatment or service will be met, or whether further research may need to be done to validate. Deviations from generally accepted national quality standards for a specific diagnosis or disease category may also impact the determination as to this factor.
Sources	• CMS • ASAM (SUD)
Evidentiary Standards	• MCG guidelines • ASAM guidelines
Factor 3	Clinical efficacy and appropriateness of a proposed treatment or service
Definition	Clinical efficacy refers to achieving a desired treatment effect. The proposed treatment or service must be safe and effective for the diagnosis based upon the information provided about the patient's condition and the proposed treatment or service will provide the optimal clinical outcome for the diagnosis based upon the information provided about the patient's condition.
Sources	• CMS • ASAM (SUD) • Claims analysis • Patient records and health history
Evidentiary Standards	• MCG guidelines • ASAM guidelines • Peer-reviewed medical literature

D. Identify the methods and analysis used in the development of the limitation(s); and

Retrospective Review eligibility criteria analyses relies on the expert opinion of CareFirst's Chief Medical Officer, senior medical directors and the behavioral health medical director. All CareFirst M/S and MH/SUD policies in the CareFirst Medical Policy Reference Manual are developed based on the most recent peer review literature and are

reviewed by CareFirst's chief medical officer, senior medical directors, and the behavioral health medical director. The criteria are not absolute but are designed to be used in conjunction with an assessment of the needs of the individual patient. All of CareFirst's medical and behavioral health policies are available on www.carefirst.com.

The criteria used for both M/S and MH/SUD are authorized by the CareFirst Criteria Review Committee. All criteria are reviewed annually and updated as needed to reflect current patterns of care. Input and suggestions are actively invited and sought from stakeholders, such as community physicians, primary care providers and behavioral health practitioners. CareFirst recognizes that standards of clinical practice may vary from region to region; therefore, criteria sets are adopted, reviewed, and modified as appropriate with the involvement and approval of practitioners. Utilization Management criteria are not absolute; the CareFirst Medical Director may consider the individual needs and circumstances of a member and make coverage decisions based on those additional considerations. CareFirst follows the same model of care and utilization management processes for both medical and behavioral health and substance use disorder services.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

The process and strategies for retrospective reviews are the same for M/S services as for MH/SUD services that are subject to retrospective reviews. CareFirst has a standard operating procedure for retrospective reviews that applies to both MH/SUD services and M/S services. The written criteria and procedures are to ensure fair and consistent retrospective reviews and utilization decisions. The UM program is designed to monitor, evaluate, and manage the cost and quality of health care services delivered to our members. The program will ensure that services are medically necessary, are of high quality, and are delivered at the appropriate level of care/place of service. Retrospective Review is applicable to both M/S and MH/SUD services that require prior authorization or concurrent authorization.

CareFirst conducts monthly Care Management audits to help ensure that medical necessity criteria are applied in a consistent and impartial manner. The Interrater Reliability Monitoring program is in place to evaluate the consistency with which Medical Director, Physician Reviewers apply Medical, Behavioral Health and Substance Use, Pharmacy, and Dental medical necessity criteria in decision making. Corrective action is initiated if an interrater score falls below 90%. A score of 90 – 100% is considered acceptable. If the results are below 90% the Senior Medical Director

will evaluate the scores and decide whether to convene a review process with the Medical Directors/Physician Reviewers.

In 2021, the Inter-rater Reliability Score (IRR) was 100% for M/S and 100% for MH/SUD. In 2021, the RN Inter-rate Reliability Score (IRR) was 97.275 for M/S and 98.25 for MH/SUD. Outcomes support the consistent application of clinical criteria is no more stringent for MH/SUD, than for M/S.

In 2023, IRR scores were collected bi-annually and reported as 96.1% and 99.2% for physician reviewers. Nurse reviewer IRR scores for 2023 are 96.6% and 97.3%. Outcomes support the consistent application of clinical criteria is no more stringent for MH/SUD, than for M/S.

Additionally, there are no disparate outcomes of concern, between M/S and MH/SUD when evaluating all phases of utilization management including prior authorization, concurrent review and retrospective review as detailed within the respective sections below. Accordingly, CareFirst concludes that the application of Medical Necessity is no more stringent for MH/SUD benefits, than it is for M/S benefits, in operation.

5. Emergency Services

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

"Emergency Services" means the treatment of a medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the lack of immediate medical attention could reasonably be expected to result in placing the health of the patient, or, in case of pregnancy, the unborn child in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. ***(Source- COMAR 31.10.51)***

These standards only apply to Emergency Services.

B. Identify the factors used in the development of the limitation(s);
C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor 1	Serious jeopardy to the mental or physical health of the individual in the absence of immediate medical attention.
Definition	Whether without immediate medical attention based upon the individual's current mental and/or physical condition, the individual will suffer serious jeopardy to their mental or physical health. In the case of a pregnant woman, serious jeopardy to the health of the pregnant woman or the fetus in the absence of immediate medical attention.
Source	• State and Federal Regulation (Md. Code, Ins. §15-1A-14; §1867 of the Social Security Act)
Evidentiary Standards	• State and Federal regulatory guidelines
Factor 2	Danger of serious impairment of the individual's bodily functions in the absence of immediate medical attention
Definition	Whether without immediate medical attention based upon the individual's current mental and/or physical condition, the individual's bodily functions will be in danger of serious impairment.

Source	• State and Federal Regulation (Md. Code, Ins. §15-1A-14; §1867 of the Social Security Act)
Factor 3	Serious dysfunction of any of the individual's bodily organs or parts in the absence of immediate medical attention
Definition	Whether without immediate medical attention based upon the individual's current mental and/or physical condition, the individual's bodily organs or parts will suffer serious dysfunction.
Sources	• State and Federal Regulation (Md. Code, Ins. §15-1A-14; §1867 of the Social Security Act)
Evidentiary Standards	• State and Federal regulatory guidelines

D. Identify the methods and analysis used in the development of the limitation(s); and

Internal Medical Policies show that the factors, evidentiary standards, and processes with respect to MH/SUD and M/S benefits are comparable and no more stringently applied to MH/SUD benefits. The policies and procedures underlying CareFirst's emergency services do not contain any written differences for the evaluation process or factors for M/S emergency services as compared to MH/SUD emergency services. No authorization is necessary for emergency and stabilization services, and no utilization review is conducted on emergency room claims. *(Emergency Services Policy CO UM 102.00, pg. 2.)*

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

The process for determining emergency services is identical for M/S and MH/SUD as it follows state and federal regulatory guidelines.

6. <u>Pharmacy Services & Formulary Design</u>

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

"Prescription Drug Formulary Design" means a continually updated list of prescription drugs approved for reimbursement, including both generic and specialty drugs, and plan features that base reimbursement, cost-sharing, or authorization requirements on the formulary category into which a drug is placed.
CVS Caremark, as part of a prescription drug benefit plan offering, utilizes formulary tools including copay tiering and specialty drug classification, as well as pharmacy utilization management (UM) tools with accompanying UM criteria. These tools and coverage limitations are essential to optimizing patient outcomes, reducing waste and unnecessary drug use, while providing cost-effective prescription drug benefit coverage. CVS Caremark considers the following formulary and UM tools as the prescription drug benefit NQTL's most used in client plan offerings for both M/S and MH/SUD services:

- Copay tiering
- Specialty drug classification
- UM program: Prior Authorization (PA)
- UM program: Step Therapy (ST)
- UM program: Quantity Limits (QL)

Pharmacy services only apply to the prescription benefit classification.

All pharmacy benefits are administered by CVS Caremark.

B. Identify the factors used in the development of the limitation(s);

Formulary Copay Tiering	
Factors	The same factors are considered when establishing copay tier designation for drugs used in MH/SUD conditions as for drugs used in M/S conditions: • Brand or generic status of the drug • Impact of generic drugs or drugs designated to become available over the counter • Brand and generic pipeline • Line of business

	• Drug labeling approved by the U.S. Food and Drug Administration (FDA) • Availability of therapeutic alternatives • Utilization trends • Plan sponsor cost • Applicable manufacturer agreement • Potential impact on members
Specialty Drug Designation	
Factors	The same factors are considered when applying specialty drug designation for drugs used in MH/SUD conditions as for drugs used in M/S conditions: • Pharmaceuticals, biotech, or biological drugs that are dispensed from a specialty pharmacy • Used in the management of chronic, complex, rare, or genetic diseases • Route of administration may be injectable, infused, inhaled, oral • May require unique handling, distribution and/or administration • Require clinical management to optimize safety and adherence • May have an FDA-mandated risk evaluation and mitigation strategies (REMS) drug safety programs or Black Box Warning • Monthly prescription costs typically greater than $600
Pharmacy Prior Authorization (PA)	
Factors	The same factors are considered when establishing pharmacy PA for drugs used in MH/SUD conditions as for drugs used in M /S conditions: • Patient safety concerns exist with a drug or drug class, unknown long-term safety or durability • Applicable lab values or other test results required for appropriate treatment • Appropriate medication uses for indications or conditions based on national guidelines • Use in appropriate patient populations

	• Use limited to a specific population based on FDA-approved indications, standard clinical practice, and guidelines • Potential for inappropriate or off-label use • Opportunity for optimizing patient outcomes, to ensure treatment goals of the drug are being met • Requirement for additional treatment supportive therapies, including but not limited to behavioral counseling, diet therapy, case management, and other standard non-drug supportive therapies • Reduce waste, unnecessary drug use, fraud, or abuse
Pharmacy Step Therapy (ST)	
Factors	The same factors are considered when establishing ST for drugs used in MH/SUD conditions as for drugs used in M/S conditions: • Promote the use of the most cost-effective products in the therapeutic class; promote generics and/or lower cost brands • Clinical safety and adverse events based on FDA approved labeling, national clinical guideline recommendations, and other evidentiary standards • Clinical efficacy, based on FDA approved labeling, national clinical guideline recommendations and other evidentiary standards • Multiple dosage forms available for the same or similar chemical entities, or availability of unique dosage forms • Availability of therapeutic alternatives, including generics, used to treat the same condition
Pharmacy Quantity Limits (QL)	
Factors	The same factors are considered when establishing pharmacy QL for drugs used in MH/SUD conditions as for drugs used in M/S conditions: • Enhance patient safety • Potential for a drug to be prescribed in greater quantities and/or at a higher dose than deemed safe and effective by the FDA • To promote appropriate drug dosing, including strength and frequency • To prevent overutilization

	• When abuse or misuse by the patient is possible • For opioids and narcotics, when appropriate dosing and appropriate duration of use is based on treatment for acute or chronic pain • Cost and cost effectiveness • Prevention of overutilization • Discouragement of misuse and waste through dose efficiency QLs, which ensure that the appropriate tablet strength is utilized • Lack of documented efficacy/unknown efficacy at higher doses • Discourage misuse, waste, and abuse • Maximum daily dosing or maximum duration of use limits

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Formulary Copay Tiering	
Factors with specific definition/evidentiary standards	The same factors and evidentiary standards are considered when establishing copay tier designation for drugs used in MH/SUD conditions as for drugs used in M/S conditions: • Brand or generic status of the drug, as defined by FDA product labeling • Impact of generic drugs or drugs designated to become available over the counter • Recognized drug compendia • Consensus documents and nationally sanctioned guidelines • Publications of the National Institutes of Health (NIH), Agency for Healthcare Research and Quality (AHRQ), and other organizations or government agencies • Evidence-based reviews of peer-reviewed medical literature and relevant clinical information • Standards of care recommended by clinical literature, medical or pharmacy societies, standard clinical drug references

	• Appropriate clinical drug information from other sources as applicable • Input from physicians practicing in the relevant clinical area • Review and approvals (at least annually) of formulary drug list content by external clinical experts and CVS Caremark National Pharmacy & Therapeutics Committee (P&T Committee) members • Brand and generic pipeline • Line of business • Drug labeling approved by the U.S. Food and Drug Administration (FDA) • Potential impact on members and availability of therapeutic alternatives as understood by standards of care recommended by clinical literature, medical or pharmacy societies, standard clinical drug references • Utilization trends as understood by evidence- based reviews of peer-reviewed medical literature and relevant clinical information • Applicable manufacturer agreement • Plan sponsor cost
Specialty Drug Designation	
Factors with specific definition/evidentiary standards	The same factors and evidentiary standards are considered when applying specialty drug designation for drugs used in MH/SUD conditions as for drugs used in M/S conditions: • Pharmaceuticals, biotech, or biological drugs that are dispensed from a specialty pharmacy as indicated from approved drug compendia and FDA drug labeling • Used in management of chronic, complex, rare, or genetic diseases as defined in accepted clinical practice guidelines, consensus statements, or comparable publications • Route of administration may be injectable, infused, inhaled, oral according to published peer-review clinical literature and standards of care noted in clinical literature, medical or pharmacy societies, standard clinical drug references • May require unique handling, distribution and/or administration depending on standards of care noted in clinical literature, medical or pharmacy societies, standard clinical drug references

	• Require clinical management to optimize safety and adherence by conducting comparison of similar drugs in terms of safety and efficacy • May have an FDA-mandated risk evaluation and mitigation strategies (REMS) drug safety programs or Black Box Warning • Monthly prescription costs • Review by the Pharmacy Pharmaceutical Technology Evaluation Committee (PTEC)
Pharmacy Prior Authorization (PA)	
Factors with specific definition/evidentiary standards	The same factors and evidentiary standards are considered when establishing pharmacy PA for drugs used in MH/SUD conditions as for drugs used in M/S conditions: • Patient safety concerns exist with a drug or drug class, unknown long-term safety, or durability. This is evaluated by reviewing approved drug compendia and published peer-review clinical literature • Applicable lab values or other test results required for appropriate treatment by following accepted clinical practice guidelines, consensus statements, or comparable publications • Appropriate medication uses for indications or conditions based on national guidelines • Use in appropriate patient populations as defined in accepted clinical practice guidelines, consensus statements, or comparable publications • Use limited to a specific population based on FDA-approved indications, standard clinical practice, and guidelines • Potential for inappropriate or off-label use is addressed by reviewing FDA product labeling and validating against approved drug compendia • Opportunity for optimizing patient outcomes, to ensure treatment goals of the drug are being met. This is done by conducting annual review of UM criteria and clinical programs by internal pharmacists in the Clinical Development department and medical directors in the Medical Affairs department. Review and update of UM criteria is also conducted by external clinical experts, who are physicians practicing in the relevant clinical area.

	• Requirement for additional treatment supportive therapies, including but not limited to behavioral counseling, diet therapy, case management, and other standard non-drug supportive therapies • Reduce waste, unnecessary drug use, fraud, or abuse by tasking CVS Caremark National P&T Committee with reviewing and approving any new prior auth coverage criteria for clinical appropriateness
Pharmacy Step Therapy (ST)	
Factors with specific definition/evidentiary standards	The same factors and evidentiary standards are considered when establishing ST for drugs used in MH/SUD conditions as for drugs used in M/S conditions: • Promote the use of the most cost-effective products in the therapeutic class; promote generics and/or lower cost brands, by reviewing approved drug compendia, conducting comparison of similar drugs in terms of safety and efficacy and referencing accepted clinical practice guidelines, consensus statements, or comparable publications • Clinical safety. efficacy and adverse events based on FDA approved labeling, national clinical guideline recommendations, and comparative review of similar drugs • Multiple dosage forms available for the same or similar chemical entities, or availability of unique dosage forms. • Conduct an annual review of UM criteria and clinical programs by internal pharmacists in the Clinical Development department and medical directors in the Medical Affairs department. Review and update of UM criteria is also conducted by external clinical experts, who are physicians practicing in the relevant clinical area. • Availability of therapeutic alternatives, including generics, used to treat the same condition depending on accepted clinical practice guidelines, clinical peer-review and defined standards of care • Review and approval of coverage criteria for clinical appropriateness by the CVS Caremark National P&T Committee

Pharmacy Quantity Limits (QL)

Factors with specific definition/evidentiary standards	The same factors are considered when establishing pharmacy QL for drugs used in MH/SUD conditions as for drugs used in M/S conditions: • Enhance patient safety by following FDA product labeling, reviewing approved drug compendia and published peer-review clinical literature, and following accepted clinical practice guidelines and standards of care • Potential for a drug to be prescribed in greater quantities and/or at a higher dose than deemed safe and effective by the FDA • To promote appropriate drug dosing, including strength and frequency • To prevent overutilization • When abuse or misuse by the patient is possible • For opioids and narcotics, when appropriate dosing and appropriate duration of use is based on treatment for acute or chronic pain • Cost and cost effectiveness by reviewing approved drug compendia, conducting comparison of similar drugs in terms of safety and efficacy and referencing accepted clinical practice guidelines, consensus statements, or comparable publications • Prevention of overutilization • Discouragement of misuse and waste through dose efficiency QLs, which ensure that the appropriate tablet strength is utilized • Lack of documented efficacy/unknown efficacy at higher doses • Discourage misuse, waste, and abuse by tasking CVS Caremark National P&T Committee with regularly reviewing and approving any new prior auth coverage criteria for clinical appropriateness • Maximum daily dosing or maximum duration of use limits

D. Identify the methods and analysis used in the development of the limitation(s); and

The CVS Caremark National Pharmacy and Therapeutics Committee (P&T Committee) is an external advisory body of experts from across the United States, composed of 22 independent health care professionals including 18 physicians and four pharmacists, all of whom have broad clinical backgrounds and/or academic expertise regarding

prescription drugs. Most of the P&T Committee members are actively practicing pharmacists and physicians. Two physicians and two pharmacists are experts in the care of the elderly or disabled. One of the physicians is a medical ethicist. The role of the medical ethicist is to assist in the decision-making process by facilitating the discussion, as needed, and to provide unbiased feedback with respect to the logic and appropriateness of the conclusions drawn and the decisions reached.

The P&T Committee external membership includes experts from across the country composed of:

- Four clinical pharmacists, including: an academic pharmacist, a hospital pharmacist, and two geriatric pharmacists, and
- 18 physicians who have broad clinical background and/or academic expertise with prescription drugs, including the following specialties - Allergy Cardiology, Clinical Pharmacology, Endocrinology, Family practice, Gastroenterology, Gerontology, Hematology/Oncology, Internal Medicine, Infectious Disease, Pediatrics, Neurology, Medical Ethics, Pharmacoeconomics, Pharmacology, Psychiatry (adult/pediatric/adolescent), Rheumatology.

The regular voting members on the P&T Committee are not employees of CVS Caremark. The P&T Committee is charged with reviewing all drugs, including generics that are represented on the CVS Caremark approved drug lists. The approvals made are non-biased, quality driven and evidence based. The clinical merit of the drug, not the cost, is the primary consideration of the P&T Committee.

Members are included on the current P&T Committee based on active involvement in clinical practice (patient care), whether in the academic, hospital or community setting; national recognition in their specialty; contributions to medical and/or pharmacy literature; and previous experience with pharmacy and therapeutics committees.

The P&T Committee bases decisions on scientific evidence, standards of practice, peer-reviewed medical literature, accepted clinical practice guidelines and other appropriate information. The P&T Committee reviews medications from a clinical perspective; it does not have access to, nor does it consider any information on rebates, negotiated discounts or net costs. In alignment with this clinical perspective, the P&T Committee also reviews new drug evaluations, new FDA-approved indications, new clinical line extensions and publications on new clinical practice trends. The P&T Committee ensures that each Formulary provides appropriate access to drugs that are included in broadly accepted treatment guidelines and are indicative of general best practices and ensures that each Formulary does not discourage enrollment by any group of enrollees by reviewing appropriateness of coverage for a range of

disease states and utilization management tools. The P&T Committee ensures that drugs for the treatment of mental health conditions and substance use disorders are not managed more restrictively than drugs for other disease states from a Formulary and Utilization Management perspective.

In evaluating new drugs for formulary inclusion, the P&T Committee reviews the individual drug monographs, pivotal clinical trials accompanying the drug monographs, and therapeutic class reviews prepared by the Clinical Formulary Department. P&T Committee members share insights based on their clinical practice and the quality of published literature. FDA-approved drug products are reviewed and considered for inclusion on standard formularies/drug lists by the P&T Committee. The P&T Committee also reviews and approves all utilization management (UM) criteria (i.e., prior authorization, step therapy and quantity limits outside of FDA-approved labeling).

The P&T Committee reviews all standard formularies annually. The review is conducted by drug class to assure that the formulary recommendations previously established are maintained and to recommend additional changes for clinical appropriateness if advisable based on newly available pharmaceutical information. In addition, the P&T Committee reviews all UM criteria annually.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Review of comparative analysis performed by CVS suggests that all pharmacy NQTLs are applied consistently across all drugs and drug classes and do not discriminate against individuals based on M/S condition, MH/SUD diagnosis, or other health conditions. Any pharmacy coverage factors, sources or evidentiary standards, processes and development or implementation strategies applied to drugs used to treat MH/SUD are comparable to and are applied no more stringently than the coverage factors, sources or evidentiary standards, processes and development or implementation strategies used in applying the limitations to drugs used to treat M/S conditions.

Review of comparative Rx data analysis performed by CVS Caremark suggests the following:

- When the factors for formulary copay tier designation are considered consistently across all drugs and drug classes, the outcome shows that the MH and SUD categories have either a higher or a similar percentage of

drugs covered at preferred copay tiers compared to the MED/SURG category. There are fewer drugs designated as a Specialty drug in the MH and SUD categories compared to the MED/SURG category.

- When the factors for pharmacy prior authorization are considered consistently across all drugs and drug classes, the outcome shows that the NQTL of prior authorization is applied to a varying percentage of drugs across all three categories. Outcome of Step Therapy analysis shows that when the factors for step therapy are considered consistently across all drugs and drug classes, the outcome shows that the NQTL is applied to a varying percentage of drugs across all three categories.
- Similarly, outcome of Quantity Limits shows that when the factors for quantity limits are considered consistently across all drugs and drug classes, the outcome shows that the NQTL is applied to a varying percentage of drugs across all three categories.

7. Prescription Drug Formulary Design

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;
See above Pharmacy Services & Formulary Design

B. Identify the factors used in the development of the limitation(s);
See above Pharmacy Services & Formulary Design

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;
See above Pharmacy Services & Formulary Design

D. Identify the methods and analysis used in the development of the limitation(s); and
See above Pharmacy Services & Formulary Design

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.
See above Pharmacy Services & Formulary Design

8. Case Management

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

Case Management services are optional, not required.

"Case management" means a program to assist a member in accessing necessary medical, substance use disorder, or mental health services, and may include:

- Coordinating access to care.
- Exploring service and funding source alternatives.
- Monitoring progress to established goals (set by a case manager and the patient).
- Assisting with coordinating discharge planning and follow-up.
- Helping ensure the patient's benefits are used effectively.

Care Support Programs – CareFirst offers health care programs designed to promote the collaborative process of assessment, planning, and facilitation, and advocacy for options and services to meet a Qualified Individual's health needs through communication and available resources to promote quality cost- effective outcomes. These programs are available to Qualified Individuals to manage the care of certain complex chronic or high-risk acute diseases. These programs include but are not limited to:

- Care coordination
- Case management
- Condition specific support
- Informed decision-making support
- Disease management
- Lifestyle coaching, and health promotion programs

Patient-Centered Medical Home Program (PCMH)- CareFirst utilizes the Care Management Core Target methodology for initiation of care management services all PCMH patients. As part of this program, medical and associated services directed by the PCMH team of medical professionals, assist with fostering the health care provider's partnership with a Qualifying Individual and, where appropriate, the Qualifying Individual's primary

caregiver. The program helps coordinate ongoing, comprehensive health care services for a Qualifying Individual. Medical information is exchanged with CareFirst BlueChoice, other providers, and Qualifying Individuals to create better access to health care, increase satisfaction with medical care, and improve the health of the Qualifying Individual. The program includes:

- Assess the Qualifying Individual's medical needs
- Provide liaison services between the Qualifying Individual and the health care provider(s) and the Care Management Team
- Create and supervise the Care Plan
- Educate the Qualifying Individual and family regarding the Qualifying Individual's disease and self-care techniques
- Arrange for consultations with Specialists and other Medically Necessary supplies and services, including community resources, for the Member
- Assess treatment compliance

The Substance Use Disorder Program This program is available to qualified CareFirst members with a diagnosed substance use disorder. Treatment is rendered through an intensive outpatient program (IOP) or an outpatient program at a Designated Provider as determined by CareFirst BlueChoice. The program includes:

- Ambulatory/outpatient detoxification
- Individual therapy
- Group therapy
- Medication Assisted Treatment

CareFirst's Care Management Program includes specialized case management for members whose condition triggers the need for interventions and care coordination based on meeting certain criteria, provider referral, or member request. The Care Management Program encompasses members with medical/surgical and/or mental health/substance use disorder conditions.

Members are identified for potential Care Management services through various points of entry and resources. CareFirst utilizes a risk and stratification process to identify members who are at risk for a breakdown in health status, emergency room visits, hospital admissions and/or readmissions. Members may also be identified for services from CareFirst clinical programs, accounts, member self-referrals, caregivers, facility discharge planners and providers. Care Management takes an interdisciplinary team approach to identify both clinical and non-clinical

interventions to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves a comprehensive assessment of the member's condition, determination of available benefits and resources, and development and implementation of a care plan with performance goals (monitoring and follow-up). An integral part of the care management process includes creating a member self-management plan, medication reconciliation, and referrals to other clinical programs with both internal and external partners. The care managers work with the members and their family, when appropriate, to coordinate access to care, provide education and appropriate resources, which empowers them to independently manage their health care needs. Interventions, services, and resources may include, but are not limited to:

- Assessing the member's functional capability
- Place of service review
- Review of Social Determinants to Health

The care managers provide individualized and holistic care coordination to address identified needs. This may include, but is not limited to:

- Arranging appointments
- Linkage to transportation resources
- Referrals to community resources

Case Management process for MS and MH/SUD is as follows:
Eligibility Determination: Determination of eligibility and acceptance into MS and MH/SUD Care Management programs is made through professional consideration and objective data using the following guidelines: Member must agree to participate and comply with all elements in any given Care Support Program. (***Source- Plan doc, Section F, Care Support Programs)***

- Member has an active CareFirst policy with the Case Management benefit
- Member has a diagnosis which indicates that he/she may benefit from coordination of care to assist them to gain optimal recovery and/or manage their health care independently.
- Psychosocial issues present that prevent or impede appropriate access to care which could potentially be alleviated by intervention from a Care Manager
- Member requires health education or monitoring to transition to self-care or independence

Assignment, Assessment and Engagement:

- All cases referred to Case Management are assigned to the appropriate care manager.

- Upon identification of a potential candidate, MS and MD/SUD care managers determine member needs and ability to benefit from Care Management services based on the review of the information provided by the referral source and other medical or clinical information available in CareFirst system
- Care Managers are required to reach out to the member telephonically, for introductions and explain the purpose of the call.
- Upon member engagement, care managers are required to have a minimum of two successful calls per month or as indicated to resolve issues, address needs, and assist the member towards self-management.
- Care Manager are required to make 3 attempts within 2 weeks to establish contact with the member, after which CareFirst mails a letter to the member requesting a return call.

Case Closure: Case management case is closed when the member achieves the established goals for the Plan of Care goals, and it is determined that CM interventions and/or services are no longer required. Members are referred to other support programs upon case closure for continued support as deemed appropriate.

B. Identify the factors used in the development of the limitation(s);
C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor 1	High risk for breakdown in health status
Definition	For a single high-risk disease, with the following required elements: • One complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death. • Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient. • Whether a member has a high risk for breakdown of health status due to an adverse event or negative health consequence related to member's existing disease/condition.
Sources	• Member's medical history • CareFirst risk and stratification process (CareFirst utilizes a risk and stratification process to identify members who are at risk for a breakdown in health status, emergency room visits, hospital admissions and/or readmissions.) • CMS

Evidentiary Standards	• CMS chronic care management guidelines
Threshold or explanation	• One complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/ decompensation, functional decline, or death. • Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient. • Whether a member has a high risk for breakdown of health status due to an adverse event or negative health consequence related to member's existing disease/condition.
Factor 2	Hospital admissions and/or readmissions
Definition	Whether the total count of member hospital admissions and/or readmissions within 30 days of being discharged from a previous hospital stay.
Sources	• Member's medical history • CareFirst risk and stratification process (CareFirst utilizes a risk and stratification process to identify members who are at risk for a breakdown in health status, emergency room visits, hospital admissions and/or readmissions.) • CMS
Evidentiary Standards	• CMS chronic care management guidelines
Threshold or Explanation	Standard benchmark used by CMS is the 30-day readmission rate, which is the benchmark utilized by CareFirst.
Factor 3	Emergency room visits
Definition	Whether the total count of member emergency room visits warrants case management.
Sources	• Member's medical history • CareFirst risk and stratification process (CareFirst utilizes a risk and stratification process to identify members who are at risk for a breakdown in health status, emergency room visits, hospital admissions and/or readmissions.) • CMS

Evidentiary Standards	• CMS chronic care management guidelines
Threshold or Explanation	More than 4 ER visits in the past 6 months.
Factor 4	Diagnosis indicators
Definition	Diagnosis indicating the need for coordination of care to assist members gain optimal recovery and/or manage their health care needs independently. Whether the medical diagnosis from the Physician indicates the need for case management services.
Sources	• Member's medical history • Physician diagnosis/referral
Evidentiary Standards	• Identification and stratification measures and tools • Clinical severity of diagnosis
Factor 5	Presence of psychosocial issues that prevent or impede appropriate access to care.
Definition	Presence of psychosocial issues that prevent or impede appropriate access to care: • Questions asked during Care Manager assessment include: how much of the following applies: drinking alcohol, smoking, recreational drugs; depression screening, any recent anxiety and/or behavior changes. • Whether it is determined that psychosocial issues may be preventing appropriate access to care and optimization of a health outcome like financial difficulties, loss of job, divorce, grief/loss issues etc.
Sources	• Physician's referral • Member's medical history • Care Manager assessment • CareFirst policy
Evidentiary Standards	As a certified case management organization, this is standard protocol for criteria to trigger the option for case management. Criteria is the same for M/S and MH/SUD.
Factor 6	Members requiring health education or monitoring to help them transition to self-care or independence

Definition	Whether it is determined that a member needs health education or monitoring to optimize the outcome of their health condition.
Sources	• Member's medical history • Care Manager assessment
Evidentiary Standards	As a certified case management organization, this is standard protocol for criteria to trigger the option for case management. Criteria is the same for M/S and MH/SUD.
Factor 7	Members requiring assistance
Definition	Members requiring assistance with arranging appointments, transportation, or referrals to available community resources. It is determined that the deliberate organization of patient care activities such as arranging appointments, transportation, referrals to community resources will facilitate the appropriate delivery of healthcare services.
Sources	• Member's medical history • Care Manager assessment
Threshold or Explanation	There is no threshold here, the criteria is the same for M/S and MH/SUD.
Factor 8	Members indicating presence of social determinants to health
Definition	Members indicating presence of social determinants to health: • Social determinants of health can cause challenges for members, which may vary widely based on the area in which they live. This contributes to variations in health by region and in each of the areas we serve, with different geographic areas presenting different challenges. Chronic issues such as lack of access to healthy food, poverty, poor housing, and lack of access to medical care all contribute to reduced health outcomes. • Care Manager's assessment would include asking about the member's current housing situation; social support, transportation, financial considerations, food security and access to meet dietary needs, job occupation/security, and any hazards they may be exposed to. • Whether social determinants of health may be preventing a member from optimizing recovery and/or manage their health care needs independently.

Sources	• Member's medical history • Care Manager assessment
Evidentiary Standards	• Care Plan Development Policy • CareFirst Provider Manual
Factor 9	Medical non-compliance
Definition	Medications and appointments non-compliance: • Whether the patient actively decides not to use the medications and keep up appointments or follow treatment recommendations due to adverse side effects, complex medication schedules, lack of symptoms, forgetfulness, fear/worry, misunderstanding or presence of mental health issues, and/or denial of current M/S or MH/SUD health condition.
Sources	• Member's medical history
Evidentiary Standards	As a certified case management organization, this is standard protocol for criteria to trigger the option for case management. Criteria is the same for M/S and MH/SUD.

D. Identify the methods and analysis used in the development of the limitation(s); and

CareFirst's Care Management Program includes specialized case management for members whose condition triggers the need for interventions and care coordination based on meeting certain criteria, provider referral, or member request. The Care Management Program encompasses members with medical/surgical and/or mental health/substance use disorder conditions.

CareFirst utilizes a risk and stratification process to identify members who are at risk for a breakdown in health status, emergency room visits, hospital admissions and/or readmissions. Members may also be identified for services from CareFirst clinical programs, accounts, member self-referrals, caregivers, facility discharge planners and providers.

CareFirst ID/Strat Predictive Composite Score: Since 2022, CareFirst uses predictive modeling to identify potential candidates for its care coordination programs, including case management. CareFirst has developed a predictive

identification and stratification algorithm that incorporates industry standard medical and pharmacy Prospective Risk scores, Episode Grouper, and social determinants of health (SDOH). The care management programs that are currently supported by the ID/Strat composite score include: Behavioral Health Complex Care Management, Complex Care Management, Oncology, HIV/AIDS, and Pediatrics. *Care Management Core Target methodology* is used by CareFirst for initiation of care management services all PCMH patients. To identify members in need of medical care plans, CareFirst uses the Core Target criteria; Core Target 1, Core Target 2, and Core Target 3.

- Core Target 1 (CT1) identifies through specific criteria and is characterized as having high costs, high hospital utilization, and health instability. (See Medical Core Target (CT1) Criteria)
- Core Target 2 (CT2) identifies as members who do not yet meet the criteria for inclusion in Core Target 1 but have been identified by the PCP, in collaboration with the LCC, as needing Care Coordination.
- Core Target 3 (CT3) identifies as members who have been an IBS>=6, identified through other means, having a potential to be included in CT1. IBS (Illness Burden Score) in the above-mentioned chart is the score for each member and is based on the Member's unique claims history using the trailing 12 months of claims experience. This score shows the relative current illness level of the Member and helps identify Members that are most likely to have high future costs.

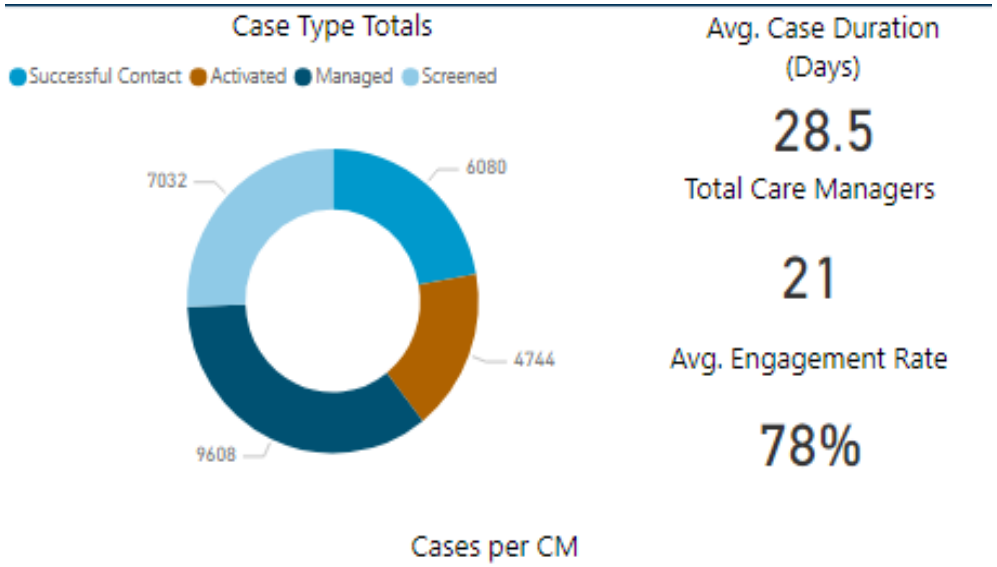
CareFirst follows the MCG Guidelines 25th edition, for Behavioral Health, The American Society of Addiction Medicine (ASAM) criteria, Case Management Society of America's (CMSA) protocols and CareFirst Medical Policy Reference Manual to provide case management services to qualified individuals.

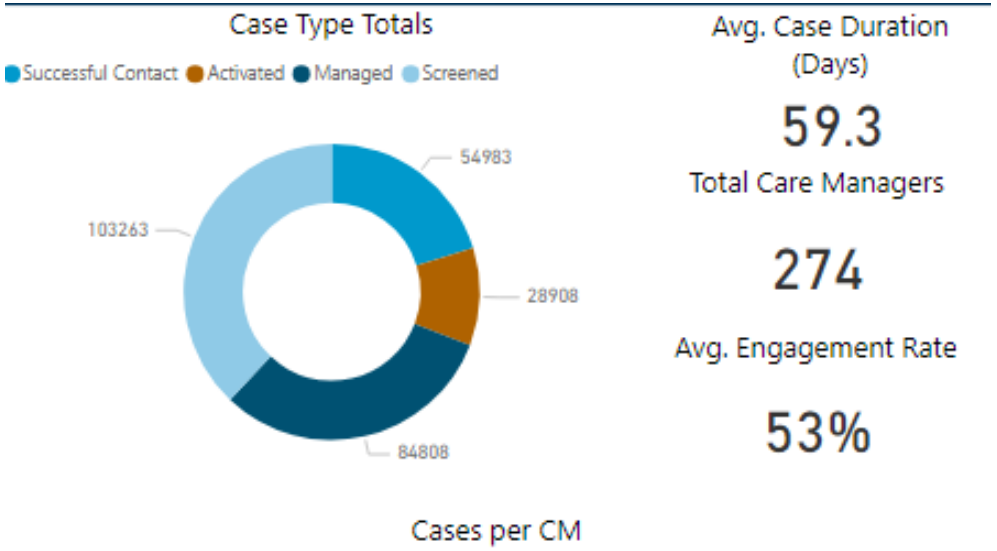
E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

CareFirst follows the MCG Guidelines 25th edition, for Behavioral Health, The American Society of Addiction Medicine (ASAM) criteria, Case Management Society of America's (CMSA) protocols and CareFirst Medical Policy Reference Manual to provide case management services to qualified individuals.
Additionally, to ensure comparable design, development and application, M/S and MH/SUD care managers conduct Care Management QI reviews. CM care plans are reviewed for adherence to departmental guidelines and benefit administration. CareFirst's quality team conducts quarterly file review audits of care management cases, including MH/SUD and M/S. A sample of cases is selected at random and reviewed for compliance with specific criteria. For each case, there is a review of specific criteria for the Initial Assessment and the Ongoing Management.

The data below for the year **2023** shows the total number of CareFirst case management cases for M/S and MH/SUD.

MHPAEA Summary Form





9. Process for Assessment of New Technologies

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

"Process for Assessment of New Technology" means a systematic, scientific process to follow for evaluating medical and surgical treatments and mental health and substance use treatment in order to ensure that members under the carrier's health benefit plan have access to appropriate treatments not previously covered by the carrier.
As stated in Medical Policy Reference Manual (MPRM) Policy Number 0.00.001, the term "experimental/investigational" is described as services or supplies that are in the developmental stage and are in the process of human or animal testing.
According to the plan document, Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

- The Technology* must have final approval from the appropriate government regulatory bodies
- The scientific evidence must permit conclusions concerning the effect of the Technology on health outcomes
- The Technology must improve the net health outcome
- The Technology must be as beneficial as any established alternatives
- The improvement must be attainable outside the Investigational settings

*Technology includes drugs, devices, processes, systems, or techniques.

To determine if the new or emerging technology is medically appropriate or efficacious/effective for the individual or the desired population or if the new technology is an appropriately managed investigational treatment the BlueCross BlueShield Technology Evaluation Center and the five-factor criterion is applied.

Process for Assessment of New Technologies criteria is applicable to both Med/Surg and MH/SUD benefits, classifications, and sub-classifications. Assessment of New Technologies applies to the following benefit classifications: In-network Inpatient, Out-of-network Inpatient, In-network Outpatient, Out-of-network Outpatient, and Prescription Drugs.

B. Identify the factors used in the development of the limitation(s);

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor 1	Final approval
Definition	The technology must have final approval from the appropriate U.S. government regulatory bodies.
Sources	• FDA • Medical Specialty Societies • American Medical Association (AMA) • American Hospital Association (AHA) • American Psychiatric Association • American Psychological Association • National Institute of Mental Health • Anxiety Disorders Association of America • Substance Abuse and Mental Health Services Administration (SAMHSA)

Evidentiary Standards	• FDA approval
	• Information from appropriate medical association such as:
	  o Medical Specialty Societies
	  o American Medical Association (AMA)
	  o American Hospital Association (AHA)
	  o American Psychiatric Association
	  o American Psychological Association
	  o National Institute of Mental Health
	  o Anxiety Disorders Association of America
	  o Substance Abuse and Mental Health Services Administration (SAMHSA)

Factor 2	Proven effectiveness
Definition	The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes

Sources	• Data and results from resources such as:
	  o Hayes Technology Inc.
	  o Cochrane Library
	  o Centers for Medicare & Medicaid Services

	○ National Institute of Health U.S. National Library of Medicine • CMS • National Institute of Health (NIH) • National Cancer Institute (NCI) • Centers for Disease Control (CDC) • The Agency for Healthcare Research and Quality (AHRQ) • Information from appropriate medical association such as: ○ Medical Specialty Societies ○ American Medical Association (AMA) ○ American Hospital Association (AHA) ○ American Psychiatric Association ○ American Psychological Association ○ National Institute of Mental Health ○ Anxiety Disorders Association of America ○ Substance Abuse and Mental Health Services Administration (SAMHSA)
Evidentiary Standards	• Peer-reviewed medical literature • Expert review • Professional opinions
Factor 3	Improve net health outcome
Definition	The technology must improve the net health outcome.
Sources	• Data and results from resources such as: ○ Hayes Technology Inc. ○ Cochrane Library ○ Centers for Medicare & Medicaid Services ○ National Institute of Health U.S. National Library of Medicine • CMS • National Institute of Health (NIH) • National Cancer Institute (NCI) • Centers for Disease Control (CDC) • The Agency for Healthcare Research and Quality (AHRQ)

	• Information from appropriate medical association such as:
	  o Medical Specialty Societies
	  o American Medical Association (AMA)
	  o American Hospital Association (AHA)
	  o American Psychiatric Association
	  o American Psychological Association
	  o National Institute of Mental Health
	  o Anxiety Disorders Association of America
	  o Substance Abuse and Mental Health Services Administration (SAMHSA)
	• Technology Assessment Organizations are considered including:
	  o ECRI
	  o Hayes Technology, Inc.
	  o CTAF/ICER

Evidentiary Standards	• Peer-reviewed medical literature • Expert review • Professional opinions • Recommendations from technology assessment organizations
Factor 4	As beneficial as alternatives
Definition	The technology must be as beneficial as any established alternatives

Sources	• Data and results from resources such as:
	  o Hayes Technology Inc.
	  o Cochrane Library
	  o Centers for Medicare & Medicaid Services
	  o National Institute of Health U.S. National Library of Medicine
	• CMS
	• National Institute of Health (NIH)
	• National Cancer Institute (NCI)
	• Centers for Disease Control (CDC)
	• The Agency for Healthcare Research and Quality (AHRQ)
	• Information from appropriate medical association such as:

	○ Medical Specialty Societies ○ American Medical Association (AMA) ○ American Hospital Association (AHA) ○ American Psychiatric Association ○ American Psychological Association ○ National Institute of Mental Health ○ Anxiety Disorders Association of America ○ Substance Abuse and Mental Health Services Administration (SAMHSA) • Technology Assessment Organizations are considered including: ○ ECRI ○ Hayes Technology, Inc. ○ CTAF/ICER
Evidentiary Standards	• Peer-reviewed medical literature • Expert review • Professional opinions • Recommendations from technology assessment organizations
Factor 5	Outside investigational settings
Definition	The improvement must be attainable outside the investigational settings.
Sources	• Data and results from resources such as: ○ Hayes Technology Inc. ○ Cochrane Library ○ Centers for Medicare & Medicaid Services ○ National Institute of Health U.S. National Library of Medicine • CMS • National Institute of Health (NIH) • National Cancer Institute (NCI) • Centers for Disease Control (CDC) • The Agency for Healthcare Research and Quality (AHRQ) • Information from appropriate medical association such as: ○ Medical Specialty Societies ○ American Medical Association (AMA)

	○ American Hospital Association (AHA) ○ American Psychiatric Association ○ American Psychological Association ○ National Institute of Mental Health ○ Anxiety Disorders Association of America ○ Substance Abuse and Mental Health Services Administration (SAMHSA) • Technology Assessment Organizations are considered including: ○ ECRI ○ Hayes Technology, Inc. ○ CTAF/ICER
Evidentiary Standards	• Peer-reviewed medical literature • Expert review • Professional opinions • Recommendations from technology assessment organizations

D. Identify the methods and analysis used in the development of the limitation(s); and

Technology assessment is the method by which new, emerging, or current technologies are thoroughly researched and evaluated. The Technology Assessment Committee (TAC) provides a forum in which evidence is evaluated to determine whether a procedure, technique, drug, or device will be covered. The BlueCross BlueShield Association Technology Evaluation Center criteria was created in 1985 by the Technology Assessment Group and was developed using a tournament style of progression; all five criteria must be met, and the evidence must be sufficient for a service to be considered medically necessary. The criteria is reviewed and approved annually by the BlueCross BlueShield Medical Policy Panel. This panel consists of healthcare professionals with medical degrees, doctorate level degrees, research scientists, and master level therapists. The BlueCross BlueShield Medical Policy Panel considers physician specialty society recommendations, the view of prudent medical practitioners practicing in relevant clinical areas, government agencies (such as the FDA), and any other relevant factors in the assessment of new and emerging technology and the development of medical policies.

On behalf of CareFirst, AIM manages the utilization management process for genetic tests used to assess medical, mental health, and substance use disorder. The fundamental framework for reviewing genetic tests does not vary by

the disease category, although the guidelines themselves may be organized by certain categories. To ensure comparability, the team maintains a comprehensive database of content related to genetic disease and genetic testing technology. All guidelines are formally updated semi-annually, with off-cycle revisions to coverage criteria triggered by publication of new literature, professional society guidelines and supporting evidence. Subject matter experts perform quarterly research scoping to identify new evidence for review and incorporation into the published guidelines. Because the division is also reviewing preauthorization requests in real time, AIM is tuned to clinician ordering patterns and has visibility into potential areas of abuse. Additionally, transparent, and accessible mechanisms are in place for subject matter experts to receive and evaluate feedback from clinical providers and laboratories. Finally, editorial safeguards are in place to reduce the need for updates at market adjustments by avoiding specific proprietary test names when able and instead focusing on the validated testing methods.

For Prescription drugs, CVS Caremark uses CVS Specialty app or website data to assess new technology for M/S and MH/SUD. Patients can manage all their specialty medications in real time using the CVS Specialty app or website. The team is continually innovating to meet the evolving dynamics of the market, and helping clients improve the health and outcomes of their members with specialty conditions and look far enough out to develop unique solutions, but not so far out that exciting concepts outrun the science or technology. While assessing new technology, the app captures in real time patient-reported outcomes data and alerts the CareTeam to any possible deviations from normal. Data can then be used by the CareTeam to:

- Intervene in a timely manner upon exacerbations or unexpected health care visits.
- Improve treatment compliance and reduce medication waste; and
- Improve patient safety through contextual recall alerts.

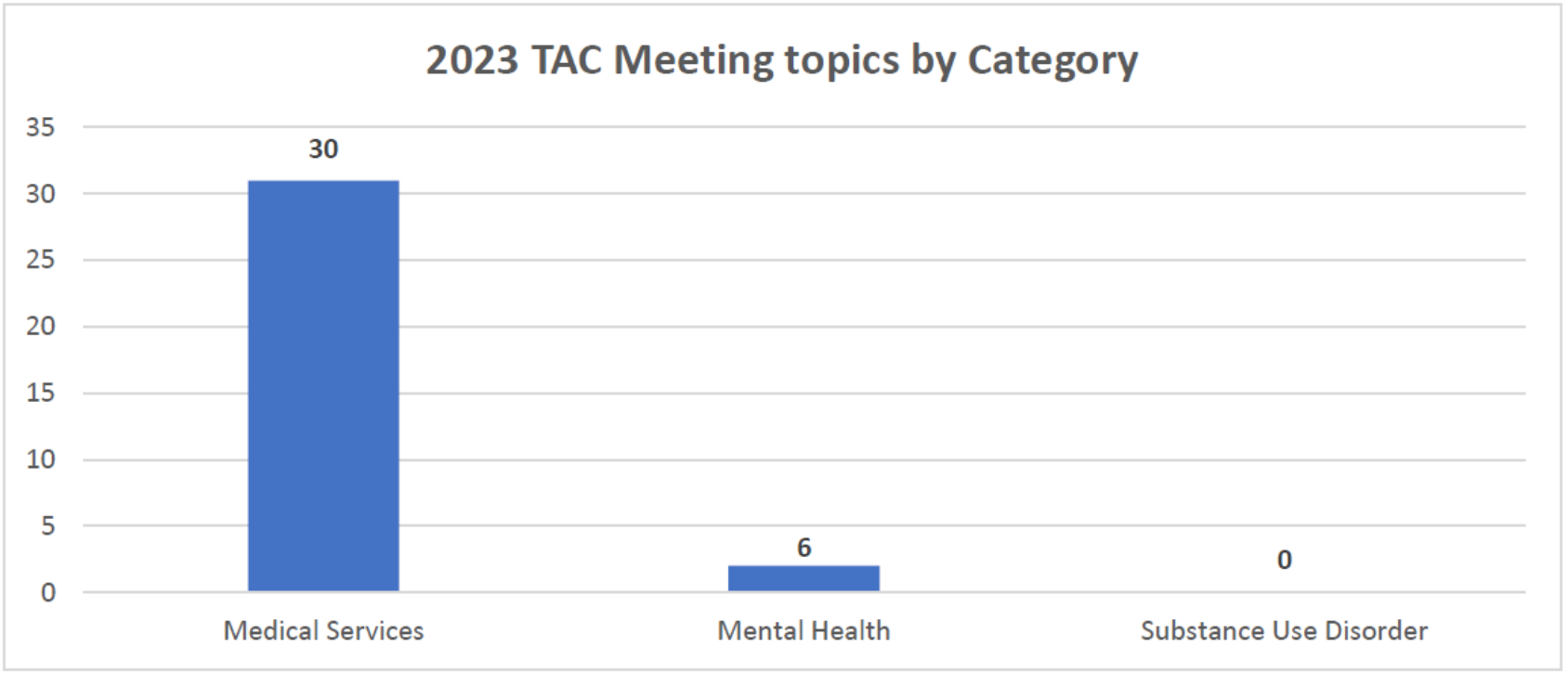
E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Internal review to determine that the CareFirst's Technology Assessment Committee (TAC) panel of experts that evaluated new technologies are comprised of comparable experts for MH/SUD conditions and M/S conditions, and that these experts evaluated and applied nationally recognized treatment guidelines and standards, in addition to the factors, in a comparable manner.

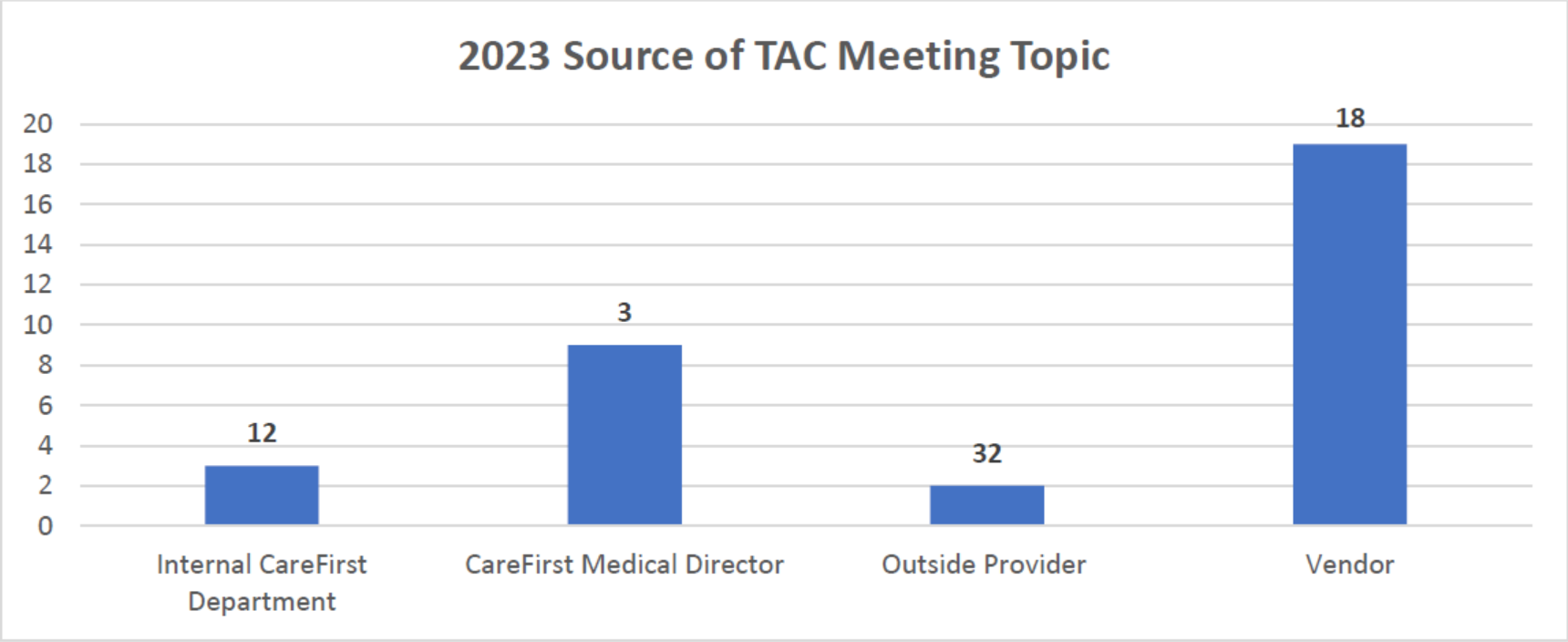
The personnel evaluating the evidence as part of TAC are highly qualified, experienced, objective, have no conflicts of interest with any proposed new technology, and have expertise with MH/SUD conditions and M/S conditions. The committee is comprised of the Plan's Medical Directors, associates of the Healthcare Policy Department, and other members of the Health Services division. The committee includes a CareFirst Medical Director who is a psychiatrist with over thirty years' experience providing care to patients with mental health and substance use disorders. This physician is also board certified by the American Board of Psychiatry & Neurology. In addition, the Director of Behavioral Health is a Licensed Clinical Professional Counselor, with a Master of Arts in Counseling Psychology and seventeen years' experience treating patients in various inpatient and outpatient settings.

The Technology Assessment process is designed to provide a systematic, scientific process for evaluating both emerging MH/SUD and M/S treatments to ensure that members have access to the latest and appropriate treatments. Technology assessment is a method by which new, emerging, or current technologies are thoroughly researched and evaluated, and the Technology Assessment Committee (TAC) provides a forum in which evidence is evaluated to determine whether a procedure, technique, drug, or device will be covered.

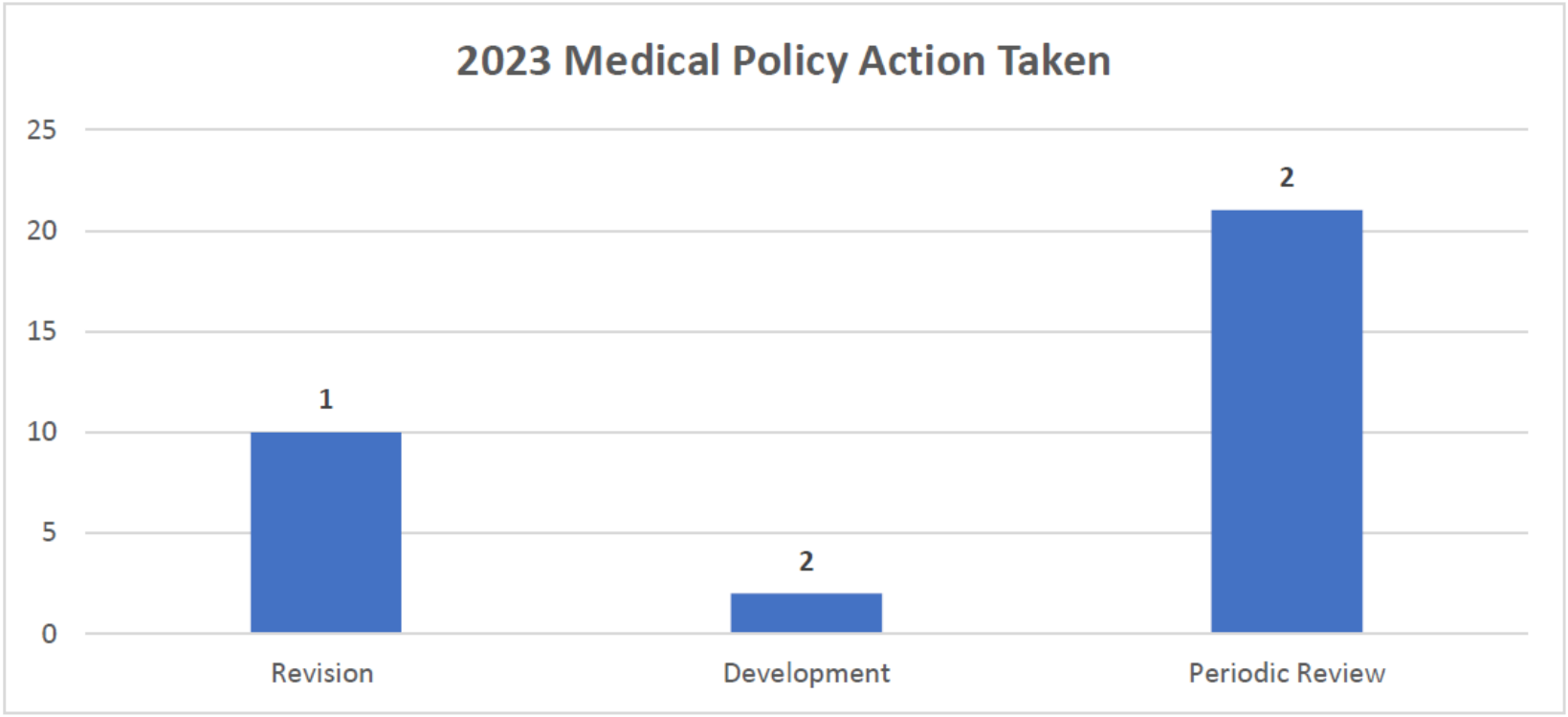
2023 MHPAEA Technology Reporting for NQTL



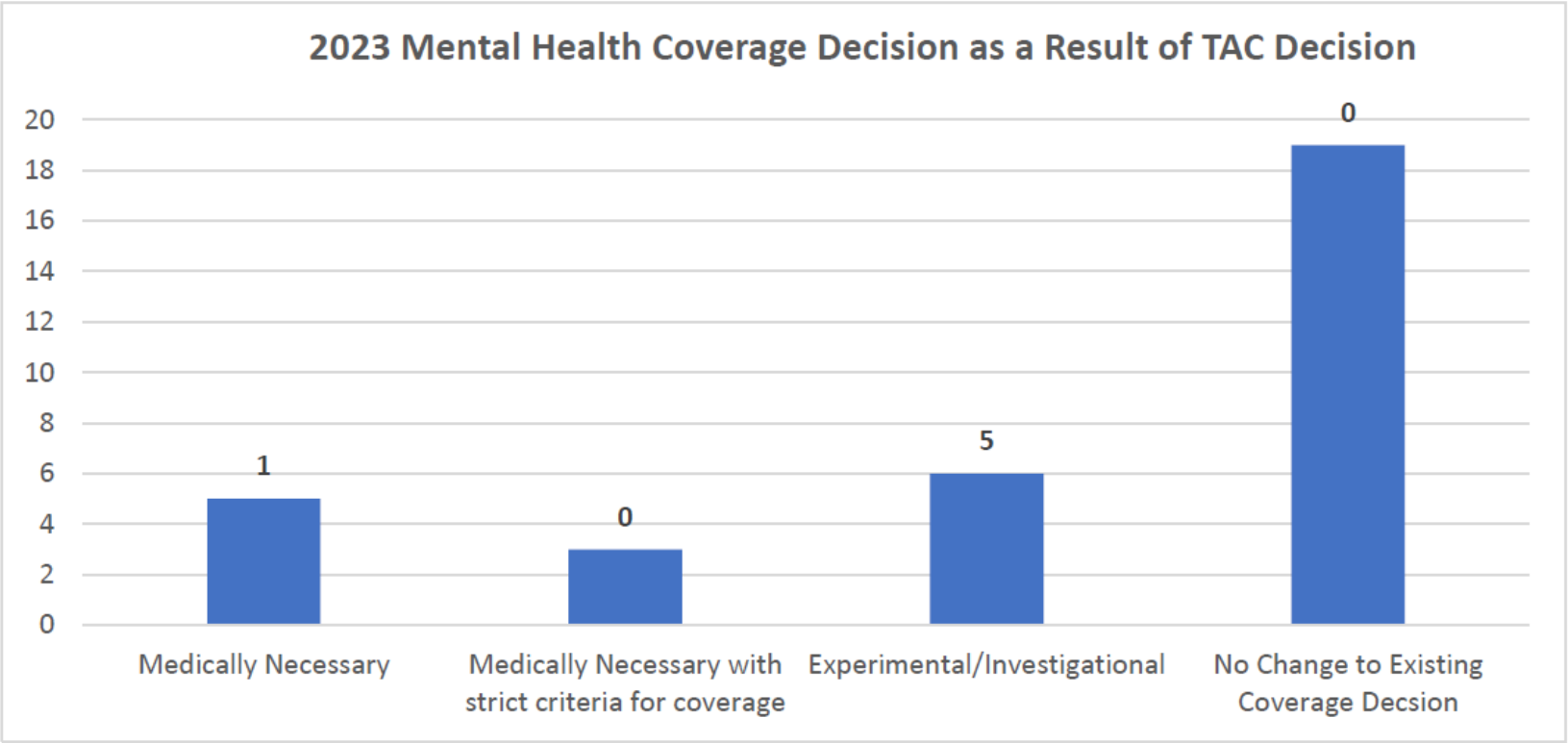
There was a total of 36 topics discussed at the Technology assessment Committee (TAC) meetings in 2023. The chart illustrates volume of topics broken down by medical services, mental health and substance use disorder. 83.3% of all meeting topics were related to medical services and 16.7% represented topics outlining mental health technologies. There was no available substance use disorder technologies for review in 2023.



The chart above illustrates the sources in which topics were received by Healthcare Policy and the sources represent internal CareFirst departments, CareFirst Medical Director recommendation, outside providers, and vendors. To explain mental health parity impact, there were a total of six (6) topics received for mental health; one (1) via a Medical Director recommendation, two (2) from internal CareFirst departments and the remaining three (3) were received from vendors.



Based on the analysis of the 2023 data, there were a total of 5 TAC topics related to medical services that resulted in actions to policy, hence presentations were given at the Medical Policy Committee. This volume represented 13.9% of the total volume of topic reviewed by then TAC. There were no medical policy impacts related to mental health topics



The above graph outlines the CareFirst coverage decisions based on the review of all topics presented to the TAC in 2023. Of the 36 topics presented, the six (6) topics brought were related to the mental health treatment: prescription digital therapeutic, pharmacogenomic testing of medication selection for Major Depressive Disorder, digital therapeutic specific to Post Traumatic Stress Disorder (PTSD) and Panic Disorder, EndeavorRX application to be used in conjunction with additional treatment for Attention Deficit Hyperactivity Disorder (ADHD), Continuous in-person monitoring and intervention (e.g., psychotherapy, crisis intervention), as needed during psychedelic medication therapy and SPRAVATO (Esketamine) The outcome of the review was as following:

- reSET Prescription Digital Therapeutic used for Psychiatric Disorders. Based on an assessment conducted by an independent review organization, the technology is still an investigational approach for treatment and the impact reSET computerized behavioral therapy device on patients beyond 12-weeks has not been studied. With this assessment, the technology is deemed experimental/investigational.

- Pharmacogenomic testing of medication selection for Major Depressive Disorder. Due to clinical utility, the decision was made to remove the exemption from vendor utilization review and render a medically necessary coverage decision.

- Digital therapeutic specific to Post Traumatic Stress Disorder (PTSD) and Panic Disorder. Based on an assessment conducted by an independent review organization, the evidence supporting the efficacy of the device was not solidified. The quality of the clinical study was not sufficient, as it lacked a control group and did not possess a randomized design, nor demonstrated efficacy as an established alternative of adjunctive pharmaceutical and/or non-pharmaceutical treatment. The results of the assessment rendered an experimental/investigational coverage decision.

- EndeavorRX application to be used in conjunction with additional treatment for Attention Deficit Hyperactivity Disorder (ADHD). Limited literature and research that lacked qualitative results on the impacts of the therapeutic on patients with ADHD; therefore, deemed experimental/investigational.

- Continuous in-person monitoring and intervention (e.g., psychotherapy, crisis intervention), as needed during psychedelic medication therapy. Psychedelic medication therapy is an emerging field, as the effective date of the services was 01/01/2024, and limited evidence has proven treatment efficacy; hence the services were deemed experimental/investigational.

- SPRAVATO® (Esketamine) for Treatment of Resistant Major Depressive Disorder. Based on reseach conducted, the studies that support SPRAVATO® have compared antidepressant-only treatment groups against treatment groups of a combination of SPRAVATO® and antidepressant. The combination treatment was at least as effective as treatment using only an antidepressant. Additionally, clinician judgment of suicide

risk was also assessed. Secondary endpoints included Montgomery-Åsberg Depression Rating Scale (MADRS) score and clinician assessment at 24 hours and day 25 post-baseline. Subsequently, group reductions in clinician global judgment of suicide risk scores were not statistically different at any time point; hence the treatment was deemed experimental/investigational.

NOTE: While not discussed by the TAC, through collaboration with Behavioral Health Director, Medical Policy 3.01.015 - Autism Spectrum Disorders (ASD) was revised to provide guidelines associated with the Developmental relationship-based intervention (DRBI) approach.

Requests for assessment of new technology are prioritized based on clinical need, legislative demands, and impact to CareFirst membership. Technologies with support from local physicians that have shown strong clinical validity are prioritized for review. All requests are directed to a qualified Healthcare Policy clinical associate, who coordinates the collection of supporting documentation including a description of the technology, the practical value the technology provides, the population affected, potential economic impact, applicable diagnoses, and procedure codes, and supporting literature. The qualified Healthcare Policy clinical associate is responsible for assessing and documenting the qualifications and credentials of specialty consultants or subject matter experts engaged in the Technology Assessment process.

10. Standards for Provider Credentialing and Contracting

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;

"Provider Credentialing and Contracting" means a carrier's processes and procedures and standards for determining which health care providers to contract with, either directly or through a subcontracting entity, to provide health care services to the carrier's enrollees under the carrier's health benefit plan.

Credentialing and Contracting standards apply to providers and not to benefits. They apply to all providers and facilities who contract with CareFirst for any level of service.

B. Identify the factors used in the development of the limitation(s);
C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Providers

Factor 1	Licensure
Definition	Provider has a valid, current, unrestricted licensure and a valid, current, Drug Enforcement Agency (DEA) and Controlled Dangerous Substance (CDS) registration, if and as applicable, for each state where the practitioner practices
Evidentiary Standards	• State law licensing requirements • Federal law licensing requirements • DEA registration • CDS registration
Threshold or explanation	There is no threshold, these requirements are the same for all providers as they meet legal requirements.
Factor 2	Education and training
Definition	The provider has appropriate education and training in a relevant field.
Evidentiary Standards	• State law licensing requirements

Threshold or Explanation	There is no threshold, these requirements are the same for all providers as they meet legal requirements.
Factor 3	Board Certification
Definition	Provider has appropriate board certification, if applicable.
Evidentiary Standards	• State law licensing requirements • Board certification records
Threshold or Explanation	There is no threshold, these requirements are the same for all providers as they meet legal requirements.
Factor 4	Work history
Definition	Work history will be reviewed if applicable to determine qualifications
Evidentiary Standards	• Internal determination by CareFirst to support evaluation of qualifications • Work history records of provider
Threshold or Explanation	The threshold is if the applicant provider has any gaps of greater than 6 months in their professional work history over the past 5 years that is unexplained.
Factor 5	Admitting privileges
Definition	Active, unrestricted, admitting privileges at a participating network hospital, except as otherwise agreed to by CareFirst in its sole discretion. Clinical privileges at a hospital, if applicable.
Evidentiary Standards	• Review of providers admitting privileges • Internal determination by CareFirst to meet member needs
Threshold or Explanation	No threshold. This is the same among M/S and MH/SUD providers.
Factor 6	Practice hours
Definition	Practice hours - At least 20 office hours per week to see patients
Evidentiary Standards	• Internal determination by CareFirst to meet member needs

	• Review of practice hours • Provider attestation • CareFirst Policy – Provider Manual
Threshold or Explanation	This requirement of 20 practice hours is the same for M/S and MH/SUD providers.
Factor 7	Liability claims
Definition	Acceptable history of professional liability claims.
Evidentiary Standards	• NCQA guidelines • Liability claims review
Threshold or Explanation	The threshold is if the applicant's malpractice history has any cases that settled with totals exceeding $3,000,000.00 in the past 10 years or has any case resulting in death within the past 10 years. For recredentialing, the evidentiary standard is whether or not the provider has more than 5 complaints within the prior credentialing cycle.
Factor 8	Sanctions review
Definition	Acceptable history of previous or current state sanctions, Medicare/Medicaid sanctions, restrictions on licensure, hospital privileges and/or limitations on scope of practice.
Evidentiary Standards	• NCQA guidelines • Provider sanction review
Threshold or Explanation	The evidentiary standard for this factor is whether or not the applicant provider has state or Medicare/Medicaid sanctions or restrictions on licensure.
Factor 9	Attestation requirement
Definition	Attestation to ability to perform the essential functions of a clinical practitioner and lack of present illegal drug use.
Evidentiary Standards	• NCQA standards • Signed attestation

Threshold or Explanation	There is no threshold, these requirements are the same for all providers to meet NCQA standards.
Factor 10	Appropriate malpractice insurance
Definition	Current malpractice insurance coverage with minimum limits
Evidentiary Standards	• NCQA standards • Insurance review
Threshold or Explanation	There is no threshold, these requirements are the same for all providers to meet NCQA standards.

Facilities

Factor 1	Licensure
Definition	State licensure as required
Evidentiary Standards	• State law licensing requirements • Federal law licensing requirements
Threshold or explanation	There is no threshold, these requirements are the same for all facilities as they meet legal requirements.
Factor 2	Certifications
Definition	CMS certification as required
Evidentiary Standards	• Federal law certification requirements
Threshold or Explanation	There is no threshold, these requirements are the same for all facilities as they meet legal requirements.
Factor 3	Accreditation
Definition	Accreditation from acceptable accrediting bodies
Evidentiary Standards	• State law licensing requirements • Federal law licensing requirements

Threshold or Explanation	There is no threshold, these requirements are the same for all facilities as they meet legal requirements.
Factor 3	Liability
Definition	General liability certificate
Evidentiary Standards	• NCQA standards
Threshold or Explanation	There is no threshold, these requirements are the same for all providers to meet NCQA standards.

D. Identify the methods and analysis used in the development of the limitation(s); and

Credentialing Committee & Process

CareFirst maintains a peer review committee, the Credentialing Committee, comprised of network providers who bring technical knowledge of current medical practice within the communities served. The Committee includes local providers practicing in multiple specialties including behavioral health. The Credentialing Committee is chaired by the CareFirst Medical Director who is responsible for the credentialing program. The Chief Medical Officer also sits on the Credentialing Committee. The Credentialing Committee meets monthly and more often on an ad-hoc basis. Membership of the Credentialing Committee includes representation from a range of participating practitioners in CareFirst's network, including representation from:

- Pediatric primary care (minimum of one pediatrician)
- Adult primary care (minimum of one family practice or internist)
- Medical and/or surgical specialists • Female adolescent or adult specialist (such as an OB/BYN); and
- Behavioral health

The Credentialing Committee has the authority to make the following decisions:

- Approve
- Deny
- Pend for further information

The Credentialing Committee develops and implements the credentialing/recredentialing processes to select and evaluate practitioners based on their ability to deliver care through recommendations for credentialing decisions using a peer review process. The Committee has the following responsibilities:

- On a weekly basis, reviews a list of names of all the practitioners who meet CareFirst's established credentialing criteria for initial or continued participation in the CareFirst practitioner networks.
- Review's summary information (the complete credentialing file is available for review if requested) for practitioners who do not meet CareFirst's established credentialing criteria for initial or continued participation in the CareFirst practitioner networks.
- Recommends actions to the CareFirst Medical Director regarding applicants (defer for additional information; approve or deny participation; approve or deny participation; approve or deny participation; approve or deny continued participation in provider programs.
- Reviews and advises the CareFirst Medical Director concerning issues and/or appeals of initial credentialing and recredentialing decisions.
- Annually reviews and discusses credentialing policies, procedures, and standards, recommends revisions, as necessary.
- Reviews providers who are no longer considered to be in good standing.
- Reviews and approves entities recommended for delegated credentialing arrangements.
- Reviews delegated credentialing reports and develops recommendations for improvements; and
- Meets routinely throughout the year to ensure timely credentialing decisions, maintains contemporaneous minutes, documenting discussions about credentialing and reporting credentialing activities and recommendations.

Role of the Medical Director: The Medical Director is responsible for the clinical aspects of the credentialing program. The Medical Director reviews and approves all credentialing and recredentialing applicants for clinical history including licensure sanctions and malpractice determinations. This also includes reviewing appeals of credentialing decisions. The Medical Director (or designee) chairs the credentialing committee.
Credentialing Timelines: Within thirty (30) days of receipt of a completed application, providers are notified of intent to continue or reject the application for network participation. Providers are initially credentialed within one hundred twenty (120) days from the notification of a complete application and are recredentialed on a thirty-six (36) month cycle.

Initial and Re-Credentialing Requirements, Sources and Criteria: To complete the credentialing process, the credentialing file for each practitioner must include the applicable data elements to satisfy all the required factors. The receipt of an application from a provider triggers the credentialing process. If the application is not complete,

CareFirst will inform the provider in writing to allow for corrections and/or to provide additional information. The completed file is then forwarded to the Medical Direct and the Credentialing Committee for review and approval, and a final decision is made. Providers requesting initial participation will be notified of the decision within one hundred fifty (120) days of receipt of a completed application or within 10 days of the Credentialing Committee decision, whichever is earlier. This notification may occur electronically or via standard mail. For denial decisions, letters are sent that include instructions for the provider on how to appeal the decision.

The re-credentialing process incorporates reverification and the identification of changes in the provider's licensure, sanctions, certification, health status and/or performance information (including, but not limited to, malpractice experience, hospital privilege or other actions) that may reflect on the provider's professional conduct and competence. This information is reviewed in order to assess whether the provider continues to meet CareFirst credentialing standards. All applicable providers in the Network within the scope of Credentialing are required to be recredentialed every thirty-six (36) months.

As for the credentialing of institutional providers, the RFI must be completed and attested to by the provider within 180 days from submission to CareFirst. Credentialing documents must meet the standards as defined on the CareFirst Credentialing Requirements for Assessment & Reassessment of Organizational Providers Chart or as defined by the CAC.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

The credentialing criteria and process is comparable for all practitioners and organizational providers regardless of type of specialty and applies to all providers and facilities who contract with CareFirst for any level of service the applications are reviewed by the same CareFirst teams, including the CAC and the Medical Director and have the same review timelines. All practitioners who apply to be credentialed follow the same review process.
All physician providers (M/S or MH/SUD) must meet the same standards of being licensed, carry unrestricted DEA and CDS licenses, and carry $1/$3M malpractice coverage. All non-physician providers (M/S or MH/SUD) must meet the same standards of being licensed and provide verification of education and training. Non-physician M/S providers must carry $1/$3M malpractice coverage, while non-physician MH/SUD providers must carry $.5/$1.5M malpractice coverage which is a lower standard to meet for MH/SUD providers.

For M/S specialties, 91% of facilities and 93% of providers that started the contract process were admitted to the PPO network. For MH/SUD specialties, 100% of facilities and 93% of providers that started the contract process were admitted to the PPO network.
For M/S specialties, 94% of facilities and 93% of providers that started the contract process were admitted to the HMO network. For MH/SUD specialties, 100% of facilities and 93% of providers that started the contract process were admitted to the PPO network.

11. Exclusions for Failure to Complete a Course of Treatment

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;
CareFirst does not apply this NQTL.

B. Identify the factors used in the development of the limitation(s);
CareFirst does not apply this NQTL.

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;
CareFirst does not apply this NQTL.

D. Identify the methods and analysis used in the development of the limitation(s); and
CareFirst does not apply this NQTL.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.
CareFirst does not apply this NQTL.

12. Restrictions that Limit Duration or Scope of Benefits for Services

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;
CareFirst does not apply this NQTL.

B. Identify the factors used in the development of the limitation(s);
CareFirst does not apply this NQTL.

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;
CareFirst does not apply this NQTL.

D. Identify the methods and analysis used in the development of the limitation(s); and
CareFirst does not apply this NQTL.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.
CareFirst does not apply this NQTL.

13. Restrictions for Provider Specialty

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;
CareFirst does not apply this NQTL.

B. Identify the factors used in the development of the limitation(s);
CareFirst does not apply this NQTL.

C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;
CareFirst does not apply this NQTL.

D. Identify the methods and analysis used in the development of the limitation(s); and
CareFirst does not apply this NQTL.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.
CareFirst does not apply this NQTL.

14. Reimbursement for INN Providers, OON Providers, INN Facilities, OON Facilities (separately)

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies;
"Reimbursement" means compensation, or the amount allowed to a health care provider, member, or other person entitled to reimbursement by a carrier, or the combined amount of the carrier's payment and member's cost-sharing responsibility, for providing health care services, medications, or supplies to enrollees of the health benefit plan. Reimbursement includes, but is not limited to, fee for service payments, capitation payments, bundled or global payments, and bonuses or other incentive payments.

Standard (or base fee schedule) Reimbursement standards apply to providers or facilities and not to benefits. They apply to all providers and facilities who contract with CareFirst for any level of service.
Participating providers agree to accept a plan allowance (also called allowed benefit or allowed amount) as payment in full for their services. Participating providers may not bill the member for amounts that exceed the allowed amount for covered services. Members may be liable for non-covered services, deductibles, copayments, and coinsurance.
Methods of Reimbursement for Facilities - CareFirst provides several methods of hospital reimbursement:

- All-inclusive per diem or case rate payments
- Predetermined per visit fees
- Percentage of charges (discounted)
- Predetermined flat fees
- Percentage of Medicare Resource Based Relative Value Scale fee schedule amounts
- Percentage of CareFirst standard Base Fee Schedule amounts

B. Identify the factors used in the development of the limitation(s);
C. Identify the sources (including any processes, strategies, or evidentiary standards) used to evaluate the factors identified above;

Factor 1	Medicare reimbursement rates
Definition	Reimbursement is based off of Medicare reimbursement rates.
Evidentiary Standards	• Rates paid by Medicare under the MPFS or MAC for local jurisdictions

	• Medicare fee schedule and annual changes
Threshold or explanation	(Work RVU x work GPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI) x CF = CMS benchmark rate • The Work RVU reflects the relative time and intensity associated with furnishing. • The Practice Expense (PE) RVU reflects the costs of maintaining a practice. • The Malpractice (MP) RVU reflects the costs of malpractice insurance. • Geographic Practice Cost Indices (GPCIs) geographic variations in the costs of practicing medicine in different areas of the country. • Conversion Factor (CF) the sum of the geographically adjusted RVUs by a CF in dollars.
Factor 2	Competitive Intelligence
Definition	Information about industry reimbursement rates or evidence of cost of care provided by the facility.
Evidentiary Standards	• Industry benchmarking data • Provider complaints and correspondence • Competitive research • Rate review • Cost of care review
Threshold or Explanation	Behavioral health services: Should be no less than Medicare when possible. At a minimum, the percent of Medicare used for these services should be no less than the methodology used for E/M office visits codes (99202-99215)
Factor 3	Geographic region
Definition	Rates applicable to the geographic region as defined by CMS.
Evidentiary Standards	• Medicare regions • CMS • DC, Baltimore Metro and Rural MD service areas are defined by county that match CMS for the same locality.
Factor 4	Place of service

Definition	Where the provider is providing the service. Facility vs non-facility,
Evidentiary Standards	• State law requirements • Industry standards
Factor 5	Training, expertise, licensing
Definition	Training, expertise, and licensure of provider– What training, license, or expertise does the provider have? Provider's specialty, license type, board certification, education, training, and experience is assessed
Evidentiary Standards	• CMS guidelines • Industry benchmarking data • Provider application • Medicare reductions for limited licensed provider • Competitive intelligence
Threshold or Explanation	Behavioral health services: Should be no less than Medicare when possible. At a minimum, the percent of Medicare used for these services should be no less than the methodology used for E/M office visits codes (99202-99215).
Factor 6	Market demands
Definition	Market demands and specialized services. Relies on the provider landscape and member needs, could be impacted by geography, abundance, or lack of providers ability to handle specialized services, or member need and access.
Evidentiary Standards	• Provider feedback • Competitive intelligence • Provider correspondence that may include blinded competitor information, this information is generally submitted by providers when providing market validation or evidence that other payors are allowing higher rates • Industry benchmarking data such as purchased market benchmarking data, i.e., IDB Watson and Truven.

Threshold or Explanation	Behavioral health services: Should be no less than Medicare when possible. At a minimum, the percent of Medicare used for these services should be no less than the methodology used for E/M office visits codes (99202-99215).

D. Identify the methods and analysis used in the development of the limitation(s); and

In developing fee schedules, CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) references many sources of competitive data to appropriately set reimbursement rates. CareFirst analyzes Medicare changes and allowances, provider complaints and correspondence, industry benchmarking data and competitive research.

CareFirst evaluates reimbursement rates annually and periodically makes changes to these fee schedules. Not all procedure codes are updated during the review process. If an update to a procedure code(s) has been made, CareFirst will provide information to providers notifying them of the change(s) to the fee schedule amounts, if applicable to their specialty.

E. Provide any evidence and documentation to establish that the limitation(s) is applied no more stringently, as written and in operation, to mental health and substance use disorder benefits than to medical and surgical benefits.

Providers –

CareFirst maintains one standard fee schedule for M/S and MH/SUD providers (used for both INN and OON, see Step 2). CareFirst maintains its standard fee schedule through ongoing evaluations and maintenance (e.g., AMA code additions/deletions), with adjustments/modifications typically once a year. We consider changes in Medicare reimbursement rates, competitive intelligence, geo graphic region, network type, Place of Service, Training (expertise and licensure) and market demands.

Development of the fee schedule is subjective, however, we are cognizant of MHPAEA, so every modification is reviewed to ensure we are not more stringent in our provider allowances for services related to mental health and substance use disorders. Such changes to the fee schedule go through a series of quality review checks and approvals throughout our company. Upon review of the standard fee schedules the assigned Reimbursement Analyst, employed by CareFirst, develops proposed rates based on the factors identified in Step 2. To ensure that we are not being more stringent on MH/SUD services the rates (listed in Step 5) are compared against Medicare to validate that the rates are not a lesser % of Medicare than M/S rates. This analysis is sent to the Manager of Provider Reimbursement for

review of all rates, % of Medicare and final approval of any changes. The Manager of Provider Reimbursement will also validate that the percentage of Medicare for MH/SUD rates is no less than that of the E/M rates used by M/S. The teams design includes certified professional coders, and individuals who have been involved in decision making over rates since at least 2009.

Facilities –

CareFirst maintains its standard fee schedule through ongoing evaluations and maintenance with adjustments/modifications as needed (used for both INN and OON, see Step 2). We consider changes in Medicare rates, competitive intelligence, geo graphic region, network type, specialized services. All our facility fee schedules are based on Revenue Codes, where new/deleted codes are very infrequent. Each Facility type has its own standard fee schedule, there are separate ones for each of the following – Birthing Center, Dialysis, SNF, Hospice, Home Health, ASC, and MHSA. Each Facility is contracted to utilization different revenue codes, and there is no overlap to the revenue codes rendered. ASCs are the only facility that has a fee schedule comprised of only CPT/HCPCS codes.

Development of the facility fee schedule is subjective, however, we are cognizant of MHPAEA, so every modification is reviewed to ensure we are not more stringent in our facility allowances for services related to mental health and substance use disorders. Such changes go through a series of quality review checks and approvals throughout our company. Upon review of the standard fee schedules the assigned Reimbursement Analyst, employed by CareFirst, develops the rates based on the factors identified in Step 2. Since Medicare rates are not published for MH/SUD facilities we are unable to use that as a source of this fee schedule. Therefore, the primary basis of the standard fee schedule is the average of negotiated rates. A database of all contracted rates for facilities is maintained and updated quarterly, along with application of the claims date to review on a weight and unweighted basis. Any change request or update analysis is sent to the Manager of Provider Reimbursement and Contracting for review and approval.

The Manager of Provider Reimbursement and Contracting will collectively work before settling on final rates. The Provider Reimbursement team design includes certified professional coders, and individuals who have been involved in decision making over rates since at least 2009.

Negotiation requests are managed by the Institutional, Ancillary and Professional Contracting Department. The teams are responsible for evaluating the Provider or Facility request and developing a recommendation. Any changes are reviewed and approved by the Executive Management Team. An analysis of Group's business with CareFirst is conducted which contains the utilization and rates for all CPT codes billed by the Group in the past year. It compares

the Group's current rates, standard rates, requested rates and Medicare rates for all services, were applicable. We also provide the group with our market validation tool to help them conduct a blinded weighted analysis to determine the gap in reimbursement between CareFirst and their other payers. This process is followed for all providers regardless of their specialty or facility type.

In-operation comparative analysis of provider reimbursement rates and Medicare fee schedule for INN and ONN for services suggests that providers reimbursement rates are comparable for M/S and MH/SUD services. Specific fee-schedules are available upon request.