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CareFirst BlueCross BlueShield is making this report available in connection with the Virginia Bureau of Insurance's 2026 Mental Health Parity and Addiction Equity Act (MHPAEA) comparative analysis reporting requirements. Virginia Code § 38.2-3412.1 E 1 requires applicable health insurance carriers to submit their federal nonquantitative treatment limitation (NQTL) comparative analyses to the Bureau and provide information showing how the analyses may be accessed publicly online.

MHPAEA prohibits financial requirements and quantitative treatment limitations applicable to mental health or substance use disorder (MH/SUD) benefits from being more restrictive than the requirements or limitations applicable to medical/surgical benefits in the same classification. It also requires that the processes, strategies, evidentiary standards, and other factors used to design and apply an NQTL to MH/SUD benefits be comparable to, and applied no more stringently than, those used for medical/surgical benefits, as written and in operation.

Consistent with the Bureau's 2026 guidance, this single PDF combines CareFirst's comparative analyses for all NQTLs included in this report, organized separately by NQTL and applicable benefit classification or sub-classification, together with relevant supporting documentation.

The analyses that follow describe the NQTLs CareFirst applies to its Virginia fully insured coverage and evaluate their design and application to MH/SUD and medical/surgical benefits. They are provided to support regulatory review and to give members and other interested parties public access to the information required by Virginia law and the Bureau's 2026 reporting guidance. The following link to the CareFirst website provides access to this report: https://individual.carefirst.com/members/mandates-policies/mental-healthy-parity-notice.page.

Sincerely,

CareFirst BlueCross BlueShield

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NQTL Table of Contents:

MEDICAL NECESSITY 3
PRIOR AUTHORIZATION 21
CONCURRENT REVIEW 57
RETROSPECTIVE REVIEW 79
POST-PAYMENT RETROSPECTIVE REVIEW 108
EXPERIMENTAL OR INVESTIGATIONAL: EVALUATION OF NEW TECHNOLOGIES 138
TREATMENT PLAN REQUIREMENT 174
CREDENTIALING (PROVIDER AND FACILITY) 185
IN-NETWORK REIMBURSEMENT (PROVIDER AND FACILITY) 206
OUT-OF-NETWORK REIMBURSEMENT (PROVIDER AND FACILITY) 228
PROVIDER DIRECTORIES 241
NETWORK ADEQUACY 267

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MEDICAL NECESSITY

Overview

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the medical necessity requirement to mental health or substance use disorder ("MH/SUD") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the medical necessity requirement to medical surgical ("M/S") benefits.

I. Description of the Medical Necessity NQTL

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; considered effective for a patient's illness, injury, or disease; not primarily for the convenience of a patient or health care provider; and 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.

A. Identification of the NQTL

i. Plan/Coverage Terms Regarding Medical Necessity

The Plan document contains the following sections regarding medical necessity. These medical necessity sections apply to both M/S benefits and MH/SUD benefits and do not differentiate between M/S and MH/SUD benefits:

- How the Plan Works
- Utilization Management Requirements
- Definitions

(*Source: Plan EOC)*

ii. Policies/Guidelines/Other Documents Describing Medical Necessity

Medical necessity appears or is described in the following documents:

- Application of Criteria: CO UM 103.00, pg. 2
- CareFirst Internal Utilization Review: Coverage Decision Procedure CO UM 105.00, pp. 2-3
- Clinical Criteria for Decision Making SOP HS.UM.03, pp. 2-3
- Medical Policy Reference Manual (MPRM) Policy Number 0.00.001

iii. Identification of All MH/SUD Benefits and M/S Benefits to Which Medical Necessity Applies by Benefit Classification

The Plan requires medical necessity review for M/S services, and MH/SUD services, as follows.

List of M/S Services that Require Medical Necessity Review	List of MH/SUD Services that Require Medical Necessity Review
Inpatient M/S Services (In-Network and Out-of-Network)	**Inpatient MH/SUD Services (In-Network and Out-of-Network)**
All services, including Emergency Care, are subject to medical necessity review.	All services, including Emergency Care, are subject to medical necessity review.
Outpatient M/S Services (In-Network and Out-of-Network)	**Outpatient MH/SUD Services (In-Network and Out-of-Network)**
All services, including Emergency Care, are subject to medical necessity review.	All services, including Emergency Care, are subject to medical necessity review.

CareFirst's broad framework excludes services that fail its definition of medical necessity and separately excludes categories such as experimental or investigational care and purely cosmetic services. Some items previously described as "blanket exclusions" are better characterized as decision standards or qualified exclusions, because exceptions may apply. The table below distinguishes those concepts:

Exclusion or standard	How it operates	Why CareFirst treats it as not medically necessary
Services that do not meet the general medical-necessity definition	Broad exclusion. Benefits are not provided when a service is not necessary for prevention, diagnosis, or treatment, even if the benefit category is otherwise covered. Additional details are available below.	The service must be consistent with accepted practice, clinically appropriate in type, frequency, extent, site, and duration, effective for the condition, not primarily for convenience, and not more costly than an equally effective alternative.

Exclusion or standard	How it operates	Why CareFirst treats it as not medically necessary
Experimental or investigational services	Broad categorical exclusion, subject to any mandated or expressly stated exceptions, such as qualifying clinical-trial coverage. Additional details are available in the Experimental/Investigational NQTL section.	The evidence is considered insufficient to establish safety, effectiveness, or acceptance within prevailing medical or psychiatric practice. The rationale is evidentiary, not merely cost-based.
Purely cosmetic surgical procedures	Categorical medical-policy determination when the primary purpose is improving appearance rather than restoring function or correcting deformity.	A procedure undertaken solely to change appearance does not prevent, diagnose, or treat illness, injury, or functional impairment. Reconstructive procedures and treatment of complications may be medically necessary.
Routine, palliative, or cosmetic foot care	Qualified exclusion. Examples include routine care of corns, calluses, toenails, fallen arches, weak feet, and chronic foot strain, unless a medical-necessity exception applies.	Routine maintenance or relief of minor symptoms generally does not require physician-level treatment and may not address disease, injury, or functional impairment. Coverage may apply when the member's condition creates a documented clinical need.
Services primarily for patient or provider convenience	Medical-necessity factor rather than a separate benefit category.	Convenience alone does not establish clinical necessity. The requested setting, frequency, duration, or modality must be needed to achieve an appropriate clinical result.
Services inconsistent with generally accepted standards of practice	Medical-necessity factor and a basis for exclusion.	CareFirst's definition relies on credible scientific evidence, recognized medical literature, specialty-society recommendations, relevant clinical views, and other pertinent factors.

Exclusion or standard	How it operates	Why CareFirst treats it as not medically necessary
More costly services when an equally effective alternative exists	Medical-necessity factor, not an automatic exclusion of every higher-cost service.	The requested service must not be more costly than an alternative service or sequence at least as likely to produce equivalent therapeutic or diagnostic results. A higher-cost option may still qualify if alternatives are not equivalent for the individual member.

II. Identification and Definition of the Factors and Evidentiary Standards Used to Design and Apply the Medical Necessity NQTL

Factor 1	Generally Accepted Standards of Medical Practice
Definition	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.
Application Benefit Classification(s)	• Inpatient In-Network • Inpatient Out-of-Network • Outpatient Office In-Network • Outpatient Office Out-of-Network • Outpatient Other In-Network • Outpatient Other Out-of-Network • Emergency Care
Description	This factor is used in the application of medical necessity to determine whether generally accepted standards of care published by industry-leading clinical guidance providers and medical societies are applied.
Source(s) of Factor	• MCG care guidelines • SAMHSA guidelines • ACOG recommendations • AAP recommendations • US Preventative Task Force evidence-based recommendations

	• CMS national and local coverage determinations
	• NIA Magellan recommendations
	• Peer-reviewed medical literature including:
	  o BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence.
	  o Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs).
	  o Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care.
	  o UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource.
	  o National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania.
	  o PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. CareFirst ensures application in parity by utilizing industry appropriate criteria and guidelines.
Source(s) of Evidentiary Standards	• MCG care guidelines • SAMHSA guidelines • ACOG recommendations • AAP recommendations • US Preventative Task Force evidence-based recommendations • CMS national and local coverage determinations • NIA Magellan recommendations • Peer-reviewed medical literature including: o BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of

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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.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other • Emergency Care
Description	This factor is used in the application of medical necessity to determine whether the service is effective and appropriate for the condition being treated.
Source(s) of Factor	• MCG care guidelines • SAMHSA guidelines • ACOG recommendations • AAP recommendations

	• US Preventative Task Force evidence-based recommendations
	• CMS national and local coverage determinations
	• NIA Magellan recommendations
	• Peer-reviewed medical literature including:
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Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. There is no threshold for number of studies reviewed. Quality of research is investigated as opposed to quantity.
Source(s) of Evidentiary Standards	• MCG care guidelines • SAMHSA guidelines • ACOG recommendations • AAP recommendations • US Preventative Task Force evidence-based recommendations • CMS national and local coverage determinations • NIA Magellan recommendations • Peer-reviewed medical literature including:

	○ BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. ○ Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). ○ Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. ○ UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. ○ National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. ○ PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

Factor 3	**Not Primarily for Convenience**
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.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the application of medical necessity to determine whether the service is merely for convenience instead of the service that presents the best outcome for the patient.
Source(s) of Factor	• Patient history review • MCG care guidelines • SAMHSA guidelines

	• ACOG recommendations
	• AAP recommendations
	• US Preventative Task Force evidence-based recommendations
	• CMS national and local coverage determinations
	• NIA Magellan recommendations
	• Peer-reviewed medical literature including:
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	  o Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs).
	  o Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care.
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	  o PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide whether a service is primarily for convenience. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. There is no threshold for number of studies reviewed. Quality of research is investigated as opposed to quantity.
Source(s) of Evidentiary Standards	• Patient history review • MCG care guidelines • SAMHSA guidelines • ACOG recommendations • AAP recommendations • US Preventative Task Force evidence-based recommendations • CMS national and local coverage determinations

	• NIA Magellan recommendations
	• Peer-reviewed medical literature including:
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Factor 4	**Not More Costly Than Alternative Service**
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.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other • Emergency Care

Description	This factor is used in the application of medical necessity to determine whether a less costly alternative service known to produce the same or better results for a patient is available.
Source(s) of Factor	• 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 • Claims analysis • Medical history of patients • Peer-reviewed medical literature including: o BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. o Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). o Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. o UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. o National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. o PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

Evidentiary Standards and Applicable Thresholds	CareFirst uses criteria appropriate to the service type to determine whether a less costly alternative service or sequence of services is at least as likely to produce equivalent therapeutic or diagnostic results. The process does not differ between M/S and MH/SUD benefits, although the criteria applied correspond to the service type. There is no fixed numerical threshold because the determination follows applicable clinical guidelines, professional recommendations, and the individual patient's circumstances. The quality and relevance of the evidence are evaluated rather than the number of studies alone.
Source(s) of Evidentiary Standards	• 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 • Claims analysis • Medical history of patients • Peer-reviewed medical literature including: o BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. o Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). o Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. o UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. o National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania.

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A. Processes

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 peer-reviewed literature. Policies are reviewed by CareFirst's Chief Medical Officer, senior medical directors, and Behavioral Health Medical Director. The criteria are always used with an assessment of the individual patient's needs. CareFirst's medical and behavioral health policies are available on web.carefirst.com.

The internal and external criteria used for both M/S and MH/SUD are authorized by the CareFirst Criteria Review Committee. Internal 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.

Written UM policies and procedures define CareFirst's utilization review program. All services authorized by the Utilization Management (UM) Staff are evaluated against appropriate benefit packages and nationally accepted medical necessity criteria. The criteria are reviewed, revised, and approved at least annually by the Quality Executive Committee (QEC). A designated senior practitioner, specifically the Chief Medical Officer (CMO), has significant involvement in the implementation of the UM Program and related policies and procedures. A formal UM Committee, under the direction of the CMO, oversees the Utilization Review process.

A licensed physician oversees UM decisions to ensure consistent medical necessity decision making. Licensed doctoral-level clinical psychologists oversee behavioral health care UM decisions for psychological testing. Licensed nurses or Licensed Clinical Social Workers (RN or LPN or LCSW) may approve benefit or medical necessity cases. These practitioners may not deny medical necessity cases.

Utilization Management Staff and their Responsibilities:

CareFirst Title	Qualifications

Medical Director/Chief Medical Officer	Board certified Medical Doctor responsible for the development and implementation of UM processes, criteria, and program outcomes. Oversees the operations of the UM department and is a liaison to the medical community regarding UM program operations. Clinical consultant for UM decisions: approves and denies care according to medical criteria and policies and procedures. Reports to Executive Vice President of Health Services and supervises all other medical directors (e.g., Behavioral Health Medical Director, Radiology/Cardiology Medical Director, etc.). Chairs the UM Committee.
Medical Director, Behavioral Health	Board-certified Medical Doctor in Psychiatry who reviews and makes medical necessity determinations for behavioral health UM cases using evidence-based UM criteria and policies and procedures. Serves as a liaison to behavioral health practitioner and provider communities and provides information and expertise to UM behavioral health staff. Reports to the Medical Director and is a member of the UM Committee.
Director of Utilization Management	A Registered Nurse who is responsible for intake, precertification, concurrent review, and retrospective review activities of the department. Develops and maintains policies and procedures for assigned areas. Approves requested care per UM criteria and policies and procedures. May deny care based on benefits or contract issues. Supervises all RN, LPN staff and UM coordinators, and is responsible for department operations. Reports to the Clinical Director of Government Programs with a dotted line to the Chief Medical Officer.
Utilization Management Manager/Supervisor	Assists UM director with day-to-day operations, oversees completion of reviews by UR Reviewers, problem- solves, conducts audits, prepares documents for weekly UM Meetings. Reports to the Director of Utilization Management.
Utilization Management Reviewer	A Licensed Nurse who conducts UM review activities. Monitors and coordinates care with participating practitioners, enrollees, and provider organizations using established criteria. Collects data for the precertification, concurrent review, and retrospective review processes. Approves requested care under UM criteria and policies and procedures. May deny authorization requests based on administrative criteria (i.e., benefit or contractual limitations). If medical necessity criteria are not met, the reviewer submits the authorization request to an MD for the medical necessity determination.
Vice President of Pharmacy and Therapeutics	The Doctor of Pharmacy is responsible for developing and maintaining the formulary and formulary policies and procedures. Researches, approves and denies requests for drugs consistent with formulary policies and procedures and UM criteria. Reports to the Medical Director/CMO and is a member of the P & T Committee. Provides support to the P & T Committee and manages the MCO's relationship with the Pharmacy Benefits Manager (PBM).
Physician Advisors	Board-certified Medical Doctors who are available to review UM cases, including appeals. They research the request and either approve or deny it according to UM criteria and policies and procedures.

B. Strategy

CareFirst uses internal clinical policy (CareFirst Medical Policy Reference Manual) for M/S and MH/SUD, which is drafted using external clinical criteria, in addition to peer-reviewed literature, clinical trials, professional opinion, and publications by professional societies or government agencies. If the internal criteria are not sufficient to render a medical necessity approval determination, then external clinical criteria will be used.

CareFirst uses appropriate, evidence-based external clinical criteria for M/S and MH/SUD benefits. These include: the Modified Appropriateness Evaluation Protocol (AEP) Criteria (for M/S inpatient), the Apollo Managed Care Physical Therapy (for Physical Therapy), Occupational Therapy, Speech Therapy and Rehabilitation Criteria (for OT, ST, and Rehabilitation), MCG Guidelines 25th edition (for Behavioral Health, Ambulatory Care, Inpatient & Surgical Care, and Home Care), and The American Society of Addiction Medicine (ASAM) criteria (for SUD).

C. Relationship Between Factors

No factors were considered and ultimately rejected. All considered factors were approved and applied as stated above. Previous NQTL analyses included clinical appropriateness, effectiveness, and safety as separate factors used to determine when and how the Medical Necessity NQTL is applied. However, contemporary review led to the development and application of additional factors, and the previous factors were combined under Factor 2, “Clinically Appropriate.”

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III. Demonstration of Comparability and Stringency as Written

This section demonstrates that in each classification, under the terms of the plan as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying medical necessity to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the medical necessity with respect to M/S benefits.

CareFirst has a standard operating procedure for the medical necessity reviews that applies to both MH/SUD services and M/S services. (Utilization Management Prior Authorization Review Process #CO UM 200.20 and Utilization Review Coverage Decision Procedure #CO UM 105.00). The written criteria and procedures are to ensure fair and consistent prior authorization reviews and utilization decisions. Each service has its own unique medical policy that includes criteria, guidelines, descriptions, thresholds, and referenced peer-reviewed medical literature to support the policy and decisions.

CareFirst recognizes a responsibility to demonstrate a commitment of superior clinical quality service that is member centric, high touch, clinically appropriate, cost effective, data driven and culturally competent. This is achieved through an organization-wide, systematic, and coordinated approach that involves input from and coordination with both internal and external stakeholders. These stakeholders include members, providers, state entities, CMS, business units, department, and staff members. 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. This is inclusive of both physical and mental health services provided in an inpatient or outpatient setting.

A review of CareFirst's written policies and processes reveals the comparable application of the Medical Necessity NQTL to M/S and MH/SUD services within the applicable benefit classifications. The Plan's medical necessity 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.

IV. Demonstration of Comparability and Stringency In Operation

This section demonstrates that, in operation, the processes, strategies, evidentiary standards, and other factors used in designing and applying the medical necessity requirement to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used in designing and applying the medical necessity requirement to M/S benefits.

A. Explanation of How CareFirst Evaluates Comparability

Below is a comprehensive explanation of how CareFirst evaluates whether, in operation, the processes, strategies, evidentiary standards, and other factors used in applying the medical necessity requirement to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, those used in applying the medical necessity requirement to M/S benefits.

B. Documentation of Outcomes

1. Evaluation of Relevant Data

To ensure comparable application of criteria, CareFirst performs IRR reviews for alignment in clinical decision making. The results for the 2025 IRR scores are below:

2025 Interrater Reliability Testing Results – Spring and Fall Administration

Practitioner Type	**M/S**		**MH/SUD**		**Total**
License	**MDs**	**Nurses**	**MDs**	**Nurses**	
Spring 2025	97.6	98.4	93.7	93.4	98.0
Practitioner Type	**M/S**		**MH/SUD**		**Total**
License	**MDs**	**Nurses**	**MDs**	**Nurses**	
Fall 2025	92.6	89.6	94.0	90.9	90.1

2. Justification and Analysis

CareFirst performs interrater reliability (IRR) testing to evaluate alignment and consistency in clinical decision-making across practitioner types and benefit categories. The IRR process is relevant to the application of the medical necessity criteria NQTL because it provides an internal audit mechanism for assessing whether reviewers apply clinical criteria in a consistent manner across medical/surgical and MH/SUD benefits.

The 2025 IRR results demonstrate generally high alignment across both medical/surgical and MH/SUD reviews. In the Spring 2025 administration, results were high across reviewer types and benefit categories, with medical/surgical scores of 97.6% for MDs and 98.4% for nurses, and MH/SUD scores of 93.7% for MDs and 93.4% for nurses. The total Spring 2025 score was 98.0%. These results indicate strong consistency in application of criteria across both medical/surgical and MH/SUD benefits, with MH/SUD scores somewhat lower than medical/surgical scores but still within a high range of reviewer agreement.

In the Fall 2025 administration, scores were also generally comparable across medical/surgical and MH/SUD benefits. Medical/surgical scores were 92.6% for MDs and 89.6% for nurses, while MH/SUD scores were 94.0% for MDs and 90.9% for nurses. The total Fall 2025 score was 90.1%. In Fall 2025, MH/SUD reviewer scores were slightly higher than medical/surgical scores for both MDs and nurses. This supports the conclusion that MH/SUD criteria were not applied more stringently or less consistently than medical/surgical criteria during that testing period.

Across the 2025 Spring and Fall administrations, the IRR results do not indicate a pattern of disproportionately lower consistency for MH/SUD reviews as compared to medical/surgical reviews. Although there were score variations by administration, practitioner type, and benefit category, the variation does not show that MH/SUD criteria were applied in a more stringent or less reliable manner. Rather, the results show that CareFirst uses the same type of audit mechanism to assess alignment in clinical decision-making across benefit categories and practitioner types.

V. Findings and Conclusions

The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply the medical necessity requirement to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the medical necessity requirement to M/S benefits; and (2) CareFirst complies with the relevant data requirements under the MHPAEA Final Rules.

CareFirst has a standard operating procedure for the medical necessity reviews that applies to both MH/SUD services and M/S services. (Utilization Management Prior Authorization Review Process #CO UM 200.20 and Utilization Review Coverage Decision Procedure #CO UM 105.00). The written criteria and procedures are to ensure fair and consistent prior authorization reviews and utilization decisions. Each service has its own unique medical policy that includes criteria, guidelines, descriptions, thresholds, and referenced peer-reviewed medical literature to support the policy and decisions.

A review of CareFirst's written policies and processes reveals the comparable application of the Medical Necessity NQTL to M/S and MH/SUD services within the applicable benefit classifications. The Plan's medical necessity 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.

Operationally, the 2025 IRR results support a finding of parity in operation. The internal audit data demonstrates that CareFirst monitors reviewer consistency across medical/surgical and MH/SUD benefits and that MH/SUD review outcomes were comparable to medical/surgical outcomes. The Spring and Fall 2025 results do not evidence a disparate or more stringent application of medical necessity criteria to MH/SUD benefits. Therefore, based on the available IRR testing results, the NQTL appears to be applied comparably and no more stringently to MH/SUD benefits than to medical/surgical benefits.

Proprietary and Confidential Information of CareFirst, Inc. and its affiliates and subsidiaries. This information shall only be disclosed as required by law.

VI. Required Certification

CareFirst certifies that the foregoing comparative analysis of the Medical Necessity NQTL was prepared for the Virginia fully insured coverage identified in this report and was reviewed by individuals with appropriate knowledge of the plan terms, policies, procedures, factors, evidentiary standards, operational practices, supporting documentation, and relevant data addressed in the analysis. The analysis applies to the CareFirst entities identified in this report as NAIC 53007 and NAIC 9602 to the extent the NQTL is designed and administered as described in this analysis.

To the best of CareFirst's knowledge and based on the information, documentation, and data reviewed as of the report's version date, this comparative analysis is accurate and complete in all material respects and demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the Medical Necessity NQTL to mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, those used to design and apply the NQTL to medical/surgical benefits, as written and in operation. CareFirst will maintain supporting documentation and will update or supplement the analysis if a material change, newly identified data limitation, or corrective action affects this conclusion.

PRIOR AUTHORIZATION

Overview

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the prior authorization requirement to mental health or substance use disorder ("MH/SUD") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the prior authorization requirement to medical surgical ("M/S") benefits.

I. Description of the Prior Authorization NQTL

Prior authorization is an assessment conducted prior to service to confirm that proposed service(s) are medically necessary, appropriate treatment for the patient's condition(s), and will be covered by the plan. prior authorization may also be referred to as prospective review, prior approval, precertification, or preadmission approval. A prior authorization determination made by a health carrier or its designee utilization review organization confirms that an admission, availability of care, continued stay or other health care service has been reviewed and, based on the information provided, satisfies the health carrier's requirements for medical necessity, appropriateness, health care setting, level of care and effectiveness.

A. Identification of the NQTL

i. Plan/Coverage Terms Regarding Prior Authorization

The Plan document contains the following sections regarding prior authorization. These prior authorization sections apply to both M/S benefits and MH/SUD benefits, and do not differentiate between M/S and MH/SUD benefits:

- Utilization Management Requirements
- Controlled Clinical Trial Patient Cost Coverage
- Prescription Guidelines

(*Source:* Plan EOC)

ii. Policies/Guidelines/Other Documents Describing Prior Authorization

Prior authorization appears or is described in the following documents:

- Application of Criteria: CO UM 103.00, pg. 2
- CareFirst Internal Utilization Review: Coverage Decision Procedure CO UM 105.00, pp. 2-3
- Clinical Criteria for Decision Making SOP HS.UM.03, pp. 2-3
- Medical Policy Reference Manual (MPRM) Policy Number 0.00.001
- Pharmacy Delegation Oversight Procedure CPS 500.13, pg. 2
- Pharmacy Prior Authorization Policy: HS.PH.04, pg. 2

iii. Identification of All MH/SUD Benefits and M/S Benefits to Which Prior Authorization Applies by Benefit Classification

The Plan requires prior authorization for certain M/S services, and certain MH/SUD services, as follows. Emergency services are not subject to prior authorization.

List of M/S Services that Require Prior Authorization	List of MH/SUD Services that Require Prior Authorization
Inpatient M/S Services (In-Network and Out-of-Network)	**Inpatient MH/SUD Services (In-Network and Out-of-Network)**
All Inpatient M/S Services require prior authorization. This includes: • Hospital Inpatient Services; including Ancillary services. • Inpatient rehabilitation. • Certain medications prescribed while in an inpatient place of service. • HMO Plans: Out-of-Network Covered Services, except for Out-of-Network Emergency Services.	All Inpatient MH/SUD Services require prior authorization. This includes: • Hospital Inpatient Services; including Ancillary services. • Inpatient Mental Health and Substance Use Disorder Services. • Residential treatment center services, except for emergency admissions. • Certain medications prescribed while in an inpatient place of service. • HMO Plans: Out-of-Network Covered Services, except for Out-of-Network Emergency Services.

See [https://provider.carefirst.com/providers/medical/ in- network-precertification-preauthorization.page] for a list of specific Inpatient Covered Services which require prior authorization.	See https://provider.carefirst.com/providers/medical/ in- network-precertification-preauthorization.page] for a list of specific Inpatient Covered Services which require prior authorization.
Outpatient M/S Services (In-Network and Out-of-Network)	**Outpatient MH/SUD Services (In-Network and Out-of-Network)**
• Outpatient rehabilitation therapy (physical therapy, speech therapy, occupational therapy, chiropractic and acupuncture). • Outpatient testing. • Outpatient surgery. • Facility based office visits. • Habilitative Services • Organ and Tissue Transplants. • Controlled Clinical trials. • Air Ambulance Services. (Except for Medically Necessary air ambulance services in an emergency). • Skilled Nursing Facility. • Home Health Services. • Hospice Services. • Medical Devices and Supplies. • Imaging/Radiology. • Lab Testing. • Certain medications prescribed while in an outpatient place of service. • Gender Reassignment Services. • Infusion Services. • Radiation Therapy. • Outpatient Chemotherapy • Outpatient Dialysis • Genetic Testing • Sleep Studies • Assisted Reproductive Technologies.	• Outpatient testing. • Facility based office visits. • Habilitative Services • Electroconvulsive Therapy (ECT) • Repetitive Transcranial Magnetic Stimulation (rTMS) • Controlled Clinical trials. • Air Ambulance Services. (Except for Medically Necessary air ambulance services in an emergency). • Lab Testing. • Certain medications prescribed while in an outpatient place of service. • Sleep Studies • HMO Plans: Out-of-Network Covered Services, except for Out-of-Network Emergency Services. See https://provider.carefirst.com/providers/medical/ in- network-precertification-preauthorization.page] for a list of specific Outpatient Covered Services which require prior authorization.

• HMO Plans: Out-of-Network Covered Services, except for Out-of-Network Emergency Services. See [https://provider.carefirst.com/providers/medical/ in- network-precertification-preauthorization.page] for a list of specific Outpatient Covered Services which require prior authorization.	

II. Identification and Definition of the Factors and Evidentiary Standards Used to Design or Apply Prior Authorization

A. Factors and Evidentiary Standards Used to Determine List of Services Subject to Prior Authorization

Factor 1	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 this factor.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the application of prior authorization to determine whether generally accepted standards of care published by industry-leading clinical guidance providers and medical societies are applied.
Source(s) of Factor	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines
Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. CareFirst ensures application in parity by utilizing industry appropriate criteria and guidelines.
Source(s) of Evidentiary Standards	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines

Factor 2	Clinical Efficacy and Appropriateness of a Proposed Treatment or Service
Definition	Services that have inconsistent efficacy or treatments subject to applicability in inappropriate situations. 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.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the application of prior authorization to determine whether the service is effective and appropriate for the condition being treated.
Source(s) of Factor	Peer-reviewed medical literature from databases such as Clinical Evidence-Based Research Resources: Medical Policy development and revisions are completed by conducting a thorough review of credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. Resources used are based on the below research: • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania.

	• PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.
Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. There is no threshold for number of studies reviewed. Quality of research is investigated as opposed to quantity.
Source(s) of Evidentiary Standards	Peer-reviewed medical literature from databases such as Clinical Evidence-Based Research Resources: Medical Policy development and revisions are completed by conducting a thorough review of credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. Resources used are based on the below research: • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

Factor 3	**Utilization Appropriateness**
Definition	Services that are prone to inappropriate or overutilization and/or abuse of services.

Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the design and application of prior authorization to determine whether services are inappropriate or more likely to be overutilized or abused.
Source(s) of Factor	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines
Evidentiary Standards and Applicable Thresholds	Any services on the prior authorization list that have less than a 2% denial rate are removed. Services that generally have a higher than 2% denial rate are potentially placed on the prior authorization list.
Source(s) of Evidentiary Standards	• Claims data and analysis • Utilization trend data • Denial rates

Factor 4	**Variations in Lengths 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 for the same or similar diagnosis may impact the determination of this factor.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient
Description	This factor is used in the application of prior authorization to determine whether extra consideration should be given to the length of stay due to high variations in lengths of stay.
Source(s) of Factor	• Claims data to track variations in length of stay • MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health

	Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.
Evidentiary Standards and Applicable Thresholds	Stays with higher variations in length of stay. The threshold is 30 days; any services with consistent stays over 30 days may be added to the prior authorization list.

Source(s) of Evidentiary Standards	• Claims data and analysis • Utilization trend data • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

CareFirst delegates all Utilization Management for Prescription Drugs to CVS. This includes prior authorization requirements

CVS Factor 1	**Patient Safety Concerns**
Definition	The presence of patient safety concerns exists with a drug or drug class such as unknown long-term safety or durability.
Application Benefit Classification(s)	• Prescription Drugs
Description	This factor is used in the application of prior authorization to determine whether there is a heightened risk for patient safety.
Source(s) of Factor	• Published peer-reviewed clinical literature – e.g., Journal of the American Medical Association (JAMA), New England Journal of Medicine (NEJM)

	• Accepted clinical practice guidelines, consensus statements, or comparable publications – e.g., Global Initiative for Chronic Obstructive Lung Disease (GOLD) Guidelines for treating COPD, American Diabetes Association (ADA) Guidelines for Diabetes Care for M/S drugs. • Accepted clinical practice guidelines, consensus statements, or comparable publications – e.g., Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), American Psychiatric Association (APA) Guidelines for treating Depression, Substance Abuse and Mental Health Services Administration (SAMHSA)
Evidentiary Standards and Applicable Thresholds	Drug safety concerns and determinations as indicated in peer-reviewed medical literature or comparison analyses of safety of other similar drugs.
Source(s) of Evidentiary Standards	• Peer-reviewed medical literature • Comparison analyses

CVS Factor 2	**Potential for Inappropriate or Off-Label Use**
Definition	The drug has a potential for inappropriate or off-label use.
Application Benefit Classification(s)	• Prescription Drugs
Description	This factor is used in the application of prior authorization to determine whether there is a heightened risk for inappropriate use.
Source(s) of Factor	• FDA product labeling for approved uses and safety information.
Evidentiary Standards and Applicable Thresholds	A drug with known potential of inappropriate or off-label use.
Source(s) of Evidentiary Standards	• US Food and Drug Administration labeling • Centers for Medicare & Medicaid Services accepted drug compendia • Published peer-reviewed clinical literature, accepted clinical practice guidelines, standards of care, government health agencies • External clinical experts • Similar drugs • Utilization trend reports • Applicable manufacturer agreement

CVS Factor 3	Generic or Alternative Availability
Definition	There is a generic equivalent or alternative available on preferred tier.
Application Benefit Classification(s)	• Prescription Drugs
Description	This factor is used in the design of prior authorization to determine whether a generic equivalent is available.
Source(s) of Factor	• Comparison of similar drugs in terms of safety and efficacy. • Annual review of UM criteria and clinical programs by internal pharmacists in the Clinical Development department and medical department. • Review of any new criteria, updates, and annual review of utilization management criteria, and clinical program content by external clinical experts, who are physicians practicing in the relevant clinical area. • Review and approval of prior authorization coverage criteria for clinical appropriateness by the CVS Caremark National P&T Committee. • Published peer-reviewed clinical literature – e.g., Journal of the American Medical Association (JAMA), New England Journal of Medicine (NEJM) • Published peer-reviewed clinical literature – e.g., Journal of the American Medical Association (JAMA), New England Journal of Medicine (NEJM), Journal of Clinical Psychiatry • FDA product labeling for approved uses and safety information • Nationally recognized and approved drug compendia, including American Hospital Formulary Service® Drug, Lexi-Drug, Clinical Pharmacology, Micromedex Drugdex
Evidentiary Standards and Applicable Thresholds	An alternative is available at a lower cost with the same efficacy and safety. A ratio of 1:1 is used.
Source(s) of Evidentiary Standards	• Safety and efficacy comparative analyses • Cost analysis

CVS Factor 4	Other Dosage Forms
Definition	There are multiple other dosage forms available on preferred tier.
Application Benefit Classification(s)	• Prescription Drugs
Description	This factor is used in the design and application of prior authorization to consider alternative dosage form availability.

Source(s) of Factor	• FDA product labeling for approved uses and safety information.
Evidentiary Standards and Applicable Thresholds	The availability of other dosage forms available at lower cost or on a lower drug tier. A ratio of 1:1 is used.
Source(s) of Evidentiary Standards	• Cost analysis • Drug Tier review

CVS Factor 5	**Reduce Fraud, Waste, or Abuse**
Definition	To reduce waste, unnecessary drug use, fraud, or abuse.
Application Benefit Classification(s)	• Prescription Drugs
Description	This factor is used in the design and application of prior authorization to reduce incidents of fraud, waste, or abuse.
Source(s) of Factor	• FDA product labeling for approved uses and safety information.
Evidentiary Standards and Applicable Thresholds	The drug is highly likely to be subject to fraud, waste, and abuse based on literature, FDA reports etc.
Source(s) of Evidentiary Standards	• Fraud, waste, and abuse reports • Peer-reviewed medical literature • FDA warnings

CVS Factor 6	**Additional Supportive Therapy Requirements**
Definition	A requirement for additional treatment supportive therapies, including but not limited to behavioral counseling, diet therapy, case management, and other standard non-drug supportive therapies.
Application Benefit Classification(s)	• Prescription Drugs
Description	This factor is used in the application of prior authorization to ensure non-drug required supportive therapies are paired with prescription drugs.
Source(s) of Factor	• FDA product labeling for approved uses and safety information.

Evidentiary Standards and Applicable Thresholds	The need for supportive therapy requirements in addition to prescribing the drug. The need for supportive therapy ignites a prior authorization need.
Source(s) of Evidentiary Standards	• Clinical practice guidelines

B. Factors and Evidentiary Standards Used to Determine List of Services Subject to Prior Authorization

Factor 1	**Prior Authorization Submission Timelines**
Definition	The provider and/or member must submit the prior authorization request within appropriate timelines except when it is not medically feasible due to the member's medical condition. Additionally, it should be noted that prior authorizations not received within these timelines does not automatically constitute a denial as CareFirst allowed for retrospective review of these services.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the administration of the prior authorization NQTL to set requirements for when prior authorization requests must be submitted.
Source(s) of Factor	• Internal policies and procedures • Request review timelines vary and are based on applicable NCQA, state and federal requirements.
Evidentiary Standards and Applicable Thresholds	Prior Authorization Submission Timelines: • Inpatient elective – 15 days prior • Inpatient admission – within 24 hours or next business day • Outpatient services – 15 days prior
Source(s) of Evidentiary Standards	• Internal policies and procedures • Request review timelines based on applicable NCQA, state and federal requirements. • Medical Provider manual

Factor 2	**Approval/Denial Timelines for Insurer**
Definition	The required timeline for insurers to respond to a prior authorization request.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other • Prescription Drugs
Description	This factor is used in the administration of the prior authorization NQTL to set requirements for when an insurer must respond to a completed prior authorization request.
Source(s) of Factor	• Md. Insurance Code §19-108.2 • Md. Insurance Code §15-10B-06 • D.C. Law 25-100
Evidentiary Standards and Applicable Thresholds	• For an urgent health care service, 24 hours • For long-term services and supports, 30 days; and • For all other health care services, 3 business days of receiving the request via electronic portal or 5 business days of receiving the request via mail, telephone, or facsimile.
Source(s) of Evidentiary Standards	• Md. Insurance Code §19-108.2 • Md. Insurance Code §15-10B-06 • D.C. Law 25-100

Factor 3	**Clinical Appropriateness**
Definition	The proposed treatment or service must be appropriate, 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.

Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the administration of the prior authorization NQTL to set requirements for when an insurer must respond to a completed prior authorization request before the request is automatically approved.
Source(s) of Factor	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.
Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. There is no threshold for number of studies reviewed. Quality of research is investigated as opposed to quantity.

Source(s) of Evidentiary Standards	• Patient medical records and treatment history/plan • MCG Guidelines • ASAM Guidelines • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

CareFirst delegates all Utilization Management for Prescription Drugs to CVS. This includes prior authorization requirements

CVS Factor 1	**Patient Safety Concerns**
Definition	The presence of patient safety concerns exists with a drug or drug class such as unknown long-term safety or durability.
Application Benefit Classification(s)	• Prescription Drugs
Description	This factor is used in the application of prior authorization to determine whether there is a heightened risk for patient safety.

Source(s) of Factor	• Published peer-reviewed clinical literature – e.g., Journal of the American Medical Association (JAMA), New England Journal of Medicine (NEJM) • Accepted clinical practice guidelines, consensus statements, or comparable publications – e.g., Global Initiative for Chronic Obstructive Lung Disease (GOLD) Guidelines for treating COPD, American Diabetes Association (ADA) Guidelines for Diabetes Care for M/S drugs. • Accepted clinical practice guidelines, consensus statements, or comparable publications – e.g., Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), American Psychiatric Association (APA) Guidelines for treating Depression, Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines for treating SUD for MH/SUD drugs. • Comparison of similar drugs in terms of safety and efficacy • Review and approval of prior authorization coverage criteria for clinical appropriateness by the CVS Caremark National P&T Committee drugs.
Evidentiary Standards and Applicable Thresholds	Drug safety concerns and determinations as indicated in peer-reviewed medical literature or comparison analyses of safety of other similar drugs.
Source(s) of Evidentiary Standards	• Published peer-reviewed clinical literature – e.g., Journal of the American Medical Association (JAMA), New England Journal of Medicine (NEJM) • Comparison analyses

CVS Factor 2	**Generic or Alternative Availability**
Definition	There is a generic equivalent or alternative available on preferred tier.
Application Benefit Classification(s)	• Prescription Drugs
Description	This factor is used in the design of prior authorization to determine whether a generic equivalent is available.
Source(s) of Factor	• Comparison of similar drugs in terms of safety and efficacy. • 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 of any new criteria, updates, and annual review of utilization management criteria, and clinical program content by external clinical experts, who are physicians practicing in the relevant clinical area. • Review and approval of prior authorization coverage criteria for clinical appropriateness by the CVS • Caremark National P&T Committee.

	• Published peer-reviewed clinical literature – e.g., Journal of the American Medical Association (JAMA), New England Journal of Medicine (NEJM) • Published peer-reviewed clinical literature – e.g., Journal of the American Medical Association (JAMA), New England Journal of Medicine (NEJM), Journal of Clinical Psychiatry • FDA product labeling for approved uses and safety information • Nationally recognized and approved drug compendia, including American Hospital Formulary Service® Drug, Lexi-Drug, Clinical Pharmacology, Micromedex Drugdex
Evidentiary Standards and Applicable Thresholds	An alternative is available at a lower cost with the same efficacy and safety. A ratio of 1:1 is used.
Source(s) of Evidentiary Standards	• Safety and efficacy comparative analyses • Cost analysis • Published peer-reviewed clinical literature – e.g., Journal of the American Medical Association (JAMA), New England Journal of Medicine (NEJM) and clinical trials data

CVS Factor 3	**Other Dosage Forms**
Definition	There are multiple other dosage forms available on preferred tier.
Application Benefit Classification(s)	• Prescription Drugs
Description	This factor is used in the design and application of prior authorization to consider alternative dosage form availability.
Source(s) of Factor	• Accepted clinical practice guidelines, consensus statements, or comparable publications – e.g., Global Initiative for Chronic Obstructive Lung Disease (GOLD) Guidelines for treating COPD, American Diabetes Association (ADA) Guidelines for Diabetes Care for M/S drugs. • Accepted clinical practice guidelines, consensus statements, or comparable publications – e.g., Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), American Psychiatric Association (APA) Guidelines for treating Depression, Substance Abuse and Mental Health Services Administration (SAMHSA) guidelines for treating SUD for MH/SUD drugs.

Evidentiary Standards and Applicable Thresholds	The drug is highly likely to be subject to fraud, waste, and abuse based on literature, FDA reports etc.
Source(s) of Evidentiary Standards	• Fraud, waste, and abuse reports • Published peer-reviewed clinical literature – e.g., Journal of the American Medical Association (JAMA), New England Journal of Medicine (NEJM) and clinical trials data • FDA warnings

CVS Factor 4	**Additional Supportive Therapy Requirements**
Definition	A requirement for additional treatment supportive therapies, including but not limited to behavioral counseling, diet therapy, case management, and other standard non-drug supportive therapies.
Application Benefit Classification(s)	• Prescription Drugs
Description	This factor is used in the application of prior authorization to ensure non-drug required supportive therapies are paired with prescription drugs.
Source(s) of Factor	• Accepted clinical practice guidelines, consensus statements, or comparable publications – e.g., Global Initiative for Chronic Obstructive Lung Disease (GOLD) Guidelines for treating COPD, American Diabetes Association (ADA) Guidelines for Diabetes Care for M/S drugs.
Evidentiary Standards and Applicable Thresholds	The need for supportive therapy requirements in addition to prescribing the drug. The need for supportive therapy ignites a prior authorization need.
Source(s) of Evidentiary Standards	• Clinical practice guidelines – e.g., Global Initiative for Chronic Obstructive Lung Disease (GOLD) Guidelines for treating COPD, American Diabetes Association (ADA) Guidelines for Diabetes Care for M/S drugs.

CVS Factor 5	**Cost-Effectiveness**
Definition	Whether there is another more cost-effective treatment that achieves the same results.
Application Benefit Classification(s)	• Prescription Drugs

Description	This factor is used in the application of prior authorization to ensure non-drug required supportive therapies are paired with prescription drugs.
Source(s) of Factor	• US Food and Drug Administration labeling • Centers for Medicare & Medicaid Services accepted drug compendia • Published peer-reviewed clinical literature, accepted clinical practice guidelines, standards of care government health agencies • External clinical experts • Similar drugs • Utilization trend reports • Applicable manufacturer agreement • US Food and Drug Administration labeling • Centers for Medicare & Medicaid Services accepted drug compendia • Published peer-reviewed clinical literature, accepted clinical practice guidelines, standards of care, and government health agencies • External clinical experts • Similar drugs • Utilization trend reports • Applicable manufacturer agreement
Evidentiary Standards and Applicable Thresholds	If another more cost-effective alternative exists with the same success, the request will be denied.
Source(s) of Evidentiary Standards	• Similar drugs • Utilization trend reports • Applicable manufacturer agreement

A. Processes

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. CareFirst's medical and behavioral health policies are available on web.carefirst.com.

The internal and external criteria used for both M/S and MH/SUD are authorized by the CareFirst Criteria Review Committee. Internal 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.

Written UM policies and procedures define CareFirst's prior approval and utilization review program. All services authorized by the Utilization Management (UM) Staff are evaluated against appropriate benefit packages and nationally accepted medical necessity criteria. The criteria are reviewed, revised, and approved at least annually by the Quality Executive Committee (QEC). A designated senior practitioner, specifically the Chief Medical Officer (CMO), has significant involvement in the implementation of the UM Program and related policies and procedures. A formal UM Committee, under the direction of the CMO, oversees the Utilization Review process.

Prior authorization decisions and processes are supervised by qualified licensed professionals. A licensed professional who has appropriate clinical experience in treating the enrollee's condition or disease makes a request for the CMO or Medical Director to review a request for service that does not meet medical necessity criteria. The CMO or medical director makes the final coverage determination if the clinician is unable to approve the request. A change in the amount, duration, or scope that is less than requested must be made by a healthcare physician. Licensed physician consultants from Medical Review Institute of America (MRIA) are utilized to review cases from the appropriate specialty areas as needed.

A licensed physician oversees UM decisions to ensure consistent medical necessity decision making. Licensed doctoral-level clinical psychologists oversee behavioral health care UM decisions for psychological testing. Licensed nurses or Licensed Clinical Social Workers (RN or LPN or LCSW) may approve benefit or medical necessity cases. These practitioners may not deny medical necessity cases.

Utilization Management Staff and their Responsibilities:

CareFirst Title	Qualifications
Medical Director/Chief Medical Officer	Board certified Medical Doctor responsible for the development and implementation of UM processes, criteria, and program outcomes. Oversees the operations of the UM department and is a liaison to the medical community regarding UM program operations. Clinical consultant for UM decisions: approves and denies care according to medical criteria and policies and procedures. Reports to Executive Vice President of Health Services and supervises all other medical directors (e.g., Behavioral Health Medical Director, Radiology/Cardiology Medical Director, etc.). Chairs the UM Committee.

Medical Director, Behavioral Health	Board certified Medical Doctor of Psychiatry, who reviews and makes determinations based on medical necessity on behavioral health UM cases, using evidence-based UM criteria and policies and procedures. Liaison to the behavioral health practitioner and provider communities. Provides information and expertise to the UM behavioral health staff. Reports to the Medical Director, is an enrollee of the UM Committee.
Director of Utilization Management	A Registered Nurse who is responsible for intake, precertification, concurrent review, and retrospective review activities of the department. Develops and maintains policies and procedures for assigned areas. Approves requested care per UM criteria and policies and procedures. May deny care based on benefits or contract issues. Supervises all RN, LPN staff and UM coordinators, and is responsible for department operations. Reports to the Clinical Director of Government Programs with a dotted line to the Chief Medical Officer.
Utilization Management Manager/Supervisor	Assists UM director with day-to-day operations, oversees completion of reviews by UR Reviewers, problem-solves, conducts audits, prepares documents for weekly UM Meetings. Reports to the Director of Utilization Management.
Utilization Management Reviewer	A Licensed Nurse who conducts UM review activities. Monitors and coordinates care with participating practitioners, enrollees, and provider organizations, using established criteria. Collects data for the precertification, concurrent review, and retrospective review processes. Approves requested care per UM criteria and policies and procedures. May deny authorization requests based administrative criteria (i.e., benefit or contractual limitations) In the event that medical necessity is not met, the reviewer would submit the authorization request to a MD for the medical necessity determination.
Vice President of Pharmacy and Therapeutics	The Doctor of Pharmacy is responsible for developing and maintaining the formulary and formulary policies and procedures. Researches, approves and denies requests for drugs consistent with formulary policies and procedures and UM criteria. Reports to the Medical Director/CMO and is a member of the P & T Committee. Provides support to the P & T Committee and manages the MCO's relationship with the Pharmacy Benefits Manager (PBM).
Physician Advisors	Board certified Medical Doctors who are available for review of UM cases (including appeals), or in the case of an appeal They will research and either approve or denies the authorization request according to UM criteria and policies and procedures.

B. Strategy

CareFirst uses internal clinical policy (CareFirst Medical Policy Reference Manual) for M/S and MH/SUD, which is drafted using external clinical criteria, in addition to peer-reviewed literature, clinical trials, professional opinion, and publications by professional societies or government agencies. If the internal criteria are not sufficient to render a medical necessity approval determination, then external clinical criteria will be used.

CareFirst uses appropriate, evidence-based external clinical criteria for M/S and MH/SUD benefits. These include: the Modified Appropriateness Evaluation Protocol (AEP) Criteria (for M/S inpatient), the Apollo Managed Care Physical Therapy (for Physical Therapy), Occupational Therapy, Speech Therapy and Rehabilitation Criteria (for OT, ST, and Rehabilitation), MCG Guidelines 25th edition (for Behavioral Health, Ambulatory Care, Inpatient & Surgical Care, and Home Care), and The American Society of Addiction Medicine (ASAM) criteria (for SUD).

C. Relationship Between Factors

All factors in the analyses are considered equally and there is no factor that carries more weight than another. The following factors were removed from the 2023 analysis for inpatient in-network, inpatient out-of-network, outpatient in-network, and outpatient out-of-network as they were considered, but ultimately determined to not be utilized:

- Variability in cost
- Demand for services
- Licensing and accreditation of providers

The above factors were removed after further investigation of utilization management reviews in practice. Reviewers focused on standards of care, efficacy, and length of stay. Cost was not taken into consideration in approval or denial decisions, nor was demand for services. Licensing and accreditation of providers was analyzed in a separate NQTL (credentialing) and is not reviewed during the utilization management process.

III. Demonstration of Comparability and Stringency as Written

This section demonstrates that in each classification, under the terms of the plan as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying prior authorization to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the prior authorization with respect to M/S benefits.

CareFirst has a standard operating procedure for the prior authorization reviews that applies to both MH/SUD services and M/S services. (Utilization Management Prior Authorization Review Process #CO UM 200.20 and Utilization Review Coverage Decision Procedure #CO UM 105.00). The written criteria and procedures are to ensure fair and consistent prior authorization reviews and utilization decisions.

CareFirst has a standard operating procedure for the prior authorization reviews that applies to both MH/SUD services and M/S services. The written criteria and procedures are to ensure fair and consistent prior authorization reviews and utilization decisions. If a service is potentially being added to the prior authorization list, a medical policy and reference manual is created for these services. Each service has its own unique medical policy that includes criteria, guidelines, descriptions, thresholds, and referenced peer-reviewed medical literature to support the policy and decisions. This process is the same for all services added onto the prior authorization list.

CareFirst recognizes a responsibility to demonstrate a commitment of superior clinical quality service that is member centric, high touch, clinically appropriate, cost effective, data driven and culturally competent. This is achieved through an organization-wide, systematic, and coordinated approach that involves input from and coordination with both internal and external stakeholders. These stakeholders include members, providers,

state entities, CMS, business units, department, and staff members. 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. This is inclusive of both physical and mental health services provided in an inpatient or outpatient setting.

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.

Utilization tracking and trending data are reviewed by the UM Committee quarterly and submitted on a quarterly basis to the QEC. The data are analyzed by the QEC to determine outcomes related to overutilization or underutilization of services under 42 C.F.R. § 438.240(b)(3). Further, CareFirst performs internal audits to ensure proper treatment and decision-making in relation to utilization management procedures, approvals, and denials. This audit supports CareFirst's NCQA accreditation requirements. In 2023, Behavioral Health scored a 100% and earned all points from NCQA for proper treatment of MH/SUD services in regard to prior authorization.

Prescription Drug Benefits:

CareFirst delegates all Utilization Management for Prescription Drugs to CVS. This includes prior authorization requirements. The process CVS follows for prescription drug benefits is as follows:

- The UM Clinical Development team drafts UM NQTL requirements that include coverage for use supported by evidence-based medicine and standard of care sources.
- The Formulary Review Committee (FRC) meets regularly to discuss and review drug information and makes recommendations for prior authorization for the P&T Committee's review and approval
- Standard UM NQTLs (including prior authorization) are reviewed internally by a CVS Caremark Medical Director, and externally by an external clinical specialist prescriber as a part of the Clinical Program Oversight (CPO).
- The P&T Committee reviews and approves the UM NQTLs (including prior authorization) for clinical appropriateness.

No separate policies or procedures exist with respect to UM NQTLs for MH/SUD drugs as compared to MED/SURG drugs. Additionally, no separate meetings occur to vote on decisions about MH/SUD drugs compared to MED/SURG drugs; both drugs are considered in the same meetings without regard to whether they treat MH/SUD or MED/SURG conditions.

The policies and procedures show that personnel and committee members follow a process that is no different for MH/SUD compared to MED/SURG drugs. The meeting minutes show that these experts evaluate and consider the factors for applying UM NQTLs in the same manner, regardless of whether a drug is used to treat a MH/SUD or MED/SURG condition or disease.

The sources and evidentiary standards used are different for each drug and each drug class and are disease or condition specific; however, their level of evidence is the same and consistent with the policies. The sources are cited in the monographs and therapeutic class review references, and their use is consistent with the policies and procedures. Age restrictions are applied to MH/SUD or MED/SURG drugs if clinical evidence indicates a drug is potentially harmful or not effective in a population that can be defined by age, and these restrictions were found in the sample prior authorization criteria reviewed. The P&T committee members use these monographs, therapeutic class reviews and presentations to make informed decisions and vote on recommendations using the same process and equally weighing applicable factors and sources for formulary UM NQTLs considerations.

The voting FRC and P&T Committee members have different expertise and credentials, but there is no difference in level of expertise required to participate as a voting member for MH/SUD compared to MED/SURG conditions. The members' participation is not based on whether a drug being considered is used to treat MH/SUD or MED/SURG conditions or diseases.

Prescription Drug Testing Methodology

The processed drug coverage extract file was analyzed as follows:

- Drugs with formulary UM NQTLs were grouped into MH, SUD and MED/SURG drug types, counted, and totals were used to calculate the percentages on each type.
- Drugs with formulary UM NQTLs in the MH/SUD and MED/SURG types were grouped by therapeutic class, counted, and the totals were used to calculate percentages on each class.
- Samples of drug classes for chronic MED/SURG conditions were chosen as comparators.
- Comparisons were performed at the drug class level, by count and percent, and by the factors considered and applied in each of the classes within each of the MH/SUD and MED/SURG drug types.

IV. Demonstration of Comparability and Stringency In Operation

This section demonstrates that in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying prior authorization to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying prior authorization with respect to M/S benefits.

A. Explanation of how CareFirst Evaluates Comparability

Below is a comprehensive explanation of how CareFirst evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying prior authorization to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying prior authorization with respect to M/S benefits.

B. Documentation of Outcomes

1. Evaluation of Relevant Data

CareFirst receives and regularly reviews prior authorization data from both internal and external sources. External data includes vendor data from CVS (CVS Medical, CVS Drug, and CVS NCCN) as well as Carelon (fka AIM Specialty). The rates at which M/S and MH/SUD prior authorization requests are reviewed and approved or denied is comparable for M/S and MH/SUD services for both internal and external prior authorization requests. The data summary below is based on prior authorization approval rates in the state of Virginia. Additional data supplements are available upon request.

a. In-Network Outpatient Prior Authorization Data

In-Network Outpatient	M/S Outpatient Office	M/S Outpatient Other	Total M/S Outpatient INN
Total # of Claims	722,981	512,944	1,235,925
Total # of PA Requests	1,169	5,672	6,841
Percentage of Claims Subject to PA	0.2%	1.1%	0.6%
PA Approvals and Denials			
Total # of Approved PA Requests	1059	5517	6,576
Total # of Denied PA Requests	103	144	247
Percentage of Denied PA Requests	8.9%	2.5%	3.8%
Turnaround Times and Approved Visits			
Average Number of Visits Approved	3	3	

Average Turnaround Time	2	2
Medical Director Reviews		
Number of PA Medical Director Reviews	15	67
Number of PA Medical Director Approvals	15	67
Number of PA Medical Director Denials	0	0
Percentage of PA Reviewed by Medical Director	1.3%	1.2%
Percentage of PA Denied by Medical Director	0.0%	0.0%

In-Network Outpatient	**MH Outpatient Office**	**MH Outpatient Other**	**SUD Outpatient Office**	**SUD Outpatient Other**	**Total MH/SUD Outpatient**
Total # of Claims	87,355	144,309	3,195	5,932	240,791
Total # of PA Requests	834	180	0	10	1,024
Percentage of Claims Subject to PA	1.0%	0.1%	0.0%	0.2%	0.4%
PA Approvals and Denials					
Total # of Approved PA Requests	815	166	0	9	990
Total # of Denied PA Requests	19	13	0	1	33
Percentage of Denied PA Requests	2.3%	7.3%	#DIV/0!	10.0%	3.2%
Turnaround Times and Approved Visits					
Average Number of Visits Approved	3	3	0	2.5	
Average Turnaround Time	3	3.5	0	2	
Medical Director Reviews					
Number of PA Medical Director Reviews	15	2	0	1	

Number of PA Medical Director Approvals	15	2	0	1
Number of PA Medical Director Denials	0	0	0	0
Percentage of PA Reviewed by Medical Director	1.8%	1.1%	#DIV/0!	10.0%
Percentage of PA Denied by Medical Director	0.0%	0.0%	#DIV/0!	0.0%

b. Out-of-Network Outpatient Prior Authorization Data

Out-of-Network Outpatient	M/S Outpatient Office	M/S Outpatient Other	Total M/S Outpatient OON
Total # of Claims	27,778	31,265	59,043
Total # of PA Requests	2	10	12
Percentage of Claims Subject to PA	0.0%	0.0%	0.0%
PA Approvals and Denials			
Total # of Approved PA Requests	1	7	8
Total # of Denied PA Requests	1	3	4
Percentage of Denied PA Requests	50.0%	30.0%	50.0%
Turnaround Times and Approved Visits			
Average Number of Visits Approved	3	2.5	
Average Turnaround Time	5	3.5	
Medical Director Reviews			
Number of PA Medical Director Reviews	1	5	
Number of PA Medical Director Approvals	1	5	
Number of PA Medical Director Denials	0	0	
Percentage of PA Reviewed by Medical Director	50.0%	50.0%	
Percentage of PA Denied by Medical Director	0.0%	0.0%	

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Out-of-Network Outpatient	MH Outpatient Office	MH Outpatient Other	SUD Outpatient Office	SUD Outpatient Other
Total # of Claims	8,833	11,328	320	1,552
Total # of PA Requests	0	0	0	0
Percentage of Claims Subject to PA	0%	0%	0%	0%
PA Approvals and Denials				
Total # of Approved PA Requests	0	0	0	0
Total # of Denied PA Requests	0	0	0	0
Percentage of Denied PA Requests	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Turnaround Times and Approved Visits				
Average Number of Visits Approved	0	0	0	0
Average Turnaround Time	0	0	0	0
Medical Director Reviews				
Number of PA Medical Director Reviews	0	0	0	0
Number of PA Medical Director Approvals	0	0	0	0
Number of PA Medical Director Denials	0	0	0	0
Percentage of PA Reviewed by Medical Director	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Percentage of PA Denied by Medical Director	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

c. In-Network Inpatient Prior Authorization Data

In-Network Inpatient	M/S General Hospital	M/S Specialty Hospital	M/S Inpatient Hospice	M/S Skilled Nursing Facility	Total M/S Inpatient INN
Total # of Claims	48,093	275	133	709	49,210
Total # of PA Requests	616	3	0	0	619
Percentage of Claims Subject to PA	1.3%	1.1%	0.0%	0.0%	1.3%
PA Approvals and Denials					
Total # of Approved PA Requests	610	3	0	0	613
Total # of Denied PA Requests	4	0	0	0	4
Percentage of Denied PA Requests	0.6%	0.0%	#DIV/0!	#DIV/0!	0.7%
Turnaround Times and Approved Days					
Average Number of Days Approved	2	1.5	0	0	
Average Turnaround Time	1	3	0	0	
Medical Director Reviews					
Number of PA Medical Director Reviews	40	1	0	0	
Number of PA Medical Director Approvals	36	1	0	0	
Number of PA Medical Director Denials	4	0	0	0	
Percentage of PA Reviewed by Medical Director	6.5%	33.3%	#DIV/0!	#DIV/0!	
Percentage of PA Denied by Medical Director	10.0%	0.0%	#DIV/0!	#DIV/0!	

In-Network Inpatient	MH General Hospital	MH Specialty Psychiatric Hospital	MH Residential Treatment Facility	SUD General Hospital	SUD Specialty Psychiatric Hospital	SUD Residential Treatment Facility	Total MH/SUD Inpatient INN
Total # of Claims	1947	642	528	549	9	448	4123
Total # of PA Requests	7	75	1	0	5	189	277
Percentage of Claims Subject to PA	0%	12%	0%	0%	56%	42%	6.7%
PA Approvals and Denials							
Total # of Approved PA Requests	7	75	1	0	5	188	188
Total # of Denied PA Requests	0	0	0	0	0	0	0
Percentage of Denied PA Requests	0.0%	0.0%	0.0%	#DIV/0!	0.0%	0.0%	0.0%
Turnaround Times and Approved Days							
Average Number of Days Approved	3	3	3	0	1	2	
Average Turnaround Time	4	2	5	0	1	1	
Medical Director Reviews							
Number of PA Medical Director Reviews	1	24	0	0	0	11	
Number of PA Medical Director Approvals	1	24	0	0	0	11	
Number of PA Medical Director Denials	0	0	0	0	0	0	
Percentage of PA Reviewed by Medical Director	14.3%	32.0%	0.0%	#DIV/0!	0.0%	5.9%	
Percentage of PA Denied by Medical Director	0.0%	0.0%	#DIV/0!	#DIV/0!	#DIV/0!	0.0%	

d. Out-of-Network Inpatient Prior Authorization Data

Out-of-Network Inpatient	M/S General Hospital	M/S Specialty Hospital	M/S Inpatient Hospice	M/S Skilled Nursing Facility	Total M/S Inpatient INN
Total # of Claims	2,449	3	5	234	2,691
Total # of PA Requests	0	0	0	0	0
Percentage of Claims Subject to PA	0%	0%	0%	0%	0.0%
PA Approvals and Denials					
Total # of Approved PA Requests	0	0	0	0	0
Total # of Denied PA Requests	0	0	0	0	0
Percentage of Denied PA Requests	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Turnaround Times and Approved Days					
Average Number of Days Approved	N/A	N/A	N/A	N/A	
Average Turnaround Time	N/A	N/A	N/A	N/A	
Medical Director Reviews					
Number of PA Medical Director Reviews	#VALUE!	#VALUE!	#VALUE!	#VALUE!	
Number of PA Medical Director Approvals	N/A	N/A	N/A	N/A	
Number of PA Medical Director Denials	N/A	N/A	N/A	N/A	
Percentage of PA Reviewed by Medical Director	N/A	N/A	N/A	N/A	
Percentage of PA Approved by Medical Director	N/A	N/A	N/A	N/A	
Percentage of PA Denied by Medical Director	N/A	N/A	N/A	N/A	
Percentage of Exp/Inv RR Denials Upheld	N/A	N/A	N/A	N/A	

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Out-of-Network Inpatient	MH General Hospital	MH Specialty Psychiatric Hospital	MH Residential Treatment Facility	SUD General Hospital	SUD Specialty Psychiatric Hospital	SUD Residential Treatment Facility	Total MH/SUD Inpatient OON
Total # of Claims	265	27	394	189	9	136	1020
Total # of PA Requests	0	0	0	0	5	0	5
Percentage of Claims Subject to PA	0%	0%	0%	0%	56%	0%	0.5%
PA Approvals and Denials							
Total # of Approved PA Requests	0	0	0	0	5	0	5
Total # of Denied PA Requests	0	0	0	0	0	0	0
Percentage of Denied PA Requests	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	0.0%	#DIV/0!	0.0%
Turnaround Times and Approved Days							
Average Number of Days Approved	0	0	0	0	1	0	
Average Turnaround Time	0	0	0	0	1	0	
Medical Director Reviews							
Number of PA Medical Director Reviews	0	0	0	0	0	0	
Number of PA Medical Director Approvals	N/A	N/A	N/A	N/A	N/A	N/A	
Number of PA Medical Director Denials	N/A	N/A	N/A	N/A	N/A	N/A	
Percentage of PA Reviewed by Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	
Percentage of PA Denied by Medical Director	N/A	N/A	N/A	N/A	N/A	N/A	

2. Justification and Analysis

Review of CareFirst's internal prior authorization data for Virginia fully insured risk business for the period January 1, 2025 through December 31, 2025 shows that prior authorization is applied and administered in a comparable manner for M/S and MH/SUD services. For inpatient in-network services, 619 M/S prior authorization requests were identified out of 49,210 claims, representing approximately 1.3% of M/S inpatient claims. By comparison, 277 MH/SUD prior authorization requests were identified out of 4,123 claims, representing approximately 6.7% of MH/SUD inpatient claims. M/S inpatient in-network requests were approved at a rate of 99.0% and denied at a rate of 0.6%. MH/SUD inpatient in-network requests reflected no denials among the services reported in the data set. Although certain MH/SUD inpatient subcategories had higher percentages of claims subject to prior authorization, particularly specialty psychiatric hospital and residential treatment facility services, the absence of MH/SUD denials does not indicate that the NQTL was applied more stringently to MH/SUD benefits in operation.

For outpatient in-network services, 6,841 M/S prior authorization requests were identified out of 1,235,925 claims, representing approximately 0.6% of M/S outpatient claims. MH/SUD outpatient in-network services had 1,024 prior authorization requests out of 240,791 claims, representing approximately 0.4% of MH/SUD outpatient claims. The M/S outpatient in-network approval rate was approximately 96.1%, with a denial rate of approximately 3.6%. The MH/SUD outpatient in-network approval rate was approximately 96.7%, with a denial rate of approximately 3.2%. These results show comparable approval and denial outcomes, with MH/SUD outpatient requests approved at a slightly higher rate and denied at a slightly lower rate than M/S outpatient requests. Out-of-network utilization was limited: M/S outpatient out-of-network services reflected 12 total prior authorization requests, while MH/SUD outpatient out-of-network services reflected no prior authorization requests; inpatient out-of-network M/S services reflected no prior authorization requests, and MH/SUD inpatient out-of-network services reflected five requests, all of which were approved. Because the out-of-network request volume is limited, the in-network data provides the more meaningful basis for evaluating operational comparability. Overall, the data does not show that prior authorization is applied more stringently to MH/SUD benefits than to M/S benefits in operation.

The turnaround time and medical director review data also supports operational comparability. For inpatient in-network services, average turnaround times for M/S requests were one day for general hospital services and three days for specialty hospital services, while MH/SUD inpatient requests generally ranged from one to five days depending on service category, with one-day average turnaround times for SUD specialty psychiatric hospital and residential treatment facility services and two to five days for MH general hospital, specialty psychiatric hospital, and residential treatment facility services. Approved inpatient units were also generally limited and comparable, with M/S approvals averaging 1.5 to 2 days and MH/SUD approvals generally averaging 1 to 3 days. Medical director review activity did not show a more stringent pattern for MH/SUD services. Inpatient M/S requests had 41 medical director reviews across 619 requests, with four medical director denials, while inpatient MH/SUD requests had 36 medical director reviews across 277 requests and no medical director denials. For outpatient in-network services, M/S average turnaround times were two days for both office and other outpatient services, while MH/SUD average turnaround times ranged from two to 3.5 days. Approved outpatient visits averaged three visits for M/S services and ranged from 2.5 to 3 visits for MH/SUD services with utilization. Medical director review rates were low across both classifications: M/S outpatient services had 82 medical director reviews across 6,841 requests and no medical director denials, while

MH/SUD outpatient services had 18 medical director reviews across 1,024 requests and no medical director denials. These results further support the conclusion that CareFirst's prior authorization NQTL is not applied more stringently to MH/SUD benefits than to M/S benefits in operation.

V. Findings and Conclusions

The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply the prior authorization requirement to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the prior authorization requirement to M/S benefits; and (2) CareFirst complies with the relevant data requirements under the MHPAEA Final Rules.

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.

Operationally, based on the claims volume, prior authorization request rates, approval and denial outcomes, turnaround times, approved units, and medical director review activity, the data supports a finding that CareFirst's prior authorization NQTL is applied in a comparable and no more stringent manner for MH/SUD benefits than for M/S benefits, as written and in operation. While certain MH/SUD inpatient subcategories reflect higher prior authorization request rates, those differences do not translate into less favorable outcomes for MH/SUD members; MH/SUD inpatient requests had no reported denials, MH/SUD outpatient requests were approved at a slightly higher rate and denied at a slightly lower rate than M/S outpatient requests, and medical director denials were not more prevalent for MH/SUD services. Turnaround times and approved days or visits were generally comparable across classifications, and the limited out-of-network request volume does not indicate a pattern of disparate application. Accordingly, the operational data supports the conclusion that the prior authorization process complies with MHPAEA's comparative analysis standard because the NQTL is not designed or applied more stringently to MH/SUD benefits than to M/S benefits within the same benefit classifications.

VI. Required Certification

CareFirst certifies that the foregoing comparative analysis of the Prior Authorization NQTL was prepared for the Virginia fully insured coverage identified in this report and was reviewed by individuals with appropriate knowledge of the plan terms, policies, procedures, factors, evidentiary standards, operational practices, supporting documentation, and relevant data addressed in the analysis. The analysis applies to the CareFirst entities identified in this report as NAIC 53007 and NAIC 9602 to the extent the NQTL is designed and administered as described in this analysis.

To the best of CareFirst's knowledge and based on the information, documentation, and data reviewed as of the report's version date, this comparative analysis is accurate and complete in all material respects and demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the Prior Authorization NQTL to mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, those used to design and apply the NQTL to medical/surgical benefits, as written and in operation. CareFirst will maintain supporting documentation and will update or supplement the analysis if a material change, newly identified data limitation, or corrective action affects this conclusion.

CONCURRENT REVIEW

Overview

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the concurrent review requirement to mental health or substance use disorder ("MH/SUD") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the concurrent review requirement to medical surgical ("M/S") benefits.

I. Description of the Concurrent Review NQTL

Concurrent review is a component of CareFirst's utilization management program for inpatient services. Concurrent review is not applied to any outpatient benefits and there are no visit limits for MH/SUD services. The concurrent review process helps to ensure that members are receiving appropriate care, based on their unique clinical needs. The process includes the application of evidence-based clinical guidelines, which encourage optimum clinical outcomes.

A. Identification of the NQTL

i. Plan/Coverage Terms Regarding Concurrent Review

The Plan document contains the following sections regarding concurrent review. These concurrent review sections apply to both M/S benefits and MH/SUD benefits, and do not differentiate between M/S and MH/SUD benefits:

- Utilization Management Requirements (Continued Stay Review)
- External Review Policies
- Definitions

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(*Source:* Plan EOC)

ii. Policies/Guidelines/Other Documents Describing Concurrent Review

Concurrent Review appears or is described in the following documents:

- Application of Criteria: CO UM 103.00, pg. 2
- Medical Policy Reference Manual (MPRM) Policy Number 0.00.001
- Behavioral Health (BH) Daily Routine for Concurrent Clinical Review (CCR) SOP (CO UM 200.89)
- Daily Routine for Concurrent Clinical Reviewer SOP (CC UM CCR 200.69)

iii. Identification of All MH/SUD Benefits and M/S Benefits to Which Concurrent Review Applies by Benefit Classification

The Plan requires concurrent review for certain M/S services, and certain MH/SUD services, as follows. Emergency services and prescription drugs are not subject to concurrent review.

List of M/S Services that Require Concurrent Review	List of MH/SUD Services that Require Concurrent Review
Inpatient M/S Services (In-Network and Out-of-Network)	**Inpatient MH/SUD Services (In-Network and Out-of-Network)**
All Inpatient M/S Services where a preauthorized length of stay is being extended. This includes: • Hospital Inpatient Services; including Ancillary services. • Inpatient rehabilitation. See https://provider.carefirst.com/providers/medical/ in- network-precertification-preauthorization.page] for a list of specific Inpatient Covered Services which require concurrent review for a continued inpatient stay beyond the preauthorized length of time.	All Inpatient MH/SUD Services where a preauthorized length of stay is being extended. This includes: • Hospital Inpatient Services; including Ancillary services. • Inpatient Mental Health and Substance Use Disorder Services. • Residential treatment center services See https://provider.carefirst.com/providers/medical/ in- network-precertification-preauthorization.page] for a list of specific Inpatient Covered Services which require concurrent review for a continued inpatient stay beyond the preauthorized length of time.
Outpatient M/S Services (In-Network and Out-of-Network)	**Outpatient MH/SUD Services (In-Network and Out-of-Network)**
N/A- CareFirst does not apply concurrent review to M/S Outpatient services.	N/A- CareFirst does not apply concurrent review to MH/SUD Outpatient services.

II. Identification and Definition of the Factors and Evidentiary Standards Used to Design or Apply Concurrent Review

A. Factors and Evidentiary Standards Used to Determine List of Services Subject to Concurrent Review

Factor 1	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 this factor.

Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient
Description	This factor is used in the application of concurrent review to determine whether generally accepted standards of care published by industry-leading clinical guidance providers and medical societies are applied.
Source(s) of Factor	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines
Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. CareFirst ensures application in parity by utilizing industry appropriate criteria and guidelines.
Source(s) of Evidentiary Standards	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines

Factor 2	**Clinical Efficacy and Appropriateness of a Proposed Treatment or Service**
Definition	Services that have inconsistent efficacy or treatments subject to applicability in inappropriate situations. 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.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient
Description	This factor is used in the application of concurrent review to determine whether the service is effective and appropriate for the condition being treated.
Source(s) of Factor	Peer-reviewed medical literature from databases such as Clinical Evidence-Based Research Resources: Medical Policy development and revisions are completed by conducting a thorough review of credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. Resources used are based on the below research: • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence.

	• Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.
Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. There is no threshold for number of studies reviewed. Quality of research is investigated as opposed to quantity.
Source(s) of Evidentiary Standards	Peer-reviewed medical literature from databases such as Clinical Evidence-Based Research Resources: Medical Policy development and revisions are completed by conducting a thorough review of credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. Resources used are based on the below research: • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource.

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Factor 3	**Utilization Appropriateness**
Definition	Services that are prone to inappropriate or overutilization and/or abuse of services.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient
Description	This factor is used in the design and application of concurrent review to determine whether services are inappropriate or more likely to be overutilized or abused.
Source(s) of Factor	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines
Evidentiary Standards and Applicable Thresholds	• Emergency admissions are auto approved for 5 days after initial determination of medical necessity. After those 5 days, concurrent review is conducted every 3 days for the remainder to the stay to confirm continued medical necessity. • Non-emergency medical/surgical admissions are approved for the number of days that were authorized in the requisite prior authorization request. If a member needs additional visits (outpatient) or days (inpatient), a concurrent review is required to confirm continued medical necessity. • Mental Health inpatient stays are auto approved for 30 days after initial determination of medical necessity. After those 30 days, concurrent review is performed every 14 days for the remainder of the stay to confirm continued medical necessity. • Substance Use Disorder inpatient stays are auto approved for 21 days after initial determination of medical necessity. After those 21 days, concurrent review is performed every 7 days for the remainder of the stay to confirm continued medical necessity.
Source(s) of Evidentiary Standards	• Claims data and analysis • Utilization trend data • Denial rates

Factor 4	Variations in Lengths 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 for the same or similar diagnosis may impact the determination of this factor.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient
Description	This factor is used in the application of concurrent review to determine whether extra consideration should be given to the length of stay due to high variations in lengths of stay.
Source(s) of Factor	• Claims data to track variations in length of stay • MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.
Evidentiary Standards and Applicable Thresholds	Stays with higher variations in length of stay. The threshold is 30 days; any services with consistent stays over 30 days may be added to the concurrent review list.

Source(s) of Evidentiary Standards	• Claims data and analysis • Utilization trend data • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

B. Factors and Evidentiary Standards When Applying Concurrent Review

Factor 1	**Concurrent Review Submission Timelines**
Definition	The provider and/or member must submit the concurrent review request within appropriate timelines except when it is not medically feasible due to the member's medical condition. Additionally, it should be noted that concurrent review requests to extend inpatient care not received within these timelines does not automatically constitute a denial as CareFirst allows for retrospective review of the extension of stay.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient
Description	This factor is used in the administration of the concurrent review NQTL to set requirements for when concurrent review requests must be submitted.
Source(s) of Factor	• Internal policies and procedures • Request review timelines vary and are based on applicable NCQA, state and federal requirements.

Evidentiary Standards and Applicable Thresholds	Concurrent Review Submission Timelines: • Due 48 hours before an expected original discharge date for inpatient stays • Due before any additional outpatient services are rendered beyond the pre-approved number of visits.
Source(s) of Evidentiary Standards	• Internal policies and procedures • Request review timelines based on applicable NCQA, state and federal requirements. • Medical Provider manual

Factor 2	**Clinical Efficacy and Appropriateness of a Proposed Treatment or Service**
Definition	Services that have inconsistent efficacy or treatments subject to applicability in inappropriate situations. 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.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient
Description	This factor is used in the application of concurrent review to determine whether the service is effective and appropriate for the condition being treated.
Source(s) of Factor	Peer-reviewed medical literature from databases such as Clinical Evidence-Based Research Resources: Medical Policy development and revisions are completed by conducting a thorough review of credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. Resources used are based on the below research: • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource.

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Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. There is no threshold for number of studies reviewed. Quality of research is investigated as opposed to quantity.
Source(s) of Evidentiary Standards	Peer-reviewed medical literature from databases such as Clinical Evidence-Based Research Resources: Medical Policy development and revisions are completed by conducting a thorough review of credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. Resources used are based on the below research: • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

Factor 3	**Clinical Appropriateness**

Definition	The proposed treatment or service must be appropriate, 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.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient
Description	This factor is used in the administration of the concurrent review NQTL to confirm whether a proposed extension of inpatient services is clinically appropriate based on the patient's condition.
Source(s) of Factor	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.
Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. There is no threshold for number of studies reviewed. Quality of research is investigated as opposed to quantity.

Source(s) of Evidentiary Standards	• Patient medical records and treatment history/plan • MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

A. Processes

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. CareFirst's medical and behavioral health policies are available on web.carefirst.com.

The internal and external criteria used for both M/S and MH/SUD are authorized by the CareFirst Criteria Review Committee. Internal 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.

Written UM policies and procedures define CareFirst's prior approval and utilization review program. All services authorized by the Utilization Management (UM) Staff are evaluated against appropriate benefit packages and nationally accepted medical necessity criteria. The criteria are reviewed, revised, and approved at least annually by the Quality Executive Committee (QEC). A designated senior practitioner, specifically the Chief Medical Officer (CMO), has significant involvement in the implementation of the UM Program and related policies and procedures. A formal UM Committee, under the direction of the CMO, oversees the Utilization Review process.

Concurrent review decisions and processes are supervised by qualified licensed professionals. A licensed professional who has appropriate clinical experience in treating the enrollee's condition or disease makes a request for the CMO or Medical Director to review a request for service that does not meet medical necessity criteria. The CMO or medical director makes the final coverage determination if the clinician is unable to approve the request. A change in the amount, duration, or scope that is less than requested must be made by a healthcare physician. Licensed physician consultants from Medical Review Institute of America (MRIA) are utilized to review cases from the appropriate specialty areas as needed.

A licensed physician oversees UM decisions to ensure consistent medical necessity decision making. Licensed doctoral-level clinical psychologists oversee behavioral health care UM decisions for psychological testing. Licensed nurses or Licensed Clinical Social Workers (RN or LPN or LCSW) may approve benefit or medical necessity cases. These practitioners may not deny medical necessity cases.

Utilization Management Staff and their Responsibilities:

CareFirst Title	Qualifications
Medical Director/Chief Medical Officer	Board certified Medical Doctor responsible for the development and implementation of UM processes, criteria, and program outcomes. Oversees the operations of the UM department and is a liaison to the medical community regarding UM program operations. Clinical consultant for UM decisions: approves and denies care according to medical criteria and policies and procedures. Reports to Executive Vice President of Health Services and supervises all other medical directors (e.g., Behavioral Health Medical Director, Radiology/Cardiology Medical Director, etc.). Chairs the UM Committee.
Medical Director, Behavioral Health	Board certified Medical Doctor of Psychiatry, who reviews and makes determinations based on medical necessity on behavioral health UM cases, using evidence-based UM criteria and policies and procedures. Liaison to the behavioral health practitioner and provider communities. Provides information and expertise to the UM behavioral health staff. Reports to the Medical Director, is an enrollee of the UM Committee.

Director of Utilization Management	A Registered Nurse who is responsible for intake, precertification, concurrent review, and retrospective review activities of the department. Develops and maintains policies and procedures for assigned areas. Approves requested care per UM criteria and policies and procedures. May deny care based on benefits or contract issues. Supervises all RN, LPN staff and UM coordinators, and is responsible for department operations. Reports to the Clinical Director of Government Programs with a dotted line to the Chief Medical Officer.
Utilization Management Manager/Supervisor	Assists UM director with day-to-day operations, oversees completion of reviews by UR Reviewers, problem- solves, conducts audits, prepares documents for weekly UM Meetings. Reports to the Director of Utilization Management.
Utilization Management Reviewer	A Licensed Nurse who conducts UM review activities. Monitors and coordinates care with participating practitioners, enrollees, and provider organizations, using established criteria. Collects data for the precertification, concurrent review, and retrospective review processes. Approves requested care per UM criteria and policies and procedures. May deny authorization requests based administrative criteria (i.e., benefit or contractual limitations) In the event that medical necessity is not met, the reviewer would submit the authorization request to a MD for the medical necessity determination.
Vice President of Pharmacy and Therapeutics	The Doctor of Pharmacy is responsible for developing and maintaining the formulary and formulary policies and procedures. Researches, approves and denies requests for drugs consistent with formulary policies and procedures and UM criteria. Reports to the Medical Director/CMO and is a member of the P & T Committee. Provides support to the P & T Committee and manages the MCO's relationship with the Pharmacy Benefits Manager (PBM).
Physician Advisors	Board certified Medical Doctors who are available for review of UM cases (including appeals), or in the case of an appeal They will research and either approve or denies the authorization request according to UM criteria and policies and procedures.

B. Strategy

CareFirst uses internal clinical policy (CareFirst Medical Policy Reference Manual) for M/S and MH/SUD, which is drafted using external clinical criteria, in addition to peer-reviewed literature, clinical trials, professional opinion, and publications by professional societies or government agencies. Appropriate clinical staff will review the admission or concurrent inpatient hospitalization using evidence-based clinical guidelines. Coverage determination is rendered by qualified staff (RN, LCSW, LCSW-C, LCPC). Only Medical Directors (MD, PhD) may issue a denial for medical necessity. Providers and members are notified of adverse benefit determinations consistent with state, federal, and NCQA requirements. Applicable appeal rights are provided.

If the internal criteria are not sufficient to render a medical necessity approval determination, then external clinical criteria will be used. CareFirst uses appropriate, evidence-based external clinical criteria for M/S and MH/SUD benefits. These include: the Modified Appropriateness Evaluation Protocol (AEP) Criteria (for M/S inpatient), the Apollo Managed Care Physical Therapy (for Physical Therapy), Occupational Therapy, Speech

Therapy and Rehabilitation Criteria (for OT, ST, and Rehabilitation), MCG Guidelines 25th edition (for Behavioral Health, Ambulatory Care, Inpatient & Surgical Care, and Home Care), and The American Society of Addiction Medicine (ASAM) criteria (for SUD).

C. Relationship Between Factors

All factors in the analyses are considered equally and there is no factor that carries more weight than another. The following factors were removed from the 2023 analysis for inpatient in-network and inpatient out-of-network as they were considered as potential factors, but ultimately determined to not be utilized:

- Variability in cost
- Demand for services
- Licensing and accreditation of providers

The above factors were removed after further investigation of utilization management reviews in practice. Reviewers focused on standards of care, efficacy, and length of stay. Cost was not taken into consideration in approval or denial decisions, nor was demand for services. Licensing and accreditation of providers was analyzed in a separate NQTL (credentialing) and is not reviewed during the utilization management process.

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III. Demonstration of Comparability and Stringency as Written

This section demonstrates that in each classification, under the terms of the plan as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying concurrent review to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying concurrent review with respect to M/S benefits.

CareFirst recognizes a responsibility to demonstrate a commitment of superior clinical quality service that is member centric, high touch, clinically appropriate, cost effective, data driven and culturally competent. This is achieved through an organization-wide, systematic, and coordinated approach that involves input from and coordination with both internal and external stakeholders. These stakeholders include members, providers, state entities, CMS, business units, department, and staff members. 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. This is inclusive of both physical and mental health services provided in an inpatient or outpatient setting.

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 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.

IV. Demonstration of Comparability and Stringency In Operation

This section demonstrates that in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying concurrent review to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying concurrent review with respect to M/S benefits.

A. Explanation of how the CareFirst Evaluates Comparability

Below is a comprehensive explanation of how CareFirst evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying concurrent review to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying concurrent review with respect to M/S benefits.

B. Documentation of Outcomes

1. Evaluation of Relevant Data

Concurrent review is not applied to outpatient M/S or MH/SUD services in either the in-network or out-of-network classifications. Review of CareFirst's concurrent review data in the inpatient classification shows comparable rates of approval for requests. Observation services under CPT codes 99234 and revenue code 762, as well as hospice codes S9126, G0151, and Q5001 were included in the inpatient classification for this analysis.

NOTE: CareFirst does not apply concurrent review to outpatient services, only inpatient. If a member needs additional outpatient visits or services, that information is captured with a new prior authorization request (see Prior Authorization NQTL for additional details)

a. In-Network Inpatient Concurrent Review Rates

In-Network Inpatient	M/S General Hospital	M/S Specialty Hospital	M/S Inpatient Hospice	M/S Skilled Nursing Facility
Total # of Claims	48,093	275	133	709
Total # of CR Requests	3,387	79	14	37
Percentage of Claims Subject to CR	7%	27%	11%	5%
CR Approvals and Denials				
Total # of Approved CR Requests	3,356	75	14	35
Total # of Denied CR Requests	29	4	0	1
Percentage of Denied CR Requests	0.9%	5.1%	0.0%	2.7%
Turnaround Times and Approved Days				
Average Number of Days Approved	3	2.5	3	2
Average Turnaround Time	0	1	1	0
Medical Director Reviews				
Number of CR Medical Director Reviews	64	18	0	16
Number of CR Medical Director Approvals	35	14	0	15
Number of CR Medical Director Denials	29	4	0	1
Percentage of CR Reviewed by Medical Director	1.9%	24.0%	0.0%	43.2%
Percentage of CR Denied by Medical Director	45.3%	22.2%	#DIV/0!	6.3%

In-Network Inpatient	MH General Hospital	MH Specialty Psychiatric Hospital	MH Residential Treatment Facility	SUD General Hospital	SUD Specialty Psychiatric Hospital	SUD Residential Treatment Facility
Total # of Claims	1,947	642	528	549	9	448
Total # of CR Requests	362	0	0	92	0	0
Percentage of Claims Subject to CR	18.6%	0.0%	0.0%	16.8%	0.0%	0.0%
CR Approvals and Denials						
Total # of Approved CR Requests	362	0	0	91	0	0
Total # of Denied CR Requests	0	0	0	0	0	0

Percentage of Denied CR Requests	0.0%	#DIV/0!	#DIV/0!	0.0%	#DIV/0!	#DIV/0!
Turnaround Times and Approved Days						
Average Number of Days Approved	1	0	0	8	0	0
Average Turnaround Time	0	0	0	0	0	0
Medical Director Reviews						
Number of CR Medical Director Reviews	5	0	0	1	0	0
Number of CR Medical Director Approvals	5	0	0	1	0	0
Number of CR Medical Director Denials	0	0	0	0	0	0
Percentage of CR Reviewed by Medical Director	1.4%	#DIV/0!	#DIV/0!	1.1%	#DIV/0!	#DIV/0!
Percentage of CR Denied by Medical Director	0.0%	#DIV/0!	#DIV/0!	0.0%	#DIV/0!	#DIV/0!

b. Out-of-Network Inpatient Concurrent Review Rates

Out-of-Network Inpatient	M/S General Hospital	M/S Specialty Hospital	M/S Inpatient Hospice	M/S Skilled Nursing Facility
Total # of Claims	2,449	3	5	234
Total # of CR Requests	0	0	0	0
Percentage of Claims Subject to CR	0%	0%	0%	0%
CR Approvals and Denials				
Total # of Approved CR Requests	0	0	0	0
Total # of Denied CR Requests	0	0	0	0
Percentage of Denied CR Requests	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Turnaround Times and Approved Days				
Average Number of Days Approved	0	0	0	0
Average Turnaround Time	0	0	0	0
Medical Director Reviews				
Number of CR Medical Director Reviews	0	0	0	0

Number of CR Medical Director Approvals	0	0	0	0
Number of CR Medical Director Denials	0	0	0	0
Percentage of CR Reviewed by Medical Director	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Percentage of CR Denied by Medical Director	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Out-of-Network Inpatient	**MH General Hospital**	**MH Specialty Psychiatric Hospital**	**MH Residential Treatment Facility**	**SUD General Hospital**	**SUD Specialty Psychiatric Hospital**	**SUD Residential Treatment Facility**
Total # of Claims	265	27	394	189	0	136
Total # of CR Requests	0	0	0	0	0	0
Percentage of Claims Subject to CR	0.0%	0.0%	0.0%	0.0%	#DIV/0!	0.0%
CR Approvals and Denials						
Total # of Approved CR Requests	0	0	0	0	0	0
Total # of Denied CR Requests	0	0	0	0	0	0
Percentage of Denied CR Requests	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Turnaround Times and Approved Days						
Average Number of Days Approved	0	0	0	0	0	0
Average Turnaround Time	0	0	0	0	0	0
Medical Director Reviews						
Number of CR Medical Director Reviews	0	0	0	0	0	0
Number of CR Medical Director Approvals	0	0	0	0	0	0
Number of CR Medical Director Denials	0	0	0	0	0	0
Percentage of CR Reviewed by Medical Director	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Percentage of CR Denied by Medical Director	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

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2. Justification and Analysis

Review of CareFirst's internal concurrent review data for Virginia fully insured risk business for the period January 1, 2025 through December 31, 2025 shows that concurrent review is applied principally to inpatient services and is not applied to outpatient M/S or MH/SUD services in the data set. This supports comparability across the outpatient in-network and out-of-network classifications because there were no concurrent review requests, approvals, denials, turnaround times, approved visits, or medical director reviews reported for either M/S or MH/SUD outpatient services.

For inpatient in-network services, the data reflects 3,513 M/S concurrent review requests across 49,210 inpatient claims, representing approximately 7.1% of M/S inpatient claims. By comparison, the data reflects 454 MH/SUD concurrent review requests across 4,123 inpatient claims, representing approximately 11.0% of MH/SUD inpatient claims. Although MH/SUD inpatient services reflected a higher percentage of claims subject to concurrent review, the outcome data does not indicate more stringent application to MH/SUD benefits. M/S inpatient in-network services had 34 denials across the concurrent review requests reported, while MH/SUD inpatient in-network services had no reported denials. The approval experience for MH/SUD services was therefore at least comparable to, and in key respects more favorable than, the M/S experience.

The turnaround time and approved-day data also supports operational comparability. M/S inpatient in-network average turnaround times ranged from zero to one day across the reported service categories, while MH/SUD inpatient in-network average turnaround times were zero days for the service categories with concurrent review volume. Average approved days for M/S inpatient in-network services ranged from two to three days, while MH/SUD inpatient in-network services reflected one average approved day for MH general hospital services and eight average approved days for SUD general hospital services. The longer average approved duration for SUD general hospital services does not suggest greater stringency; rather, it reflects approval of additional inpatient days where supported by the concurrent review process.

Medical director review activity likewise does not show a more stringent pattern for MH/SUD services. M/S inpatient in-network services had 98 medical director reviews across 3,513 concurrent review requests, including 34 medical director denials. MH/SUD inpatient in-network services had six medical director reviews across 454 concurrent review requests, and all six were approved with no medical director denials. The lower volume of MH/SUD medical director reviews and the absence of MH/SUD medical director denials support the conclusion that the concurrent review NQTL was not administered more stringently for MH/SUD inpatient benefits.

V. Findings and Conclusions

The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply the concurrent review requirement to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the concurrent review requirement to M/S benefits; and (2) CareFirst complies with the relevant data requirements under the MHPAEA Final Rules.

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 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.

Operationally, based on the claims volume, concurrent review request rates, approval and denial outcomes, turnaround times, approved days, outpatient non-application, and medical director review activity, the data supports a finding that CareFirst's concurrent review NQTL is applied in a comparable and no more stringent manner for MH/SUD benefits than for M/S benefits, as written and in operation. While a higher percentage of MH/SUD inpatient claims were subject to concurrent review, that difference did not result in less favorable outcomes for MH/SUD members because the data reflects no MH/SUD concurrent review denials and no MH/SUD medical director denials. Concurrent review was not applied to outpatient M/S or MH/SUD services, and there were no out-of-network concurrent review requests reported for either M/S or MH/SUD services. Accordingly, the operational data supports the conclusion that the concurrent review process complies with MHPAEA's comparative analysis standard because the NQTL is not designed or applied more stringently to MH/SUD benefits than to M/S benefits within the same benefit classifications.

VI. Required Certification

CareFirst certifies that the foregoing comparative analysis of the Concurrent Review NQTL was prepared for the Virginia fully insured coverage identified in this report and was reviewed by individuals with appropriate knowledge of the plan terms, policies, procedures, factors, evidentiary standards, operational practices, supporting documentation, and relevant data addressed in the analysis. The analysis applies to the CareFirst entities identified in this report as NAIC 53007 and NAIC 9602 to the extent the NQTL is designed and administered as described in this analysis.

To the best of CareFirst's knowledge and based on the information, documentation, and data reviewed as of the report's version date, this comparative analysis is accurate and complete in all material respects and demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the Concurrent Review NQTL to mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, those used to design and apply the NQTL to medical/surgical benefits, as written and in operation. CareFirst will maintain supporting documentation and will update or supplement the analysis if a material change, newly identified data limitation, or corrective action affects this conclusion.

RETROSPECTIVE REVIEW

Overview

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the retrospective review requirement to mental health or substance use disorder ("MH/SUD") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the retrospective review requirement to medical/surgical ("M/S") benefits.

I. Description of the Retrospective Review NQTL

Retrospective review is a component of CareFirst's utilization management program. It is used to authorize services after they have been rendered. Retrospective review is only used to authorize services that require prior approval and approval was not obtained prior to service. Retrospective review is not applied to other situations. Retrospective review is not utilized to deny previously approved services.

A. Identification of the NQTL

i. Plan/Coverage Terms Regarding Retrospective Review

The Plan document contains the following sections regarding retrospective review. These retrospective sections can be referred to as "post-service review" in the Plan document, apply to both M/S benefits and MH/SUD benefits, and do not differentiate between M/S and MH/SUD benefits:

- Utilization Management Requirements
- Claims Procedures (Internal claims and Appeal and External Review processes)
- Definitions

(*Source:* Plan EOC)

ii. Policies/Guidelines/Other Documents Describing Retrospective Review

Retrospective Review appears or is described in the following documents:

- Post Service Review SOP (CC UM CCR 200.56)
- Medical Director/Physician Interrater Reliability Monitoring Physician Interraters SOP (CC UM 200.81)
- Utilization Management Specialist Interrater Reliability SOP (CC UM 200.82)

iii. Identification of All MH/SUD Benefits and M/S Benefits to Which Retrospective Review Applies by Benefit Classification

The Plan requires retrospective review for certain M/S services, and certain MH/SUD services, where prior authorization was required but was not obtained prior to the service:

List of M/S Services that Require Prior Authorization (Retrospective Review applies if required Prior Authorization not obtained)	**List of MH/SUD Services that Require Prior Authorization (Retrospective Review applies if required Prior Authorization not obtained)**
Inpatient M/S Services (In-Network and Out-of-Network)	**Inpatient MH/SUD Services (In-Network and Out-of-Network)**
All Inpatient M/S Services require prior authorization. This includes: • Hospital Inpatient Services; including Ancillary services. • Inpatient rehabilitation. • Certain medications prescribed while in an inpatient place of service. • HMO Only: Out-of-Network Covered Services, except for Out-of-Network Emergency Services. See [https://provider.carefirst.com/providers/medical/ in- network-precertification-preauthorization.page] for a list of specific Inpatient Covered Services which require prior authorization.	All Inpatient MH/SUD Services require prior authorization. This includes: • Hospital Inpatient Services; including Ancillary services. • Inpatient Mental Health and Substance Use Disorder Services. • Residential treatment center services, except for emergency admissions. • Certain medications prescribed while in an inpatient place of service. • HMO Only: Out-of-Network Covered Services, except for Out-of-Network Emergency Services. See https://provider.carefirst.com/providers/medical/ in- network-precertification-preauthorization.page] for a list of specific Inpatient Covered Services which require prior authorization.
Outpatient M/S Services (In-Network and Out-of-Network)	**Outpatient MH/SUD Services (In-Network and Out-of-Network)**

• Outpatient rehabilitation therapy (physical therapy, speech therapy, occupational therapy, chiropractic and acupuncture). • Outpatient testing. • Outpatient surgery. • Facility based office visits. • Habilitative Services • Organ and Tissue Transplants. • Controlled Clinical trials. • Air Ambulance Services. (Except for Medically Necessary air ambulance services in an emergency). • Skilled Nursing Facility. • Home Health Services. • Hospice Services. • Medical Devices and Supplies. • Imaging/Radiology. • Lab Testing. • Certain medications prescribed while in an outpatient place of service. • Gender Reassignment Services. • Infusion Services. • Radiation Therapy. • Outpatient Chemotherapy • Outpatient Dialysis • Genetic Testing • Sleep Studies • Assisted Reproductive Technologies. • HMO Only: Out-of-Network Covered Services, except for Out-of-Network Emergency Services. See [https://provider.carefirst.com/providers/medical/ in- network-precertification-preauthorization.page] for a list of specific Outpatient Covered Services which require prior authorization.	• Outpatient testing. • Facility based office visits. • Habilitative Services • Electroconvulsive Therapy (ECT) • Repetitive Transcranial Magnetic Stimulation (rTMS) • Controlled Clinical trials. • Air Ambulance Services. (Except for Medically Necessary air ambulance services in an emergency). • Lab Testing. • Certain medications prescribed while in an outpatient place of service. • Sleep Studies • HMO Only: Out-of-Network Covered Services, except for Out-of-Network Emergency Services. See https://provider.carefirst.com/providers/medical/ in- network-precertification-preauthorization.page] for a list of specific Outpatient Covered Services which require prior authorization.

II. Identification and Definition of the Factors and Evidentiary Standards Used to Design or Apply Retrospective Review

A. Factors and Evidentiary Standards Used to Determine List of Services Subject to Retrospective Review if Prior Authorization Not Obtained

Factor 1	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 this factor.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the application of retrospective review to determine whether generally accepted standards of care published by industry-leading clinical guidance providers and medical societies are applied.
Source(s) of Factor	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines
Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. CareFirst ensures application in parity by utilizing industry appropriate criteria and guidelines.
Source(s) of Evidentiary Standards	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines

Factor 2	Clinical Efficacy and Appropriateness of a Proposed Treatment or Service
Definition	Services that have inconsistent efficacy or treatments subject to applicability in inappropriate situations. 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.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the application of retrospective review to determine whether the service is effective and appropriate for the condition being treated.
Source(s) of Factor	Peer-reviewed medical literature from databases such as Clinical Evidence-Based Research Resources: Medical Policy development and revisions are completed by conducting a thorough review of credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. Resources used are based on the below research: • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.
Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no

	specific threshold as this follows standard guidelines and professional recommendations. There is no threshold for number of studies reviewed. Quality of research is investigated as opposed to quantity.
Source(s) of Evidentiary Standards	Peer-reviewed medical literature from databases such as Clinical Evidence-Based Research Resources: Medical Policy development and revisions are completed by conducting a thorough review of credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. Resources used are based on the below research: • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

Factor 3	**Utilization Appropriateness**
Definition	Services that are prone to inappropriate or overutilization and/or abuse of services.

Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the design and application of retrospective review to determine whether services are inappropriate or more likely to be overutilized or abused.
Source(s) of Factor	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines
Evidentiary Standards and Applicable Thresholds	Any services on the prior authorization list (and therefore the retrospective review list) that have less than a 2% denial rate are removed. Services that generally have a higher than 2% denial rate are potentially placed on the list.
Source(s) of Evidentiary Standards	• Claims data and analysis • Utilization trend data • Denial rates

Factor 4	**Variations in Lengths 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 for the same or similar diagnosis may impact the determination of this factor.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient
Description	This factor is used in the application of retrospective review to determine whether extra consideration should be given to the length of stay due to high variations in lengths of stay.
Source(s) of Factor	• Claims data to track variations in length of stay • MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans

	servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.
Evidentiary Standards and Applicable Thresholds	Stays with higher variations in length of stay. The threshold is 30 days; any services with consistent stays over 30 days may be added to the retrospective review list.

Source(s) of Evidentiary Standards	• Claims data and analysis • Utilization trend data • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

B. Factors and Evidentiary Standards Used to Apply Retrospective Review

Factor 1	**Retrospective Review Submission Timelines**
Definition	Retrospective review applies when a provider and/or member cannot submit the required prior authorization request within appropriate timelines due to the member's medical condition. Under these circumstances, CareFirst will apply retrospective review to the service that should have been prior authorized, had the prior authorization request been able to be submitted timely.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other

Description	This factor is used in the administration of the Retrospective Review NQTL to set requirements for when a service without the requisite prior authorization can still be reviewed for medical necessity and claim payment.
Source(s) of Factor	• Internal policies and procedures • Request review timelines vary and are based on applicable NCQA, state and federal requirements.
Evidentiary Standards and Applicable Thresholds	When a timely prior authorization request was not feasible due to the member's condition, retrospective review applies.
Source(s) of Evidentiary Standards	• Internal policies and procedures • Request review timelines based on applicable NCQA, state and federal requirements. • Medical Provider manual

Factor 2	**Approval/Denial Timelines for Insurer**
Definition	All post service reviews must be completed, including notification of the decision to the facility/practitioner, within the specified timeframes.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other • Prescription Drugs
Description	This factor is used in the administration of the Retrospective Review NQTL to set requirements for when an insurer must respond to a completed prior authorization request before the request is automatically approved.
Source(s) of Factor	• NCQA Standards • 12 VAC 5-408-360 • 12 VAC 30-130-300
Evidentiary Standards and Applicable Thresholds	Within 30 calendar days of the receipt of the notification to the organization. All decisions must be made within 2 working days of receiving sufficient clinical information. Notification to the facility/practitioner of the decision must be made within 5 working days of receiving sufficient clinical information.
Source(s) of Evidentiary Standards	• 12 VAC 5-408-360 • 12 VAC 30-130-300

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Factor 3	Clinical Appropriateness
Definition	The proposed treatment or service must be appropriate, 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.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the administration of the Retrospective Review NQTL to set requirements for when an insurer must respond to a completed retrospective review request before the request is automatically approved.
Source(s) of Factor	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. There is no threshold for number of studies reviewed. Quality of research is investigated as opposed to quantity.
Source(s) of Evidentiary Standards	• Patient medical records and treatment history/plan • MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

A. Processes

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 peer reviewed 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. CareFirst's medical and behavioral health policies are available on web.carefirst.com.

The internal and external criteria used for both M/S and MH/SUD are authorized by the CareFirst Criteria Review Committee. Internal 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.

Written UM policies and procedures define CareFirst's prior approval and utilization review program. All services authorized by the Utilization Management (UM) Staff are evaluated against appropriate benefit packages and nationally accepted medical necessity criteria. The criteria are reviewed, revised, and approved at least annually by the Quality Executive Committee (QEC). A designated senior practitioner, specifically the Chief Medical Officer (CMO), has significant involvement in the implementation of the UM Program and related policies and procedures. A formal UM Committee, under the direction of the CMO, oversees the Utilization Review process.

Retrospective review decisions and processes are supervised by qualified licensed professionals. A licensed professional who has appropriate clinical experience in treating the enrollee's condition or disease makes a request for the CMO or Medical Director to review a request for service that does not meet medical necessity criteria. The CMO or medical director makes the final coverage determination if the clinician is unable to approve the request. A change in the amount, duration, or scope that is less than requested must be made by a healthcare physician. Licensed physician consultants from Medical Review Institute of America (MRIA) are utilized to review cases from the appropriate specialty areas as needed.

A licensed physician oversees UM decisions to ensure consistent medical necessity decision making. Licensed doctoral-level clinical psychologists oversee behavioral health care UM decisions for psychological testing. Licensed nurses or Licensed Clinical Social Workers (RN or LPN or LCSW) may approve benefit or medical necessity cases. These practitioners may not deny medical necessity cases.

Utilization Management Staff and their Responsibilities:

CareFirst Title	Qualifications
Medical Director/Chief Medical Officer	Board certified Medical Doctor responsible for the development and implementation of UM processes, criteria, and program outcomes. Oversees the operations of the UM department and is a liaison to the medical community regarding UM program operations. Clinical consultant for UM decisions: approves and denies care according to medical criteria and policies and procedures. Reports to Executive Vice President of Health Services and supervises all other medical directors (e.g., Behavioral Health Medical Director, Radiology/Cardiology Medical Director, etc.). Chairs the UM Committee.

Medical Director, Behavioral Health	Board certified Medical Doctor of Psychiatry, who reviews and makes determinations based on medical necessity on behavioral health UM cases, using evidence-based UM criteria and policies and procedures. Liaison to the behavioral health practitioner and provider communities. Provides information and expertise to the UM behavioral health staff. Reports to the Medical Director, is an enrollee of the UM Committee.
Director of Utilization Management	A Registered Nurse who is responsible for intake, precertification, concurrent review, and retrospective review activities of the department. Develops and maintains policies and procedures for assigned areas. Approves requested care per UM criteria and policies and procedures. May deny care based on benefits or contract issues. Supervises all RN, LPN staff and UM coordinators, and is responsible for department operations. Reports to the Clinical Director of Government Programs with a dotted line to the Chief Medical Officer.
Utilization Management Manager/Supervisor	Assists UM director with day-to-day operations, oversees completion of reviews by UR Reviewers, problem- solves, conducts audits, prepares documents for weekly UM Meetings. Reports to the Director of Utilization Management.
Utilization Management Reviewer	A Licensed Nurse who conducts UM review activities. Monitors and coordinates care with participating practitioners, enrollees, and provider organizations, using established criteria. Collects data for the precertification, concurrent review, and retrospective review processes. Approves requested care per UM criteria and policies and procedures. May deny authorization requests on based administrative criteria (i.e., benefit or contractual limitations) In the event that medical necessity is not met, the reviewer would submit the authorization request to a MD for the medical necessity determination.
Vice President of Pharmacy and Therapeutics	The Doctor of Pharmacy is responsible for developing and maintaining the formulary and formulary policies and procedures. Researches, approves and denies requests for drugs consistent with formulary policies and procedures and UM criteria. Reports to the Medical Director/CMO and is a member of the P & T Committee. Provides support to the P & T Committee and manages the MCO's relationship with the Pharmacy Benefits Manager (PBM).
Physician Advisors	Board certified Medical Doctors who are available for review of UM cases (including appeals), or in the case of an appeal They will research and either approve or denies the authorization request according to UM criteria and policies and procedures.

B. Strategy

Retrospective review begins when CareFirst receives a notification or claim post-discharge, that an inpatient hospitalization occurred, or post-service, that outpatient services were rendered, and prior authorization of the services was not previously obtained when required. CareFirst uses internal clinical policy (CareFirst Medical Policy Reference Manual) for M/S and MH/SUD, which is drafted using external clinical criteria, in addition to peer-reviewed literature, clinical trials, professional opinion, and publications by professional societies or government agencies. If the internal criteria are not sufficient to render a medical necessity approval determination, then external clinical criteria will be used.

CareFirst uses appropriate, evidence-based external clinical criteria for M/S and MH/SUD benefits. These include: the Modified Appropriateness Evaluation Protocol (AEP) Criteria (for M/S inpatient), the Apollo Managed Care Physical Therapy (for Physical Therapy), Occupational Therapy, Speech Therapy and Rehabilitation Criteria (for OT, ST, and Rehabilitation), MCG Guidelines 25th edition (for Behavioral Health, Ambulatory Care, Inpatient & Surgical Care, and Home Care), and The American Society of Addiction Medicine (ASAM) criteria (for SUD).

C. Relationship Between Factors

All factors in the analyses are considered equally and there is no factor that carries more weight than another. The following factors were removed from the 2023 analysis for inpatient in-network, inpatient out-of-network, outpatient in-network, and outpatient out-of-network as they were considered, but ultimately determined to not be utilized:

- Variability in cost
- Demand for services
- Licensing and accreditation of providers

The above factors were removed after further investigation of utilization management reviews in practice. Reviewers focused on standards of care, efficacy, and length of stay. Cost was not taken into consideration in approval or denial decisions, nor was demand for services. Licensing and accreditation of providers was analyzed in a separate NQTL (credentialing) and is not reviewed during the utilization management process.

III. Demonstration of Comparability and Stringency as Written

This section demonstrates that in each classification, under the terms of the plan as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying retrospective review to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the retrospective review with respect to M/S benefits.

CareFirst has a standard operating procedure for retrospective reviews that applies to both MH/SUD services and M/S services. (Utilization Management Prior Authorization Review Process #CO UM 200.20 and Utilization Review Coverage Decision Procedure #CO UM 105.00). The written criteria and procedures are to ensure fair and consistent prior authorization reviews and utilization decisions.

CareFirst has a standard operating procedure for the 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. If a service is potentially being added to the retrospective review list, a medical policy and reference manual is created for those services. Each service has its own unique medical policy that includes criteria, guidelines, descriptions, thresholds, and referenced peer-reviewed medical literature to support the policy and decisions. This process is the same for all services added onto the retrospective review list.

CareFirst recognizes a responsibility to demonstrate a commitment of superior clinical quality service that is member centric, high touch, clinically appropriate, cost effective, data driven and culturally competent. This is achieved through an organization-wide, systematic, and coordinated approach that involves input from and coordination with both internal and external stakeholders. These stakeholders include members, providers,

state entities, CMS, business units, department, and staff members. 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. This is inclusive of both physical and mental health services provided in an inpatient or outpatient setting.

A review of CareFirst's written policies and processes reveals the comparable application of the Retrospective Review NQTL to M/S and MH/SUD services within the applicable benefit classifications. The Plan's retrospective 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.

IV. Demonstration of Comparability and Stringency In Operation

This section demonstrates that in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying retrospective review to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying retrospective review with respect to M/S benefits.

A. Explanation of how the CareFirst Evaluates Comparability

Below is a comprehensive explanation of how CareFirst evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying retrospective review to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying retrospective review with respect to M/S benefits.

B. Documentation of Outcomes

1. Evaluation of Relevant Data

CareFirst reviews retrospective review outcomes and compares rates for M/S and MH/SUD services to confirm utilization management techniques are applied no more stringently to MH/SUD services.

a. In-Network Outpatient Retrospective Review Rates

In-Network Outpatient	M/S Outpatient Office	M/S Outpatient Other
Total # of Claims	722,981	512,944
Total # of RR Requests	9	36
Percentage of Claims Subject to RR	0.0%	0.0%
RR Approvals and Denials		

Total # of Approved RR Requests	8	35
Total # of Denied RR Requests	1	1
Percentage of Denied RR Requests	11.1%	2.8%
Turnaround Times and Approved Visits		
Average Number of Visits Approved	9	25
Average Turnaround Time	48	0
Medical Director Reviews		
Number of RR Medical Director Reviews	0	0
Number of RR Medical Director Approvals	0	0
Number of RR Medical Director Denials	0	0
Percentage of RR Reviewed by Medical Director	0.0%	0.0%
Percentage of RR Denied by Medical Director	0.0%	0.0%

In-Network Outpatient	MH Outpatient Office	MH Outpatient Other	SUD Outpatient Office	SUD Outpatient Other
Total # of Claims	87,355	144,309	3,195	5,932
Total # of RR Requests	3	1	0	0
Percentage of Claims Subject to RR	0%	0%	0%	0%
RR Approvals and Denials				
Total # of Approved RR Requests	3	1	0	0
Total # of Denied RR Requests	0	0	0	0
Percentage of Denied RR Requests	0.0%	0.0%	0.0%	0.0%
Turnaround Times and Approved Visits				

Average Number of Visits Approved	3	0	0	0
Average Turnaround Time	1	0	0	0
Medical Director Reviews				
Number of RR Medical Director Reviews	0	0	0	0
Number of RR Medical Director Approvals	0	0	0	0
Number of RR Medical Director Denials	0	0	0	0
Percentage of RR Reviewed by Medical Director	0.0%	0.0%	0.0%	0.0%
Percentage of RR Denied by Medical Director	0.0%	0.0%	0.0%	0.0%

b. Out-of-Network Outpatient Retrospective Review Rates

Out-of-Network Outpatient	M/S Outpatient Office	M/S Outpatient Other
Total # of Claims	27,778	31,265
Total # of RR Requests	0	0
Percentage of Claims Subject to RR	0.0%	0.0%
RR Approvals and Denials		
Total # of Approved RR Requests	0	0
Total # of Denied RR Requests	0	0
Percentage of Denied RR Requests	#DIV/0!	#DIV/0!
Turnaround Times and Approved Visits		
Average Number of Visits Approved	0	0
Average Turnaround Time	0	0
Medical Director Reviews		
Number of RR Medical Director Reviews	0	0

Number of RR Medical Director Approvals	0	0
Number of RR Medical Director Denials	0	0
Percentage of RR Reviewed by Medical Director	0.0%	0.0%
Percentage of RR Denied by Medical Director	0.0%	0.0%

Out-of-Network Outpatient	**MH Outpatient Office**	**MH Outpatient Other**	**SUD Outpatient Office**	**SUD Outpatient Other**
Total # of Claims	8,833	11,328	320	1,552
Total # of RR Requests	0	0	0	0
Percentage of Claims Subject to RR	0%	0%	0%	0%
RR Approvals and Denials				
Total # of Approved RR Requests	0	0	0	0
Total # of Denied RR Requests	0	0	0	0
Percentage of Denied RR Requests	0.0%	0.0%	0.0%	0.0%
Turnaround Times and Approved Visits				
Average Number of Visits Approved	0	0	0	0
Average Turnaround Time	0	0	0	0
Medical Director Reviews				
Number of RR Medical Director Reviews	0	0	0	0
Number of RR Medical Director Approvals	0	0	0	0
Number of RR Medical Director Denials	0	0	0	0
Percentage of RR Reviewed by Medical Director	0.0%	0.0%	0.0%	0.0%

Percentage of RR Denied by Medical Director	0.0%	0.0%	0.0%	0.0%

c. In-Network Inpatient Retrospective Review Rates

In-Network Inpatient	M/S General Hospital	M/S Specialty Hospital	M/S Inpatient Hospice	M/S Skilled Nursing Facility
Total # of Claims	48,093	275	133	709
Total # of RR Requests	26	8	0	2
Percentage of Claims Subject to RR	0.1%	2.9%	0.0%	0.3%
RR Approvals and Denials				
Total # of Approved RR Requests	26	0	0	2
Total # of Denied RR Requests	0	0	0	0
Percentage of Denied RR Requests	0.0%	0.0%	#DIV/0!	0.0%
Turnaround Times and Approved Days				
Average Number of Days Approved	1	0	0	30
Average Turnaround Time	0	0	0	16
Medical Director Reviews				
Number of RR Medical Director Reviews	0	0	0	0
Number of RR Medical Director Approvals	0	0	0	0
Number of RR Medical Director Denials	0	0	0	0
Percentage of RR Reviewed by Medical Director	0.0%	0.0%	#DIV/0!	0.0%
Percentage of RR Denied by Medical Director	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

In-Network Inpatient	MH General Hospital	MH Specialty Psychiatric Hospital	MH Residential Treatment Facility	SUD General Hospital	SUD Specialty Psychiatric Hospital	SUD Residential Treatment Facility
Total # of Claims	1,947	642	528	549	9	448
Total # of RR Requests	4	0	0	0	0	3
Percentage of Claims Subject to PA	0%	0%	0%	0%	0%	1%
RR Approvals and Denials						
Total # of Approved PA Requests	4	0	0	0	0	3
Total # of Denied RR Requests	0	0	0	0	0	0
Percentage of Denied RR Requests	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Turnaround Times and Approved Days						
Average Number of Days Approved	1	0	0	0	0	2
Average Turnaround Time	0	0	0	0	0	2
Medical Director Reviews						
Number of RR Medical Director Reviews	0	0	0	0	0	0
Number of RR Medical Director Approvals	0	0	0	0	0	0
Number of RR Medical Director Denials	0	0	0	0	0	0
Percentage of RR Reviewed by Medical Director	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Percentage of RR Denied by Medical Director	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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d. Out-of-Network Inpatient Retrospective Review Rates

Out-of-Network Inpatient	M/S General Hospital	M/S Specialty Hospital	M/S Inpatient Hospice	M/S Skilled Nursing Facility
Total # of Claims	2,449	3	5	234
Total # of RR Requests	0	0	0	0
Percentage of Claims Subject to RR	0.0%	0.0%	0.0%	0.0%
RR Approvals and Denials				
Total # of Approved RR Requests	0	0	0	0
Total # of Denied RR Requests	0	0	0	0
Percentage of Denied RR Requests	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Turnaround Times and Approved Days				
Average Number of Days Approved	0	0	0	0
Average Turnaround Time	0	0	0	0
Medical Director Reviews				
Number of RR Medical Director Reviews	0	0	0	0
Number of RR Medical Director Approvals	0	0	0	0
Number of RR Medical Director Denials	0	0	0	0
Percentage of RR Reviewed by Medical Director	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Percentage of RR Denied by Medical Director	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!

Out-of-Network Inpatient	MH General Hospital	MH Specialty Psychiatric Hospital	MH Residential Treatment Facility	SUD General Hospital	SUD Specialty Psychiatric Hospital	SUD Residential Treatment Facility
Total # of Claims	265	27	394	189	0	136
Total # of RR Requests	0	0	0	0	0	0
Percentage of Claims Subject to PA	0%	0%	0%	0%	#DIV/0!	0%
RR Approvals and Denials						
Total # of Approved PA Requests	0	0	0	0	0	0
Total # of Denied RR Requests	0	0	0	0	0	0
Percentage of Denied RR Requests	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Turnaround Times and Approved Days						
Average Number of Days Approved	0	0	0	0	0	0
Average Turnaround Time	0	0	0	0	0	0
Medical Director Reviews						
Number of RR Medical Director Reviews	0	0	0	0	0	0
Number of RR Medical Director Approvals	0	0	0	0	0	0
Number of RR Medical Director Denials	0	0	0	0	0	0
Percentage of RR Reviewed by Medical Director	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

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Percentage of RR Denied by Medical Director	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

2. Justification and Analysis

Review of CareFirst's internal retrospective review data for Virginia fully insured risk business for the period January 1, 2025 through December 31, 2025 shows that retrospective review was used at very low volumes across both M/S and MH/SUD services and was not applied to any out-of-network inpatient or outpatient services in the data set. The data reflects limited retrospective review activity, low or no denial activity, no partial or lower-level care denials, and no medical director review activity for either M/S or MH/SUD services. These operational results support comparability in the application of the retrospective review NQTL.

For inpatient in-network services, the data reflects 36 M/S retrospective review requests across 49,210 inpatient claims, representing approximately 0.07% of M/S inpatient claims. By comparison, the data reflects seven MH/SUD retrospective review requests across 4,123 inpatient claims, representing approximately 0.17% of MH/SUD inpatient claims. Although the MH/SUD inpatient request rate is higher on a percentage basis, the underlying volume is very small and does not indicate more stringent administration. M/S inpatient in-network services had no retrospective review denials, and MH/SUD inpatient in-network services also had no retrospective review denials. The inpatient data therefore shows comparable outcomes and does not show that retrospective review creates less favorable results for MH/SUD benefits.

For outpatient in-network services, retrospective review activity was also limited. M/S outpatient services had 45 retrospective review requests across 1,235,925 claims, representing less than 0.01% of outpatient M/S claims. MH/SUD outpatient services had four retrospective review requests across 240,791 claims, also representing less than 0.01% of outpatient MH/SUD claims. M/S outpatient requests included 43 approvals and two denials, resulting in an approximate 95.6% approval rate and 4.4% denial rate. MH/SUD outpatient requests were all approved, with no reported denials. The outpatient data therefore reflects a more favorable denial experience for MH/SUD services and does not indicate that retrospective review was applied more stringently to MH/SUD outpatient benefits.

Turnaround time, approved days or visits, partial denial, and medical director review data further support operational comparability. For inpatient in-network services, M/S average turnaround times were zero days for general hospital and specialty hospital services and 16 days for skilled nursing facility services, while MH/SUD inpatient average turnaround times were zero days for MH general hospital services and two days for SUD residential treatment facility services. Approved inpatient days varied by service category, with M/S approvals averaging one day for general hospital services and 30 days for skilled nursing facility services, while MH/SUD approvals averaged one day for MH general hospital services and two days for SUD residential treatment facility services. For outpatient in-network services, M/S average turnaround times were 48 days for outpatient office services and zero days for outpatient other services, while MH/SUD average turnaround times were one day for MH outpatient office services and zero days for MH outpatient other services. The data also reflects no partial or lower-level care denials and no retrospective review medical director reviews, approvals, or denials for either M/S or MH/SUD inpatient or outpatient services. These results do not show medical director-level or partial-denial activity being used more stringently for MH/SUD benefits.

V. Findings and Conclusions

The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply the retrospective review requirement to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the retrospective review requirement to M/S benefits; and (2) the Plan complies with the relevant data requirements under the MHPAEA Final Rules.

A review of CareFirst's written policies and processes reveals the comparable application of the Retrospective Review NQTL to M/S and MH/SUD services within the applicable benefit classifications. The Plan's retrospective 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.

Operationally, based on the claims volume, retrospective review request rates, approval and denial outcomes, turnaround times, approved units, absence of partial or lower-level care denials, out-of-network non-application, and medical director review activity, the data supports a finding that CareFirst's retrospective review NQTL is applied in a comparable and no more stringent manner for MH/SUD benefits than for M/S benefits, as written and in operation. Retrospective review request rates were very low across both classifications; no out-of-network retrospective review activity was reported; and MH/SUD inpatient and outpatient requests had no denials. In addition, there were no retrospective review medical director reviews or medical director denials for either M/S or MH/SUD services. Accordingly, the operational data supports the conclusion that the retrospective review process complies with MHPAEA's comparative analysis standard because the NQTL is not designed or applied more stringently to MH/SUD benefits than to M/S benefits within the same benefit classifications.

VI. Required Certification

CareFirst certifies that the foregoing comparative analysis of the Retrospective Review NQTL was prepared for the Virginia fully insured coverage identified in this report and was reviewed by individuals with appropriate knowledge of the plan terms, policies, procedures, factors, evidentiary standards, operational practices, supporting documentation, and relevant data addressed in the analysis. The analysis applies to the CareFirst entities identified in this report as NAIC 53007 and NAIC 9602 to the extent the NQTL is designed and administered as described in this analysis.

To the best of CareFirst's knowledge and based on the information, documentation, and data reviewed as of the report's version date, this comparative analysis is accurate and complete in all material respects and demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the Retrospective Review NQTL to mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, those used to design and apply the NQTL to medical/surgical benefits, as written and in operation. CareFirst will maintain supporting documentation and will update or supplement the analysis if a material change, newly identified data limitation, or corrective action affects this conclusion.

POST-PAYMENT RETROSPECTIVE REVIEW

Overview

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply post-payment retrospective review of services for clinical review, coding edits, or fraud, waste and abuse (FWA) investigations to mental health or substance use disorder ("MH/SUD") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply post-payment retrospective review of services to medical surgical ("M/S") benefits.

I. Description of the Post-Payment Retrospective Review NQTL

Post-Payment Retrospective Review includes three types of review that occur after a claim is paid. These include 1) clinical review when a required authorization is not obtained, 2) coding validation to reconcile claims for accuracy, and 3) FWA investigations. Post-claim medical review (PCMR) is defined as the process followed when contracts require a facility or provider to obtain prior authorization for inpatient and/or outpatient services.

Claims that are submitted without a required authorization on file are denied and the provider/facility (in-network) or member (out-of-network) must submit an appeal that explains the reason prior authorization was not obtained before the service and include supporting medical documentation showing the service was medically necessary. That appeal is then reviewed by the clinical team as if it had been submitted timely for medical necessity, and if medical necessity criteria were met, the claim is paid, and no further action is taken.

Coding validation is defined as the review of claims by CareFirst clinical experts for appropriateness, based on the information provided on the claim, as well as the history of the member's claims. These reviews are to ensure that providers and facilities are following correct coding practices.

FWA investigations include regular ongoing data collection and review to prevent and/or mitigate any losses due to FWA and report any illegal activity to the proper authorities to act. Fraud is defined as false representations of material fact, whether by words or by conduct, by false or misleading allegations, or by concealment of that which should have been disclosed, which deceives another so that he/she acts or fails to act to his/her detriment. Waste is defined as members not receiving reasonable value for money in connection with services rendered due to an improper or negligent use of finite resources. Abuse is defined as behavior that is deficient or improper when compared with behavior that a prudent person would consider reasonable and necessary given the facts and circumstances. Abuse also includes misuse of authority or position for personal financial interests or those of an immediate or close family member or business associate.

A. Identification of the NQTL

i. Plan/Coverage Terms Regarding Post-Payment Retrospective Review

The Plan document contains the following sections regarding post-payment retrospective review. These medical necessity sections apply to both M/S benefits and MH/SUD benefits, and do not differentiate between M/S and MH/SUD benefits:

- Claims Procedures- Internal Claims and Appeals and External Review Processes
- Definitions
- Utilization Management Requirements

(*Source: Plan EOC)*

ii. Policies/Guidelines/Other Documents Describing Post-Payment Retrospective Review

Post-payment retrospective review policies appear or are described in the following documents:

- Coding Validation – Professional and Facility (PP CO 002.02)
- PCMR PPACA Full and Fair Review (SOP P03)
- PCMR Representative Authorization and Precertification Penalty Review (SOP P01)
- Program Integrity- Special Investigations Unit (SIU) Policy (COMP 0016)
- Reporting Suspected Fraud Waste and Abuse to Compliance (PHM0019)

iii. Identification of All MH/SUD Benefits and M/S Benefits to which Post-Payment Retrospective Review Applies

All claims are subject to post-payment retrospective review for Coding Validation and FWA Investigations. All claims where an authorization was required but was not on file when the claim was submitted are subject to post-payment Clinical Review to determine Medical Necessity of the services rendered.

List of M/S Services	List of MH/SUD Services
Inpatient M/S Services (In-Network and Out-of-Network)	**Inpatient MH/SUD Services (In-Network and Out-of-Network)**
All claims are subject to post-payment retrospective review for Coding Validation and FWA Investigations. All claims where an authorization was required but was not on file when the claim was submitted are subject to post-payment Clinical Review to determine Medical Necessity of the services rendered.	All claims are subject to post-payment retrospective review for Coding Validation and FWA Investigations. All claims where an authorization was required but was not on file when the claim was submitted are subject to post-payment Clinical Review to determine Medical Necessity of the services rendered.
Outpatient M/S Services (In-Network and Out-of-Network)	**Outpatient MH/SUD Services (In-Network and Out-of-Network)**
All claims are subject to post-payment retrospective review for Coding Validation and FWA Investigations. All claims where an authorization was required but was not on file when the claim was submitted are subject to post-payment Clinical Review to determine Medical Necessity of the services rendered.	All claims are subject to post-payment retrospective review for Coding Validation and FWA Investigations. All claims where an authorization was required but was not on file when the claim was submitted are subject to post-payment Clinical Review to determine Medical Necessity of the services rendered.
Emergency Services	**Emergency Services**
All claims are subject to post-payment retrospective review for Coding Validation and FWA Investigations. All claims where an authorization was required but was not on file when the claim was submitted are subject to post-payment Clinical Review to determine Medical Necessity of the services rendered.	All claims are subject to post-payment retrospective review for Coding Validation and FWA Investigations. All claims where an authorization was required but was not on file when the claim was submitted are subject to post-payment Clinical Review to determine Medical Necessity of the services rendered.
Prescription Drugs	**Prescription Drugs**
All claims are subject to post-payment retrospective review for Coding Validation and FWA Investigations. All claims where an authorization was required but was not on file when the claim was submitted are subject to post-payment Clinical Review to determine Medical Necessity of the services rendered.	All claims are subject to post-payment retrospective review for Coding Validation and FWA Investigations. All claims where an authorization was required but was not on file when the claim was submitted are subject to post-payment Clinical Review to determine Medical Necessity of the services rendered.

II. Identification and Definition of the Factors and Evidentiary Standards Used to Design and Apply the Post-Payment Retrospective Review NQTL

A. Factors and Evidentiary Standards Used to Determine List of Services Subject to Clinical Retrospective Review

Factor 1	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 this factor.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the application of retrospective review to determine whether generally accepted standards of care published by industry-leading clinical guidance providers and medical societies are applied.
Source(s) of Factor	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines
Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. CareFirst ensures application in parity by utilizing industry appropriate criteria and guidelines.
Source(s) of Evidentiary Standards	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines

Factor 2	Clinical Efficacy and Appropriateness of a Proposed Treatment or Service
Definition	Services that have inconsistent efficacy or treatments subject to applicability in inappropriate situations. 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.

Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the application of retrospective review to determine whether the service is effective and appropriate for the condition being treated.
Source(s) of Factor	Peer-reviewed medical literature from databases such as Clinical Evidence-Based Research Resources: Medical Policy development and revisions are completed by conducting a thorough review of credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. Resources used are based on the below research: • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.
Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. There is no threshold for number of studies reviewed. Quality of research is investigated as opposed to quantity.

Source(s) of Evidentiary Standards	Peer-reviewed medical literature from databases such as Clinical Evidence-Based Research Resources: Medical Policy development and revisions are completed by conducting a thorough review of credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community. Resources used are based on the below research: • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

Factor 3	**Utilization Appropriateness**
Definition	Services that are prone to inappropriate or overutilization and/or abuse of services.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the design and application of retrospective review to determine whether services are inappropriate or more likely to be overutilized or abused.

Source(s) of Factor	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines
Evidentiary Standards and Applicable Thresholds	Any services on the prior authorization list (and therefore the retrospective review list) that have less than a 2% denial rate are removed. Services that generally have a higher than 2% denial rate are potentially placed on the list.
Source(s) of Evidentiary Standards	• Claims data and analysis • Utilization trend data • Denial rates

Factor 4	**Variations in Lengths 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 for the same or similar diagnosis may impact the determination of this factor.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient
Description	This factor is used in the application of retrospective review to determine whether extra consideration should be given to the length of stay due to high variations in lengths of stay.
Source(s) of Factor	• Claims data to track variations in length of stay • MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and

	valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.
Evidentiary Standards and Applicable Thresholds	Stays with higher variations in length of stay. The threshold is 30 days; any services with consistent stays over 30 days may be added to the retrospective review list.
Source(s) of Evidentiary Standards	• Claims data and analysis • Utilization trend data • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

B. Factors and Evidentiary Standards Used to Determine List of Services Subject to Coding Edits

All M/S and MH/SUD benefits in all classifications except inpatient INN and OON are subject to post-claim payment Coding Edits. Therefore, there is no list of services subject to coding edits, and no factors and evidentiary standards were used to create a list.

C. Factors and Evidentiary Standards Used to Determine List of Services Subject FWA Investigations

All M/S and MH/SUD benefits in all classifications except inpatient INN and OON are subject to post-claim payment FWA investigations. Therefore, there is no list of services subject to FWA investigations, and no factors and evidentiary standards were used to create a list.

D. Factors and Evidentiary Standards Used to Apply Clinical Retrospective Review

Factor 1	**Retrospective Review Submission Timelines**
Definition	Retrospective review applies when a provider and/or member cannot submit the required prior authorization request within appropriate timelines due to the member's medical condition. Under these circumstances, CareFirst will apply retrospective review to the service that should have been prior authorized, had the prior authorization request been able to be submitted timely.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the administration of the Retrospective Review NQTL to set requirements for when a service without the requisite prior authorization can still be reviewed for medical necessity and claim payment.
Source(s) of Factor	• Internal policies and procedures • Request review timelines vary and are based on applicable NCQA, state and federal requirements.
Evidentiary Standards and Applicable Thresholds	When a timely prior authorization request was not feasible due to the member's condition, retrospective review applies.
Source(s) of Evidentiary Standards	• Internal policies and procedures • Request review timelines based on applicable NCQA, state and federal requirements. • Medical Provider manual

Factor 2	**Approval/Denial Timelines for Insurer**

Definition	All post service reviews must be completed, including notification of the decision to the facility/practitioner, within the specified timeframes.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other • Prescription Drugs
Description	This factor is used in the administration of the Retrospective Review NQTL to set requirements for when an insurer must respond to a completed prior authorization request before the request is automatically approved.
Source(s) of Factor	• NCQA Standards
Evidentiary Standards and Applicable Thresholds	Within 30 calendar days of the receipt of the notification to the organization. All decisions must be made within 2 working days of receiving sufficient clinical information. Notification to the facility/practitioner of the decision must be made within 5 working days of receiving sufficient clinical information.
Source(s) of Evidentiary Standards	• NCQA Standards

Factor 3	**Clinical Appropriateness**
Definition	The proposed treatment or service must be appropriate, 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.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other

Description	This factor is used in the administration of the Retrospective Review NQTL to set requirements for when an insurer must respond to a completed retrospective review request before the request is automatically approved.
Source(s) of Factor	• MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.
Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on standards of care. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. There is no threshold for number of studies reviewed. Quality of research is investigated as opposed to quantity.
Source(s) of Evidentiary Standards	• Patient medical records and treatment history/plan • MCG Guidelines • ASAM Guidelines • SAMHSA Guidelines • BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health

	Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence. • Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). • Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care. • UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. • National Comprehensive Cancer Network® (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. • PubMed® - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval.

E. Factors and Evidentiary Standards Used to Apply Coding Edits

Factor 1	Billing Outliers
Definition	Coding edits are applied to claims with billing outliers where billing data does not align with predefined data patterns and risk indicators that are applied uniformly across all service categories.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	CareFirst relies upon multiple vendors to monitor claim editing activities and ensure consistency in billing. Chart reviews for inpatient treatment only apply to medical/surgical claims as MH/SUD claims which are reimbursed at per diem rates are not within their scope to review. Data mining services are performed by Optum and Trend Health Partners. Internal coding edits are based on coding errors derived from the CPT code. If there is a pattern of specific billing behaviors, providers/facilities may be referred to the Special Investigations Unit (SIU) for further investigation.
Source(s) of Factor	• Internal CareFirst policy • Third-party vendor contracts
Evidentiary Standards and Applicable Thresholds	There are no specific thresholds for making coding edits. If billing is incorrect, the issue is corrected and reviewed with the provider or facility. If there is an ongoing pattern of billing 'errors' by a provider or facility, then an SIU investigation may be opened.
Source(s) of Evidentiary Standards	• Internal CareFirst policy • Third-party vendor contracts

F. Factors and Evidentiary Standards Used for Fraud Investigations

Factor 1	Data Mining and Analytics
Definition	CareFirst uses fraud detection software and data analytics to track trends and mitigate the risk of fraudulent claims.

Application Benefit Classification(s)	• In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	The SIU uses its Data Analysts and commercial software applications to proactively analyze claims data, seeking patterns and utilization trends that warrant further review and investigation.
Source(s) of Factor	Internal Anti-fraud plan.
Evidentiary Standards and Applicable Thresholds	All tips submitted in good faith related to potential FWA activity are screened and investigated when appropriate. SIU has a $20,000 threshold unless the allegation indicates member or reputational harm.
Source(s) of Evidentiary Standards	• CareFirst internal policies and anti-FWA procedures • Anti-Fraud Plan • The False Claims Act – U.S. Code: Title 31: Section 3729 • The Anti-Kickback Statute – 41 U.S.C. §51 et seq.

Factor 2	**Reporting**
Definition	CareFirst members, subscribers, providers, associates, and/or others may submit an anonymous report to the FWA Hotline or through other channels to notify CareFirst of potential FWA.
Application Benefit Classification(s)	• In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	CareFirst relies in part on members, subscribers, providers, and associates referring suspicious activity that could be deemed FWA. Additional referral sources for FWA activity may include other insurance carriers or Blues Plans, national associations, vendors (PBM or Delegated Service Providers), law enforcement (FBI, State and Local Police, Medicaid Fraud Control Unit, and OIG), and regulatory agencies (state DOIs, CMS).
Source(s) of Factor	Internally and externally available FWA reporting options.
Evidentiary Standards and Applicable Thresholds	All tips submitted in good faith related to potential FWA activity are screened and investigated when appropriate. SIU has a $20,000 threshold unless the allegation indicates member or reputational harm.

Source(s) of Evidentiary Standards	• CareFirst internal policies and anti-FWA procedures • Anti-Fraud Plan • The False Claims Act – U.S. Code: Title 31: Section 3729 • The Anti-Kickback Statute – 41 U.S.C. §51 et seq.

G. Factors and Evidentiary Standards Used for Waste Investigations

Factor 1	**Data Mining and Analytics**
Definition	CareFirst uses fraud detection software and data analytics to track trends and mitigate the risk of wasteful claims.
Application Benefit Classification(s)	• In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	CareFirst relies in part on members, subscribers, providers, and associates referring suspicious activity that could be deemed FWA. Additional referral sources for FWA activity may include other insurance carriers or Blues Plans, national associations, vendors (PBM or Delegated Service Providers), law enforcement (FBI, State and Local Police, Medicaid Fraud Control Unit, and OIG), and regulatory agencies (state DOIs, CMS).
Source(s) of Factor	Internally and externally available FWA reporting options.
Evidentiary Standards and Applicable Thresholds	All tips submitted in good faith related to potential FWA activity are screened and investigated when appropriate. SIU has a $20,000 threshold unless the allegation indicates member or reputational harm.
Source(s) of Evidentiary Standards	• CareFirst internal policies and anti-FWA procedures • Anti-Fraud Plan • The False Claims Act – U.S. Code: Title 31: Section 3729 • The Anti-Kickback Statute – 41 U.S.C. §51 et seq.

H. Factors and Evidentiary Standards Used for Abuse Investigations

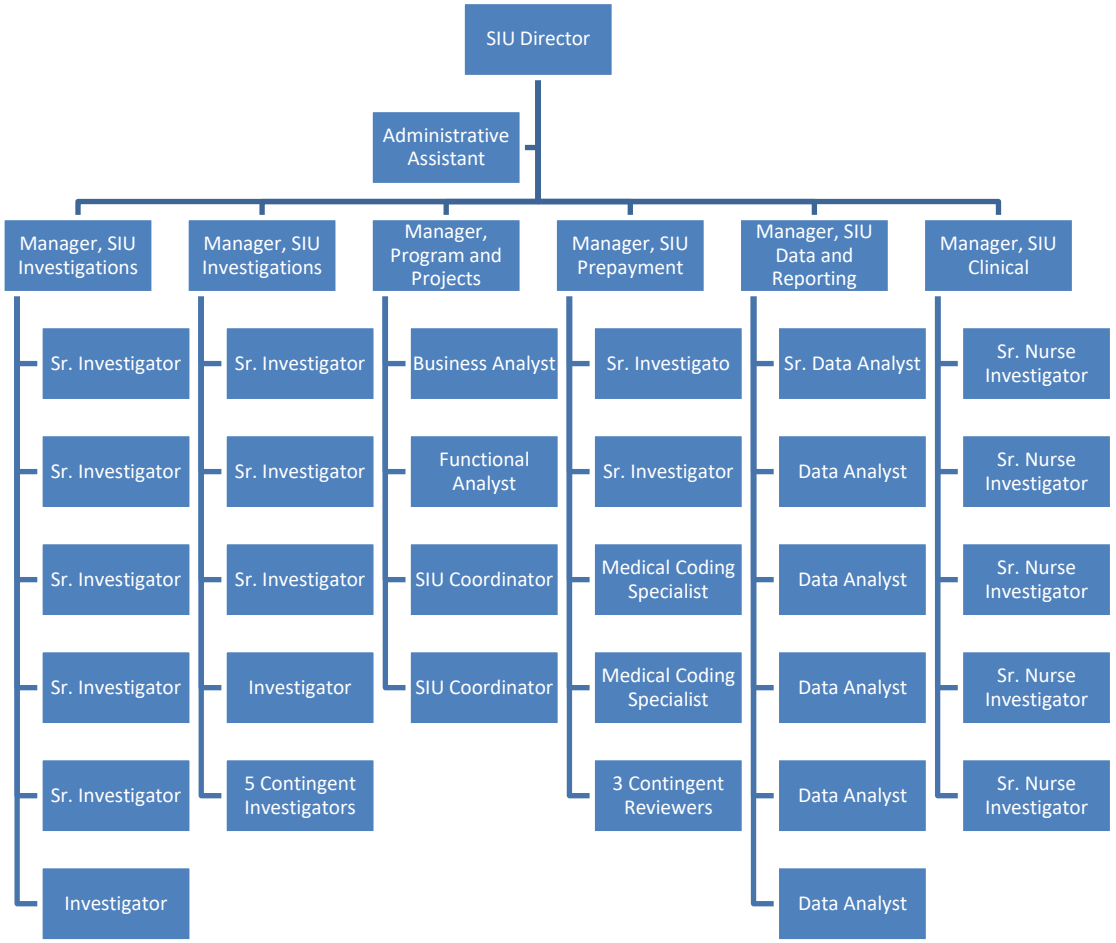
Factor 1	**Data Mining and Analytics**
Definition	CareFirst uses fraud detection software and data analytics to track trends and mitigate the risk of abusive claims.

Application Benefit Classification(s)	• In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	CareFirst relies in part on members, subscribers, providers, and associates referring suspicious activity that could be deemed FWA. Additional referral sources for FWA activity may include other insurance carriers or Blues Plans, national associations, vendors (PBM or Delegated Service Providers), law enforcement (FBI, State and Local Police, Medicaid Fraud Control Unit, and OIG), and regulatory agencies (state DOIs, CMS).
Source(s) of Factor	Internally and externally available FWA reporting options.
Evidentiary Standards and Applicable Thresholds	All tips submitted in good faith related to potential FWA activity are screened and investigated when appropriate. SIU has a $20,000 threshold unless the allegation indicates member or reputational harm.
Source(s) of Evidentiary Standards	• CareFirst internal policies and anti-FWA procedures • Anti-Fraud Plan • The False Claims Act – U.S. Code: Title 31: Section 3729 • The Anti-Kickback Statute – 41 U.S.C. §51 et seq.

A. Clinical Review Processes

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 and senior medical directors, including the behavioral health medical director. The criteria are always used with an assessment of the individual patient's needs. CareFirst's medical and behavioral health policies are available on web.carefirst.com.

In the routine course of business, CareFirst relies on internal teams to conduct post-payment retrospective reviews unless a request is submitted by an Independent Review Organization (IRO).The internal and external criteria used for both M/S and MH/SUD are authorized by the CareFirst Criteria Review Committee. Internal 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. The functional organization chart for the SIU team, including the post-payment clinical review team is included here for reference:



The Post-Claim Medical Review (PCMR) unit reviews claims submitted without the requisite authorization as an appeal. The appeal must include the reason for not submitting the authorization request timely and all supporting medical documentation to support a finding of medical necessity. PCMR reviews inquiries for retrospective authorizations from members and providers (participating and non-participating) that are contract and platform specific. Services that require authorization deny with a platform specific “no precertification on file” rejection code when a matching approved authorization is not on file. Services may also process to allow benefits with a contract specific late notification penalty applied or at the out-of-network benefit level.

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.

Written UM policies and procedures define CareFirst's prior approval and utilization review program. All services authorized by the Utilization Management (UM) Staff are evaluated against appropriate benefit packages and nationally accepted medical necessity criteria. The criteria are reviewed, revised, and approved at least annually by the Quality Executive Committee (QEC). A designated senior practitioner, specifically the Chief Medical Officer (CMO), has significant involvement in the implementation of the UM Program and related policies and procedures. A formal UM Committee, under the direction of the CMO, oversees the Utilization Review process.

Retrospective review decisions and processes are supervised by qualified licensed professionals. A licensed professional who has appropriate clinical experience in treating the enrollee's condition or disease makes a request for the CMO or Medical Director to review a request for service that does not meet medical necessity criteria. The CMO or medical director makes the final coverage determination if the clinician is unable to approve the request. A change in the amount, duration, or scope that is less than requested must be made by a healthcare physician. Licensed physician consultants from Medical Review Institute of America (MRIA) are utilized to review cases from the appropriate specialty areas as needed.

A licensed physician oversees UM decisions to ensure consistent medical necessity decision making. Licensed doctoral-level clinical psychologists oversee behavioral health care UM decisions for psychological testing. Licensed nurses or Licensed Clinical Social Workers (RN or LPN or LCSW) may approve benefit or medical necessity cases. These practitioners may not deny medical necessity cases.

Utilization Management Staff and their Responsibilities:

CareFirst Title	Qualifications
Medical Director/Chief Medical Officer	Board certified Medical Doctor responsible for the development and implementation of UM processes, criteria, and program outcomes. Oversees the operations of the UM department and is a liaison to the medical community regarding UM program operations. Clinical consultant for UM decisions: approves and denies care according to medical criteria and policies and procedures. Reports to Executive Vice President of Health Services and supervises all other medical directors (e.g., Behavioral Health Medical Director, Radiology/Cardiology Medical Director, etc.). Chairs the UM Committee.
Medical Director, Behavioral Health	Board certified Medical Doctor of Psychiatry, who reviews and makes determinations based on medical necessity on behavioral health UM cases, using evidence-based UM criteria and policies and procedures. Liaison to the behavioral health practitioner and provider communities. Provides information and expertise to the UM behavioral health staff. Reports to the Chief Medical Director, is an enrollee of the UM Committee.

Director of Utilization Management	A Registered Nurse who is responsible for intake, precertification, concurrent review, and retrospective review activities of the department. Develops and maintains policies and procedures for assigned areas. Approves requested care per UM criteria and policies and procedures. May deny care based on benefits or contract issues. Supervises all RN, LPN staff and UM coordinators, and is responsible for department operations. Reports to the Clinical Director of Government Programs with a dotted line to the Chief Medical Officer.
Utilization Management Manager/Supervisor	Assists UM director with day-to-day operations, oversees completion of reviews by UR Reviewers, problem- solves, conducts audits, prepares documents for weekly UM Meetings. Reports to the Director of Utilization Management.
Utilization Management Reviewer	A Licensed Nurse who conducts UM review activities. Monitors and coordinates care with participating practitioners, enrollees, and provider organizations, using established criteria. Collects data for the precertification, concurrent review, and retrospective review processes. Approves requested care per UM criteria and policies and procedures. May deny authorization requests based administrative criteria (i.e., benefit or contractual limitations) In the event that medical necessity is not met, the reviewer would submit the authorization request to a MD for the medical necessity determination.
Vice President of Pharmacy and Therapeutics	The Doctor of Pharmacy is responsible for developing and maintaining the formulary and formulary policies and procedures. Researches, approves and denies requests for drugs consistent with formulary policies and procedures and UM criteria. Reports to the Medical Director/CMO and is a member of the P & T Committee. Provides support to the P & T Committee and manages the MCO's relationship with the Pharmacy Benefits Manager (PBM).
Physician Advisors	Board certified Medical Doctors who are available for review of UM cases (including appeals), or in the case of an appeal They will research and either approve or denies the authorization request according to UM criteria and policies and procedures.

B. Coding Edit Processes

All claims submitted to CareFirst are subject to review. Reviews may extend across claims, referencing additional claims if more than one claim is received for a member for related services, regardless of the provider or setting. These reviews are to ensure that providers and facilities are following correct coding practices. Coding Validation is commonly performed in, but is not limited to, the scenarios below:

- Add-on code when the primary code has been denied.
- Procedure to modifier combinations. This includes distinct service modifiers.
- Procedure to procedure combinations.
- Procedure to revenue code combinations.

- Admission/discharge dates or discharge status codes on facility claims.
- Duplicate services.
- E/M codes when billed with modifiers on any 0-, 10- or 90-day surgical procedure.
- 0, 10 or 90-day surgical procedures when appended with modifiers and another surgical procedure has been billed in the previous 90 days.
- Procedures with modifier billed out of sequence.
- ICD-10-PCS procedures based on the procedure code definition.

As part of the coding validation process, CareFirst may request medical record documentation for verification of appropriate billing or for other purposes from any provider. Providers must submit the requested information within 15 days of receipt of request or in accordance with the terms of the agreement. If the information provided on the claim(s) does not support what is being billed, the claim or claim lines will be denied.

Beyond the internal review processes, CareFirst contracts with third-party vendors, Optum and Trend Health Partner, to audit claims for potential coding errors via data mining. The vendors are unable to provide the specific algorithms relied upon for data mining as the information is considered proprietary and confidential. Optum confirmed that, "mental health and substance abuse claims are audited using the same process as medical claims. Specifically, all claims are reviewed against the applicable facility rate sheets. If a discrepancy is identified during the audit, the paid rate does not align with the contracted rate, the claim is flagged and submitted for a refund. This process is applied uniformly across all claim types to ensure consistency, compliance, and accuracy." Trend Health Partners stated, "We apply the same standards, scope, and processes as those applied to medical/surgical claims and apply client policies and contractual guidelines to each claim.

This includes:

- Claim Selection: Claims are selected based on predefined data patterns and risk indicators that are applied uniformly across all service categories.
- Audit Scope and Frequency: The frequency and scope are aligned to ensure no greater stringency is applied to one category over the other.
- Reviewer Qualifications: All audits are performed consistently with expertise relevant to the services under review."

As noted below, CareFirst does not have operational data for coding edits that can be split by M/S and MH/SUD diagnoses codes as the vendors referenced above do not require diagnosis code information in the claim audit and code editing process.

C. FWA Processes

The Special Investigations Unit (SIU) is CareFirst's in-house, dedicated unit responsible for coordinating the detection, investigation, referral and prevention of suspected fraud, waste, and abuse (FWA). In addition to the analysis and detection of fraud, waste, and abuse through claims data, the SIU is also responsible for identifying and resolving subscriber/provider fraud, application and underwriting fraud, broker fraud, and pharmacy fraud.

Additionally, SIU personnel are responsible for training other Associates and/or customers to recognize potential schemes and potentially abusive acts. The SIU is separate and distinct from the Company's Underwriting and Claim Departments, although there is close cooperation between departments.

CareFirst defines Fraud, Waste, and Abuse as follows:

- **Fraud:** The intentional or deliberate deception for personal gain, to deprive another of property or money by deception or other unfair means, such as submitting false claims or falsifying information.
- **Waste**: Careless or needless practices that, directly or indirectly, result in unnecessary costs, such as overuse of services, often due to mismanagement or inefficient practices. Waste is generally not considered to be caused by criminally negligent actions but rather by the misuse of resources.
- **Abuse**: Improper use of resources or actions that deviate from acceptable practices and may result in unnecessary costs.

The SIU's anti-fraud activities are proactive and reactive. Cases are derived from a variety of internal and external sources, such as tips, calls to the anonymous anti-fraud hotline, referrals from internal departments or external agencies, and leads generated from profile analysis of data stored in internal operating and claims processing systems. Case resolution results in educational opportunities, changes in internal policies, processes, practices, or procedures, recovered savings, referrals to law enforcement for criminal investigations and/or civil recovery of assets, termination of providers from CareFirst networks, and/or administrative referrals to applicable professional boards. CareFirst also relies upon Health Care Fraud Shield, a third-party vendor, to monitor and detect FWA activities.

The SIU, originally created in 1982, is a dedicated unit under the scope of control under CareFirst's Enterprise Shared Services Division. The unit is led by the SIU Director and comprised of various professionals, including investigators, data analysts, nurse auditors, and compliance personnel. The SIU also works closely with CareFirst's Office of Corporate Counsel (OCC) and has dedicated counsel that provide legal and investigative support.

All members of the investigative staff must have experience in various functions of the insurance industry and CareFirst's product lines. Orientation to the Company's systems and structure is provided to new investigators immediately after hire. Associates are encouraged to take additional classes and opportunities to continue their education and may enroll in special in-house training classes that provide overview to those processes, as well as external seminars, conferences, or other learning activities.

Most SIU associates have industry-specific expertise and professional designations, including Certified Fraud Examiner (CFE), Certified Professional Coder (CPC), and Accredited Healthcare Fraud Investigator (AHFI) accreditations. Education is an important part of CareFirst SIU, and Associates are active at the local and national level of the Association of Certified Fraud Examiners (ACFE) Organization and National Health Care Anti-Fraud Association (NHCAA). SIU management also is active with the American Academy of Professional Coders (AAPC) and the BlueCross BlueShield Association National Anti-fraud Advisory Board (NAAB).

To augment capabilities and effectiveness, the SIU works closely with various other units in CareFirst, including the Company's auditors in the Corporate Audit & Assurance Services Department, attorneys in the Office of Corporate Counsel, and compliance professionals in the Compliance

and Ethics Office. These additional resources and functions assist the SIU in anti-fraud efforts and allow it to leverage internal expertise in financial and information systems, internal policy enforcement and documentation standards, and legal support. Using these functions also permits the SIU to access Associates involved with the Institute of Internal Auditors (IIA), Maryland Association of Certified Public Accountants (MSCPA), Information Systems Audit and Control Association, Inc. (ISACA) and be in possession of additional relevant certifications (CIA, CPA, CISCA, etc.). The SIU also works closely with a dedicated Medical Director on medical policy issues and to support clinical record reviews and a dedicated member of the Provider Networks team. If outside firms are used to assist with any investigations, such firms will comply with all applicable laws and regulations.

An insurance fraud investigation begins with an internal investigation or a referral to SIU of an activity that is sufficiently questionable. The means of insurance fraud are as varied as human ingenuity and can penetrate the claims reimbursement process at any stage. Valid claims may be exaggerated; false claims may be made on behalf of real diseases, or their proximate causes may be faked. The malefactor may be a patient, provider, or a group of individuals. The act of fraudulent and abusive billing can also originate from a customer. As such, tips and the pipeline to the SIU (as well as its investigative functions) can be as varied as the schemes themselves, and the SIU generates cases and referrals received from a variety of internal and external sources.

CareFirst's fraud detection starts with data mining and analytics. All professional and outpatient claims and fed into the analytics to detect and prevent fraud. The algorithms, models, and machine learning used to identify leads are based on known fraud schemes within the healthcare industry. SIU validates leads based on identified aberrant billing patterns, outliers of billing norms through peer-to-peer comparison, national standards, spike patterns, and complaints. CareFirst's vendor platform, Health Care Fraud Shield, owns the logic and algorithms relied upon and considers them confidential and proprietary. The algorithms, models, and machine learning are applied across all professional and outpatient claims regardless of provider type or specialty.

As part of the manual review process when potential FWA is identified, medical records are requested and reviewed and compared to CPT/HCPC codes billed for accuracy of the services rendered. To ensure that the extent of medical records required is comparable between MH/SUD and M/S benefits, SIU investigators pull a statistically valid random sample (SVRS) via RAT-STATS for all investigations warranting a post payment record review, regardless of the benefit level being reviewed. Guidelines for reviews include industry standard guidelines (CMS, AMA, and MCG). If there is a concern with whether a service was medically necessary or experimental/investigational, the SIU clinical reviewer consults with the appropriate CareFirst medical director for their determination(s).

The SIU uses its Data Analysts and commercial software applications to proactively analyze claims data, seeking patterns and utilization trends that warrant further review and investigation. Provider claims are also analyzed to identify billing "outliers" among peer providers, which is sometimes an indicator of potential FWA. CareFirst's Pharmacy Benefit Manager (PBM) also performs data mining and analytics on pharmacy claims. The SIU works with its PBM to determine whether member or provider fraud, waste, or abuse is connected to prescription drug cases.

When investigating a tip, the SIU compiles relevant information and prepares a report that outlines the actions taken to review claims and develop audit findings. All cases are logged into the SIU case management system, assigned, and distributed to Associates to be pursued to completion. The beginning date of cases is logged, and periodic case review meetings are held between responsible associates, SIU Management, and the OCC.

CareFirst investigations can result in a variety of outcomes including flagging providers for prepayment review of claims, pending claims, and engaging in provider education. Cases involving suspected fraudulent or abusive activity are referred to the appropriate regulatory and/or law enforcement agencies, using the designated forms or referral process in place. In appropriate cases involving patient harm or inappropriate professional behavior, referrals are also made to appropriate Board of Medicine or Physicians, including, but not limited to the Maryland Physicians Board of Quality Assurance, D.C. Board of Medicine, and the Virginia Board of Medicine.

When appropriate, CareFirst requires 100% review of claims related to the identified issue(s) withing one year of the date that CareFirst paid the claims. When overpayment is due to false statements or false claims, the overpayment is based on the full paid amount. Otherwise, the identified overpayment will be based on a net amount, after giving consideration for any amount properly payable. SIU associates calculate the overpayment amount, known as identified overpayment, according to procedures outlined in this guidance. Overpayments are determined in accordance with the law, regulation, guidance, or payment policy in effect at the time the claims were paid. The identified overpayment will generally cover the period of the FWA, after analyzing at least 3 years or longer, to cover the period of fraud. A medical review will occur when the identified overpayment relates to certain medical issues. The identified overpayment amount will be finalized after the medical validation has occurred.

The identified overpayment amount will be highlighted in an audit report for the provider and/or SIU reports drafted for other purposes. When settlement is sought, the SIU Director and/or management requests the total amount paid to a provider for the claims at issue (the gross amount) and the net amount, after giving consideration for any amounts properly payable had the claims been submitted correctly. An identified overpayment amount may also be calculated during an ongoing criminal or civil investigation, or in anticipation of a law enforcement referral. In such cases, the findings/results and identified overpayment amount are not immediately forwarded to the provider/subscriber to request repayment. Decisions to request repayment from providers/subscribers are made in consultation with the SIU Director and/or management.

If a provider does not agree with the audit findings, they may request reconsideration. Reconsideration requests must be made in writing, including the basis of the dispute, and received no later than 30 days from the written audit findings. If payment or a reconsideration request is not received within 30 days, CareFirst reserves all rights to recover the overpayment, including conducting an onsite audit, payment retractions, and/or offsets of future claims. If a provider is found to have improperly billed CareFirst without the member's knowledge, there is no member liability in instances of FWA. If a service is deemed not medically necessary during post-payment retrospective review, the member is not liable and generally is not notified about recoupment efforts against the provider or facility that provided the service.

D. Post-Payment Retrospective Review Strategy

All forms of post-payment retrospective review are intended to protect members and further CareFirst's mission to provide affordable and accessible healthcare to members and subscribers. Actions that wrongfully increase the cost of carrier or create barriers to access for care must be mitigated to reduce costs associated with unnecessary care, claim coding errors (whether incidental or malicious), and FWA activities that limit CareFirst's ability to provide the highest quality care at an affordable cost point. To tackle these issues, CareFirst pursues a wide scope of strategies ranging from educational activities to financial recovery of improperly paid funds, to termination of network providers. If actions rise to the level of illegality, CareFirst will also inform local and/or federal law enforcement.

CareFirst members and subscribers are also an effective source of leads concerning possible FWA. When claims are paid, subscribers or policyholders receive an Explanation of Benefits Statement (EOB) that explains the date and type of care, the name of the provider, the amount charged, the amount CareFirst pays, and the patient's financial liability. When subscribers question any of this information, they often seek clarification. Each EOB contains a message notifying members and subscribers of CareFirst's tollfree Fraud Hotline and how to report suspected FWA.

Providers and Associates are also sources of FWA tips. Providers may report a peer provider that they believe is engaged in questionable behavior and Associates have become accustomed to identifying suspicious claims through ongoing training. Tips may come from claims processors, provider/client service representatives, utilization review analysts, sales representatives, medical review professionals, underwriters, and many others. To assist in this process, SIU Associates participate in a variety of cross functional workgroups and meetings to maintain an up-to-date edge on business and policy issues (e.g., Medical Policy, Nurses Forum etc.) and to understand the practical implications of how FWA may present itself throughout the organization.

Additional referral sources may include other insurance carriers or Blues Plans, national associations, vendors (PBM or Delegated Service Providers), law enforcement (FBI, State and Local Police, Medicaid Fraud Control Unit, and OIG), and regulatory agencies (state DOIs, CMS).

Once the SIU receives a complaint involving potential FWA, a standard process is followed to ensure the consistent and professional development of the case file and related evidence:

1. The complaint is logged, and a case number is assigned.
2. Any background information is reviewed. If needed, the complainant is contacted for additional information or clarification of the allegation.
3. The SIU case log and other resources (e.g., the NHCAA's SIRIS reporting website) is reviewed for other
4. complaints involving the same person or provider of the service. If other complaints are found that information is also reviewed.
5. Claims information to support the potential FWA scheme is obtained and developed as needed, including copies of claims submissions, check/payment vouchers, EOBs, and Notices of Provider Payments.
6. An internal check is performed for processing or clerical errors. (Note: When a determination is made that the complaint is the result of a processing or clerical error, the error is corrected, and the case is closed.)
7. If the allegation is from a subscriber and involves the non-rendering of services, the SIU will contact the provider for documentation to substantiate any claims submissions. (Note: Sometimes a visit to the provider's office is warranted in accordance with the terms of the network participation agreement.)
8. If the allegation is from a provider (e.g., physician, hospital, or supplier) and involves the subscriber submitting claims for services not received or altered bills, the SIU will contact the provider for a statement verifying that services were not provided.

9. If after review of all relevant information it is determined that the findings do not substantiate an allegation of FWA, the matter is closed, and a letter is sent to the referring source (if possible and appropriate) explaining the findings and advising them that the case is being closed.

Each investigation begins as an opportunity to educate either the investigative target (on proper billing or claims submissions procedures) or the Company (on industry standards and changes related to certain procedure codes, etc.). As an investigation develops and more facts emerge, the SIU then assesses whether there are opportunities for further return, including assessment of potential recoupment or recovery strategies from the target, opportunities to create or modify billing or medical policies, opportunities to improve network provider contracts, decisions about a provider's network status, litigation or other action, or referral for administrative or law enforcement engagement. Additionally, at the conclusion of each investigation, root cause analysis is performed to identify internal issues that may have allowed fraud, waste, or abuse to occur. The SIU reports any issues to management for resolution.

As a result of SIU activities and recommendations, corporate guidelines and policies are refined and developed to improve existing processes and procedures. SIU-based recommendations are also made to strengthen internal controls in areas that are vulnerable to fraud, waste, or abuse. Guidelines have included instructions for referral of potential fraud, waste, or abuse cases to the SIU for review and reconciliation. Systems-based anti-fraud controls also include:

Utilization Review Tools: CareFirst utilizes McKesson ClaimsXten™ software as part of the overall claims editing process on professional claims. When appropriate, ClaimsXten™ reviews Current Procedural Terminology (CPT®) codes in the system prior to claims being paid. If services are determined to be incidental, mutually exclusive, integral to or included in other services rendered or part of a global allowance, they are not eligible for separate reimbursement. The Smart Suspense feature is also utilized which compares certain CPT® codes with the diagnosis code submitted to ensure billing is appropriate.

Industry Databases: The Internet is used for research and gathering of information on particular cases. CareFirst also leverages third-party resources and databases, such as the NHCAA's SIRIS website and Lexis Nexis Risk Solutions Accurint database.

Licensed Anti-Fraud Technology: In 2021, CareFirst implemented Healthcare Fraud Shield, a state-of-the-art software product that supports the detection, investigation, and documentation of health care fraud and abuse. Complementary features support medical review audits, peer-to-peer utilization analysis, ad hoc data inquiry, and ad hoc report generation. The case management tool creates an electronic environment in which information is readily available and shared by all authorized users from the convenience of their workstations, without the need for programming support and special computer runs. Healthcare Fraud Shield offers various modules and is expandable to meet the growing needs and demands of the SIU. The sophistication and flexibility of the software enables CareFirst to make better decisions, faster, and with more verifiability.

E. Relationship Between Factors

No factors were considered and ultimately rejected. All considered factors were approved and applied as stated above.

III. Demonstration of Comparability and Stringency as Written

This section demonstrates that in each classification, under the terms of the plan as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying FWA monitoring and post-payment retrospective reviews to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the medical necessity with respect to M/S benefits.

CareFirst relies upon multiple vendors and/or purchases proprietary software from third parties to combat FWA activities. Algorithms and predetermined criteria flag services that may not be medically necessary or may be FWA activity. These algorithms and criteria are objective and based on industry research and trends and are applied without consideration for whether a benefit/service or provider/facility treats M/S, MH, or SUD conditions. By granting third parties' access to review all outpatient and professional claims for instances of FWA activity, CareFirst has removed subjectivity through standard data mining and reporting activities to detect and prevent instances of FWA.

All factors, evidentiary standards, processes and strategies are identical for post-payment retrospective review of both M/S and MH/SUD services. There are minor deviations in the sources relied upon to determine medical necessity for clinical retrospective reviews, however, those variations like using ASAM for SUD and MCG for M/S reviews are aligned with industry standards. Inpatient services are not reviewed internally for FWA activity but could be flagged by a third-party vendor for billing inconsistencies. Furthermore, coding edits are not applied to MH or SUD inpatient services as they follow standard per diem rates. Members are not charged recoupment fees unless they are engaging in FWA activity (typically any recoupment is taken from the provider/facility filing the claim(s)).

IV. Demonstration of Comparability and Stringency in Operation

This section demonstrates that in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the post-payment retrospective review NQTL to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the post-payment retrospective review NQTL with respect to M/S benefits.

Below is an explanation of how CareFirst evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the post-payment retrospective review NQTL to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the post-payment retrospective review NQTL with respect to M/S benefits.

A. Explanation of how CareFirst Evaluates Comparability

CareFirst historically has not considered post-payment retrospective reviews, whether clinical, coding edits, or for FWA monitoring and prevention, as a non-quantitative treatment limitation. The logic behind this determination is that NQTLs are specifically focused on activities that could limit treatment or limit access to treatment. With post-payment reviews, the member has already received treatment and either the provider/facility claim(s) had errors, a medical necessity determination was incorrect, or FWA activity has been substantiated. In any of those 3 instances, unless the member is directly involved in FWA activity, no recoupment of funds is requested from the member.

CareFirst does not currently receive data from external vendors regarding the number of coding edits or claims with suspected FWA activity by M/S or MH/SUD condition as that level of data is not within the current scope. Therefore, CareFirst is able to provide a summary of post-claim

retrospective review activity at the jurisdiction level, showing that a comparable percentage of M/S and MH/SUD claims in each classification are investigated. These charts only include outpatient data as outpatient office and outpatient other data is gathered and reviewed by CareFirst's internal SIU team.

The data below is based on clinical and FWA post-payment retrospective review activity ranging from 1/1/2025-12/31/2025 CareFirst does not perform clinical or FWA retrospective reviews for any inpatient services whether M/S or MH/SUD. However, CareFirst maintains the right to perform site visits to inpatient facilities to confirm processes and procedures meet clinical and SIU guidelines for proper levels of care and FWA prevention. CareFirst is unable to split this data by legal entity or specific plans, therefore, the below is inclusive of all Virginia fully insured plan data. Since SIU investigations are lengthy and involve review, negotiations, and a settlement process, CareFirst does not have recoupment data or other steps such as marking a provider for prepayment available at this time.

B. Documentation of Outcomes

1. Evaluation of Relevant Data: Post-Payment Retrospective Review

Summary of Post-Payment Retrospective Reviews and Outcomes Outpatient Office (POS Code 11)				
	M/S In-Network	**M/S Out-of-Network**	**MH/SUD In-Network**	**MH/SUD Out-of-Network**
Total Claims **Lines** Reviewed	2,609	0	812	88
Number of Post-Payment Investigations	9	0	7	1
% **Total** Claims Reviewed Retrospectively	.006%	N/A	.007%	.08%
Number of Reviews Ending in Recoupment	TBD	TBD	TBD	TBD
% Claims Ending in Recoupment	TBD	TBD	TBD	TBD
Number of Reviews Ending in No Recoupment	TBD	TBD	2	TBD
% Claims Ending in No Recoupment	TBD	TBD	TBD	TBD

Summary of Post-Payment Retrospective Reviews and Outcomes Outpatient Other				
	M/S In-Network	**M/S Out-of-Network**	**MH/SUD In-Network**	**MH/SUD Out-of-Network**
Total Claims **Lines** Reviewed	0	0	94	100
Number of Post-Payment Investigations	0	0	1	1
% **Total** Claims Reviewed Retrospectively	0	0	.0041%	.15%

Number of Reviews Ending in Recoupment	TBD	TBD	TBD	TBD
% Claims Ending in Recoupment	TBD	TBD	TBD	TBD
Number of Reviews Ending in No Recoupment	TBD	TBD	TBD	TBD
% Claims Ending in No Recoupment	TBD	TBD	TBD	TBD

2. Justification and Analysis

CareFirst analyzed the percentage of claims lines reviewed through post-payment retrospective review to determine whether M/S and MH/SUD outpatient claims were investigated in a comparable manner after payment. In the Outpatient Office benefit classification, 2,609 M/S in-network claim lines were reviewed, resulting in nine post-payment investigations, compared to 812 MH/SUD in-network claim lines reviewed, resulting in seven post-payment investigations. No M/S out-of-network Outpatient Office claim lines were reviewed, while 88 MH/SUD out-of-network Outpatient Office claim lines were reviewed, resulting in one post-payment investigation. For Outpatient Other services, there were no M/S in-network or out-of-network claim lines reviewed and no M/S post-payment investigations. By comparison, 94 MH/SUD in-network Outpatient Other claim lines were reviewed, resulting in one investigation, and 100 MH/SUD out-of-network Outpatient Other claim lines were reviewed, resulting in one investigation.

The post-payment data reflects very low review and investigation activity across the outpatient classifications and does not indicate that post-payment retrospective review is applied more stringently to MH/SUD benefits than to M/S benefits. Although MH/SUD claim lines show some post-payment activity in categories where M/S had no out-of-network or Outpatient Other activity, the underlying volumes are very small, and the available outcome fields are incomplete because recoupment and no-recoupment results remain marked as TBD in several categories. The available data does not show a pattern of adverse outcomes, treatment limitations, or recoupment activity being imposed more stringently on MH/SUD claims. Accordingly, based on the available claim-line review counts, investigation counts, and limited outcome data, CareFirst's post-payment retrospective review process supports a finding of comparable, no-more-stringent application to MH/SUD benefits in operation and does not identify a parity concern under MHPAEA.

V. Findings and Conclusions

The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply the post-payment retrospective review NQTL to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the post-payment retrospective review NQTL to M/S benefits; and (2) CareFirst complies with the relevant data requirements under the MHPAEA Final Rules.

CareFirst relies upon multiple vendors and/or purchases proprietary software from third parties to combat FWA activities. Algorithms and predetermined criteria flag services that may not be medically necessary or may be FWA activity. These algorithms and criteria are objective and based on industry research and trends and are applied without consideration for whether a benefit/service or provider/facility treats M/S, MH, or SUD conditions. By granting third parties' access to review all outpatient and professional claims for instances of FWA activity, CareFirst has removed subjectivity through standard data mining and reporting activities to detect and prevent instances of FWA.

All factors, evidentiary standards, processes and strategies are identical for post-payment retrospective review of both M/S and MH/SUD services. There are minor deviations in the sources relied upon to determine medical necessity for clinical retrospective reviews, however, those variations like using ASAM for SUD and MCG for M/S reviews are aligned with industry standards. Inpatient services are not reviewed internally for FWA activity but could be flagged by a third-party vendor for billing inconsistencies. Furthermore, coding edits are not applied to MH or SUD inpatient services as they follow standard per diem rates. Members are not charged recoupment fees unless they are engaging in FWA activity (typically any recoupment is taken from the provider/facility filing the claim(s)).

Based on the SIU post-payment retrospective review data, the available operational results support a finding that the post-payment retrospective review process is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits. In the Outpatient Office classification, M/S in-network services had 2,609 claim lines reviewed and nine post-payment investigations, while MH/SUD in-network services had 812 claim lines reviewed and seven investigations; the reported retrospective review percentages were similarly low at approximately 0.006% for M/S in-network and 0.007% for MH/SUD in-network. M/S out-of-network Outpatient Office services had no reviewed claim lines or investigations, while MH/SUD out-of-network Outpatient Office services had 88 claim lines reviewed and one investigation, representing approximately 0.08%. In the Outpatient Other classification, there were no M/S in-network or out-of-network claim lines reviewed and no M/S investigations, while MH/SUD in-network services had 94 claim lines reviewed and one investigation and MH/SUD out-of-network services had 100 claim lines reviewed and one investigation. Although MH/SUD activity appears in categories where there was no corresponding M/S activity, the investigation volumes are very small and do not establish a pattern of more stringent application. Accordingly, based on the claim-line review counts, investigation counts, review percentages, and limited outcome data available, the SIU post-payment retrospective review data does not identify a parity concern and supports the conclusion that the process complies with MHPAEA's comparative analysis standard because it is not designed or applied more stringently to MH/SUD benefits than to M/S benefits within the same outpatient benefit classifications.

VI. Required Certification

CareFirst certifies that the foregoing comparative analysis of the Post-Payment Retrospective Review NQTL was prepared for the Virginia fully insured coverage identified in this report and was reviewed by individuals with appropriate knowledge of the plan terms, policies, procedures, factors, evidentiary standards, operational practices, supporting documentation, and relevant data addressed in the analysis. The analysis applies to the CareFirst entities identified in this report as NAIC 53007 and NAIC 9602 to the extent the NQTL is designed and administered as described in this analysis.

To the best of CareFirst's knowledge and based on the information, documentation, and data reviewed as of the report's version date, this comparative analysis is accurate and complete in all material respects and demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the Post-Payment Retrospective Review NQTL to mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, those used to design and apply the NQTL to medical/surgical benefits, as written and in operation. CareFirst will maintain supporting documentation and will update or supplement the analysis if a material change, newly identified data limitation, or corrective action affects this conclusion.

EXPERIMENTAL OR INVESTIGATIONAL: EVALUATION OF NEW TECHNOLOGIES

Overview

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the new technology assessments to determine whether a service is experimental or investigational to mental health or substance use disorder ("MH/SUD") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the experimental/investigational determinations to medical surgical ("M/S") benefits.

I. Description of the Evaluation of New Technologies NQTL

Technology assessments are a structured analysis of a technology, drug, or treatment performed to provide input to clinical policy. Technology assessments include examining safety, efficacy, feasibility outside the investigational setting, comparability to existing technologies relative to outcomes, indications for use, and ethical implications and consequences. Technology assessments are comprehensive and are firmly based on research, clinical evidence, and application of the scientific method. Technologies and services that are not consistent with evidence-based clinical standards are considered experimental or investigational and are excluded from coverage as ineffective, unproven, or unsafe for the condition being treated.

A. Identification of the NQTL

i. Plan/Coverage Terms Regarding Experimental/Investigational and New Technologies and Associated Policies/Guidelines/Other Documents Describing Experimental/Investigational

Description and Definitions:

Technology Assessment:

Technology assessment is a method by which new, emerging, or current technologies are thoroughly researched; it is a review process that determines if a medical and behavioral health technology (medical drug, device, process, system, or technique) is safe, effective, and generally accepted in the medical and behavioral health community. New and emerging healthcare technologies are presented before a committee comprised of the Plan's Medical Directors and associates of the Health Services division, including the Healthcare Policy department.

The technology assessment procedure encompasses 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.

Experimental / Investigational (*Policy 0.00.011, retired 9/1/2025 due to SOP #HCP 100.04 being in place)*:

Medical and behavioral health services, medical and behavioral health and surgical procedures, devices, radiology and nuclear medicine procedures, anesthesia services, durable medical equipment, diagnostic tests, laboratory procedures, and pharmaceuticals may be reviewed for technology assessment.

Services, supplies or technology that do not meet all five (5) of the criteria listed below adopted by the BlueCross BlueShield Association (BCBSA) Medical Policy Services (MPS) Assessment Criteria (formerly known as the TEC Criteria or "Technology Evaluation Center" criteria are deemed to be experimental/investigational:

1. The technology must have final approval from the appropriate U.S.1 government regulatory bodies; and
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes; and
3. The technology must improve the net health outcome; and
4. The technology must be as beneficial as any established alternatives; and
5. The improvement must be attainable outside the investigational settings.

CareFirst Healthcare Policy Number 0.00.011, Technology Assessment, defines technology assessment as a method by which new, emerging, or current technologies are thoroughly researched and evaluated. The Technology Assessment Committee (TAC) provides the forum in which evidence is evaluated to determine whether a procedure, technique, drug, or device will be covered. This policy applies to all lines of business and further

states that its purpose is to provide a systematic, scientific process for evaluating emerging medical, behavioral health, and surgical treatments to ensure that members have access to the latest appropriate treatments.

CareFirst's technology assessments include a comprehensive review of medical and behavioral health literature and data evaluation, such that these assessments are comprehensive and firmly based on research, clinical evidence, and application of the scientific method. (*Policy 0.00.011*)

In addition, Medical Policy Reference Manual (MRPR) Policy Number 0.00.001 defines experimental/investigational services or supplies for both medical and behavioral health as those that are in the developmental stage and are in the process of human or animal testing, and those that do not meet all five of the criteria listed above in Healthcare Policy Number 0.00.011. (*MRPR Policy 0.00.001*)

Systemic Scientific Process for Evaluating Emerging Treatments

Requests to cover new technologies are submitted from a variety of sources. External requests primarily come from the provider community and companies in the healthcare technology industry. These requests are prioritized based upon clinical need, legislative demands, and impact to CareFirst membership. CareFirst's technology assessment includes a comprehensive review of medical and behavioral health literature and data evaluation.

For a new or emerging technology, service, or supply to be deemed medically appropriate and effective, it must meet five (5) criteria adopted by the BlueCross BlueShield Association Technology Evaluation Center (TEC) ("Five Criteria")(*Policy 0.00.011, pg. 3; MRPR Policy 0.00.001, pg. 5*.) which are:

1. The technology must have final approval from the appropriate U.S. government regulatory bodies;
2. The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes;
3. The technology must improve the net health outcome;
4. The technology must be as beneficial as any established alternatives; and
5. The improvement must be attainable outside the investigational settings.

If a new or emerging technology, service, or supply does not meet all five criteria, it is deemed experimental/investigational and flagged for review and update in 24 months. (Policy 0.00.011, pg. 3.)

Strategy and Technology Assessment Committee (TAC):

The TAC includes Plan Medical Directors and Registered Nurses, and uses the Five Criteria to assess new and evolving technology. Within a structured framework, the TAC conducts an independent and unbiased assessment of the new or emerging technology. The committee meets six times per year and as needed. During the meeting, a healthcare professional or a company in the healthcare technology industry may present the key

technology features, the research methodology, and the study results. The TAC evaluates all research used to test the validity and reliability of each technology to reach an evidenced-based decision. (*Policy 0.00.011, pp. 3-4*.)

The assessment process includes an analysis of the condition or illness and available treatments for which the new or emerging technology is intended. Research regarding the benefits, risk and health outcomes from the available clinical data and other information submitted by the interested physician, organization, or vendor is considered by the committee. The Committee reviews scientific evidence and outcomes from randomized control trials, observational studies, and safety surveillance. The Committee's decisions help protect against the use of treatments, devices, and medications that are not proven, or not safe.

Qualifications of Individuals Evaluating New Technologies: Members of the TAC include CareFirst's Vice President of Clinical Operations, who is a Medical Director, or designee, CareFirst's Medical Directors, Behavioral Health Medical Director, Healthcare Policy team members, and other Health Services associates with clinical experience such as Registered Nurses. (*Policy 0.00.011, pg. 3*.) Currently, the Committee includes a CareFirst Medical Director who is a psychiatrist with over 30 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 17 years' experience treating patients in various inpatient and outpatient settings.

CareFirst also requires participation of a local specialist with knowledge and current experience relevant to the technology being presented when such expertise is warranted. (*Policy 0.00.011, pg. 3*.)

Process and Evaluation: Requests to cover new technologies may be received by a variety of CareFirst departments including Provider or Member services, Health Services, Government Affairs, Special Investigations Unit, or Legal. Submitters may include providers (internal or external), members, or the healthcare technology industry. CareFirst may also identify a new technology during routine clinical research, or during medical policy 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. The technology review begins with a comprehensive review of the current body of evidence and data outcomes. Research includes consideration of the Five Criteria.

A review determines if the technology is subject to approval by U.S. government regulators, such as the Food and Drug Administration (FDA). If so, information is gathered about the status of regulatory approval.

Next, online resources such as Hayes Technology Inc. (www.hayesinc.com), the Cochrane Library (www.cochranelibrary.com), the Centers for Medicare & Medicaid Services (www.cms.gov), and the National Institute of Health U.S. National Library of Medicine (http://nlm.nih.gov/bsd/pmresources.html) are researched for study abstracts and articles related to the technology in question. The literature supporting the technology is evaluated based on the merit of the scientific evidence. CareFirst considers randomized, double-blinded, controlled trials to be most credible source of evidence, followed by non-randomized and/or non-controlled trials, meta-analyses, case series, case studies, individual case reports, and individual or consensus opinion.

Other considerations for evaluating the scientific evidence include the number of subjects, patient selection criteria, homogeneity of the study group, measurement criteria, follow-up periods, complicating factors, dropout rates, and possible conflicts of interest. (*Policy 0.00.011, pp. 2-3*.)

Consultations Used in Evaluations: CareFirst also considers input from physicians and other recognized experts who are not employees of CareFirst; and who are currently treating patients for the disease or condition being evaluated; and/or are board certified in the pertinent specialty or subspecialty area of the disease or condition being evaluated; and/or are generally recognized by their peers to be authoritative resources in the clinical area being evaluated; and/or have a demonstrated history of substantial experience and practical knowledge in the specialty or subspecialty area in question.

Specialty consultants, local providers outside of CareFirst and/or subject matter experts in the field, are called upon to offer guidance or an opinion regarding whether enough scientific studies were completed to establish safety and efficacy. CareFirst may utilize Independent Review Organizations (IRO) for unbiased opinions from board certified practitioners who have a demonstrated history of substantial experience and knowledge. These consultants are board certified in the specialty or subspecialty area of the disease, condition, device, or technology being evaluated; and if the technology is extremely complex, it may be reviewed by experts in academic and medical institutions.

These practitioners offer insight based on their current patient experience, studies, or publications. They assist CareFirst with evaluating the quality of the technology and describe how other payors have adopted the technology. Conflict of Interest Disclosures are requested of all physicians or subject matter experts. The opinions of our consultants are considered tools in the evaluation process and are not binding for acceptance or rejection of technology.

During the meeting, a healthcare professional or a company in the healthcare technology industry may present the key technology features, the research methodology, and the study results.

The TAC evaluates all evidence and research used to test the validity and reliability of each technology to reach an evidenced-based decision. The final decision of the TAC shall result from the consensus of the TAC, with the formal decision being finalized by the Vice President of Clinical Operations, who is the Chief Medical Director, or the designee. (*Policy 0.00.011, pp. 3-4*.)

Selection of Medical Treatments for Review and Timeline

Requests to cover new technologies may be received by a variety of CareFirst departments including but not limited to: Provider or Member services, Health Services, Government Affairs, Special Investigations Unit, or Legal. Submitters may include providers (internal or external), members, or the healthcare technology industry. CareFirst may also identify a new technology during routine clinical research, or during medical policy review.

CareFirst does not limit or restrict who can submit a request to the TAC for review of new or emerging technology; nor is there any limit on the number of MH/SUD or M/S requests that can be submitted and received by the TAC. A request may be submitted by any provider, vendor, interested organization, a representative from the legislative community, a CareFirst Medical Director, or an internal CareFirst department who has experience or knowledge regarding new or emerging treatment.

All requests are reviewed. Incoming requests are prioritized based on clinical need, legislative demands, and impact to CareFirst membership. Technologies with support from local physicians that have shown strong evidence (e.g., peer reviewed literature) of safety and/or efficacy are prioritized for review. The TAC meets every two months to review new technologies. Following TAC meetings, associated medical policies are created and implemented within the two months following the meeting (*HCP 100.04).*

Technology Assessment Document Process

A technology assessment is completed for all technology topics presented to the Committee, for the purpose of providing information that supports the coverage decision made by the Committee. If a file or request already exists for a technology, the information and resources are assessed to determine if the clinical evidence is current and relevant to the requested topic. If there is no review or if the review is more than two years old, the review process is initiated, and a provider or other recognized expert is consulted (*HCP 100.04).*

The Technology Assessment document is completed to outline the review findings which includes, but is not limited to, the name and brief description of the technology, the findings from the literature review and the associated references. Prepare a reference sheet with all articles used in the review process in standard bibliography format. The evidence summary, including all research materials submitted by outside experts and all reports/presentations generated by expert consultants (*HCP 100.04).*

Development and Communication of Experimental Medical Care Definition/Criteria

The definition of experimental medical care and the criteria developed to determine if a service/treatment/device is experimental is derived from the Blue Cross Blue Shield Association (BCBSA) Medical Policy Services (MPS) (formerly: Technology Evaluation Center (TEC)) (*Policy 0.00.01*)

This definition is communicated to providers and members through:

- Public Medical Policy Reference Manual (Policy 0.00.01) (available on the CareFirst website and linked within the Provider Manual)
- The Provider Manual (available on the CareFirst website and supplied directly to providers)

- Any denial letters for denials based on experimental/investigational determination

CareFirst follows the above process for determining coverage of a new treatment, for determining coverage of previously excluded treatments and to determine if CareFirst should stop covering previously covered treatment.

ii. Identification of All MH/SUD Benefits and M/S Benefits to the New Technologies Assessment Applies by Benefit Classification

The Plan requires new technology review for all new services across all benefit classifications, including Prescription Drugs and Emergency Care. Services deemed experimental or investigational during the new technology assessment are excluded.

List of M/S Services	List of MH/SUD Services
Inpatient M/S Services (In-Network and Out-of-Network)	**Inpatient MH/SUD Services (In-Network and Out-of-Network)**
The Plan requires new technology review for all new services across all benefit classifications, including Prescription Drugs and Emergency Care. Services deemed experimental or investigational as ineffective, unproven, or unsafe during the new technology assessment are excluded.	The Plan requires new technology review for all new services across all benefit classifications, including Prescription Drugs and Emergency Care. Services deemed experimental or investigational as ineffective, unproven, or unsafe during the new technology assessment are excluded.

Outpatient M/S Services (In-Network and Out-of-Network)	Outpatient MH/SUD Services (In-Network and Out-of-Network)
The Plan requires new technology review for all new services across all benefit classifications, including Prescription Drugs and Emergency Care. Services deemed experimental or investigational as ineffective, unproven, or unsafe during the new technology assessment are excluded.	The Plan requires new technology review for all new services across all benefit classifications, including Prescription Drugs and Emergency Care. Services deemed experimental or investigational as ineffective, unproven, or unsafe during the new technology assessment are excluded.

Note: CareFirst does not maintain a set list of experimental/investigational exclusions as CareFirst does not apply a blanket exclusion based on experimental/investigational. CareFirst reviews services as appropriate based on the guidelines below to make experimental/investigational determinations. If a service or treatment is deemed experimental/investigational, that service or treatment may be re-evaluated with new or emerging evidence as it becomes available.

II. Identification and Definition of the Factors and Evidentiary Standards Used to Design and Apply the New Technologies Assessment NQTL

Factor 1	Request to Cover New Technologies
Definition	CareFirst receives an internal or external request from a member, provider, vendor, interested organization, legislative community representative, health services, government affairs, special investigations unit, legal, or other party for the Technology Assessment Committee (TAC) to review a new or emerging technology
Application Benefit Classification(s)	• Inpatient In-Network • Inpatient Out-of-Network • Outpatient Office In-Network • Outpatient Office Out-of-Network • Outpatient Other In-Network • Outpatient Other Out-of-Network • Emergency Care • Prescription Drugs
Description	This factor is used in the application of the new technology assessment to determine whether there is sufficient clinical evidence that the new technology is proven, effective, and safe for the condition being treated.
Source(s) of Factor	• Internal Policy – Standard Operating Procedure: HCP 100.04 • Clinical evidence or new evidence identified during routine clinical research or medical policy review

Evidentiary Standards and Applicable Thresholds	• Any internal or external request for a technology assessment for coverage of a new technology is reviewed.
	• During medical policy reviews or routine research, internal requests for review may be recommended. For example:
	  o If a policy is more than two years old
	  o Emerging evidence is identified that demonstrates below requirements OR disproves below requirements
	  o Industry trends necessitate a review or re-review (i.e. previously covered treatment no longer covered; previously not covered treatment is covered; any new emerging technology within the industry)

Source(s) of Evidentiary Standards	• Internal or External Requests by telephone, e-mail, postal mail, or fax
	  o External requests primarily originate from the provider community and companies in the healthcare technology industry. An assessment request may also be made by a member or community representative.
	  o Internal requests primarily originate from Provider or Member Services, Health Services, Government Affairs, Special Investigations Unit (SIU), and/or Legal teams.
	• FDA guidelines
	• MCG care guidelines
	• SAMHSA guidelines
	• ACOG recommendations
	• AAP recommendations
	• NIH recommendations
	• US Preventative Task Force evidence-based recommendations
	• CMS national and local coverage determinations
	• NIA Magellan recommendations
	• Cochrane Library
	• Peer-reviewed medical literature including:
	  o BlueCross BlueShield Association - Evidence Street Positioning - A unique software as a service (SaaS) platform that allows quick, efficient comparisons of the evidence and the evidence-based decisions of Health Plans servicing the U.S. healthcare market. EPS® makes it faster and easier for healthcare stakeholders to compare, issues related to evidence.
	  o Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs).
	  o Hayes Knowledge Center (Hayes®) - A software portal to world-class research and unbiased analyses on the clinical, financial, and risk impacts of emerging and disruptive healthcare technologies. With this robust and valuable database, you can develop defensible, transparent coverage policies and make decisions that drive high-quality care.

	○ UptoDate® - A company in the Wolters Kluwer Health division of Wolters Kluwer whose main product is UpToDate, a software system that is a point-of-care medical resource. ○ National Comprehensive Cancer Network (NCCN) - An alliance of 30 cancer centers in the United States, most of which are designated by the National Cancer Institute as comprehensive cancer centers. It is a non-profit organization with offices in Plymouth Meeting, Pennsylvania. ○ PubMed - A free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics. The United States National Library of Medicine at the National Institutes of Health maintain the database as part of the Entrez system of information retrieval. ○ National Center for Biotechnology Information (NCBI) ○ U.S. National Library of Medicine (NLM)

Factor 2	**Final Regulatory Approval**
Definition	The technology must have final approval from the appropriate U.S. government regulatory bodies. This criterion applies to medical drugs, biological products, devices, and any other product or procedure that must have final approval to market from the U.S. Food and Drug Administration (FDA) or any other federal governmental body with authority to regulate the technology.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other • Emergency Care • Prescription Drugs
Description	This factor is used in the application of medical necessity to determine whether the service is approved for use.
Source(s) of Factor	• Internal Policies – Conducting a Technology Assessment: HCP 100.04; Technology Assessment Committee Meeting: HCP 100.09 • BlueCross BlueShield Association (BCBSA) MPS Assessment Criteria (formerly known as the TEC Criteria or "Technology Evaluation Center"
Evidentiary Standards and Applicable Thresholds	• Final approval from appropriate U.S. regulatory bodies such as the Food and Drug Administration (FDA) or any other federal governmental body with authority to regulate the technology.

	○ Any approval that is granted as an interim step in the Food and Drug Administration (FDA) regulatory process is not sufficient. ○ If the technology is not subject to FDA approval, the criterion may be considered met if no other governmental body with authority is required to approve and no FDA review is applicable.
Source(s) of Evidentiary Standards	• FDA database approvals can be found at the FDA's Internet site at www.fda.gov/.

Factor 3	**Scientific Evidence Proving Health Outcomes**
Definition	The scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. The evidence should demonstrate that the technology can measure or alter the physiological changes related to a disease, injury, illness, or condition. In addition, there should be evidence, or a convincing argument based on established medical facts, that such measurement or alteration affects health outcomes.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other • Emergency Care • Prescription Drugs
Description	This factor is used in the application of criteria to ensure appropriate health outcomes.
Source(s) of Factor	• Internal Policies – Conducting a Technology Assessment: HCP 100.04; Technology Assessment Committee Meeting: HCP 100.09 • BlueCross BlueShield Association (BCBSA) MPS Assessment Criteria (formerly known as the TEC Criteria or "Technology Evaluation Center"
Evidentiary Standards and Applicable Thresholds	• The literature supporting the technology is evaluated based on the merit of the scientific evidence. The most credible source of evidence is randomized double blinded control trials, followed by nonrandomized and/or non-controlled trials, meta-analyses, case series, case studies, individual case reports, and individual or consensus opinion. • Research Resource Hierarchy: This hierarchy is designed to provide a standardized protocol to follow when researching sources for the purpose of developing and revision Medical Policies and Medical Policy Operating

	Procedures. The hierarchy outlines the sources in order of importance when conducting clinical evidence-based research. (Refer to additional attachment: Research Resource Hierarchy Template) • Consultations from experienced providers or other recognized expert. Specialty consultants, providers outside of CareFirst and/or subject matter experts in the field, may be called upon to offer guidance or an opinion regarding whether enough scientific studies have been performed to establish safety and efficacy. Consultation may be requested through an Independent Review Organization (IRO) or physicians who can offer insight based on their current experience in clinical practice, studies, or publications.
Source(s) of Evidentiary Standards	• Industry expert consultations • Independent review organization consultations • FDA guidelines • MCG care guidelines • ACOG recommendations • AAP recommendations • NIH recommendations • US Preventative Task Force evidence-based recommendations • CMS national and local coverage determinations • NIA Magellan recommendations • Cochrane Library • Peer-reviewed medical literature including: o BlueCross BlueShield Association - Evidence Street Positioning – o Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). o Hayes Knowledge Center o UptoDate o National Comprehensive Cancer Network (NCCN) o PubMed o National Center for Biotechnology Information (NCBI) o U.S. National Library of Medicine (NLM)

Factor 4	**Improves Net Health Outcomes**
Definition	The technology must improve the net health outcome. The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes.

Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other • Emergency Care • Prescription Drugs
Description	This factor is used in the application of criteria to ensure improvement in health outcomes.
Source(s) of Factor	• Internal Policies – Conducting a Technology Assessment: HCP 100.04; Technology Assessment Committee Meeting: HCP 100.09 • BlueCross BlueShield Association (BCBSA) MPS Assessment Criteria (formerly known as the TEC Criteria or "Technology Evaluation Center"
Evidentiary Standards and Applicable Thresholds	• The literature supporting the technology is evaluated based on the merit of the scientific evidence. The most credible source of evidence is randomized double blinded control trials, followed by nonrandomized and/or non-controlled trials, meta-analyses, case series, case studies, individual case reports, and individual or consensus opinion. • Research Resource Hierarchy: This hierarchy is designed to provide a standardized protocol to follow when researching sources for the purpose of developing and revision Medical Policies and Medical Policy Operating Procedures. The hierarchy outlines the sources in order of importance when conducting clinical evidence-based research. (Refer to additional attachment: Research Resource Hierarchy Template) • Consultations from experienced providers or other recognized expert. Specialty consultants, providers outside of CareFirst and/or subject matter experts in the field, may be called upon to offer guidance or an opinion regarding whether enough scientific studies have been performed to establish safety and efficacy. Consultation may be requested through an Independent Review Organization (IRO) or physicians who can offer insight based on their current experience in clinical practice, studies, or publications.

Source(s) of Evidentiary Standards	• Industry expert consultations
	• Independent review organization consultations
	• FDA guidelines
	• MCG care guidelines
	• ACOG recommendations
	• AAP recommendations
	• NIH recommendations
	• US Preventative Task Force evidence-based recommendations
	• CMS national and local coverage determinations
	• NIA Magellan recommendations
	• Cochrane Library
	• Peer-reviewed medical literature including:
	  o BlueCross BlueShield Association - Evidence Street Positioning –
	  o Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs).
	  o Hayes Knowledge Center
	  o UptoDate
	  o National Comprehensive Cancer Network (NCCN)
	  o PubMed
	  o National Center for Biotechnology Information (NCBI)
	  o U.S. National Library of Medicine (NLM)

Factor 5	**At Least as Beneficial as Alternatives**
Definition	The technology must be as beneficial as any established alternatives. The technology should improve the net health outcome as much as, or more than, established alternatives.
Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other • Emergency Care • Prescription Drugs

Description	This factor is used in the application of criteria to ensure benefits in comparison to alternatives.
Source(s) of Factor	• Internal Policies – Conducting a Technology Assessment: HCP 100.04; Technology Assessment Committee Meeting: HCP 100.09 • BlueCross BlueShield Association (BCBSA) MPS Assessment Criteria (formerly known as the TEC Criteria or "Technology Evaluation Center"
Evidentiary Standards and Applicable Thresholds	• Industry expert consultations • Independent review organization consultations • FDA guidelines • MCG care guidelines • ACOG recommendations • AAP recommendations • NIH recommendations • US Preventative Task Force evidence-based recommendations • CMS national and local coverage determinations • NIA Magellan recommendations • Cochrane Library • Peer-reviewed medical literature including: o BlueCross BlueShield Association - Evidence Street Positioning – o Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). o Hayes Knowledge Center o UptoDate o National Comprehensive Cancer Network (NCCN) o PubMed o National Center for Biotechnology Information (NCBI) o U.S. National Library of Medicine (NLM)

Factor 6	**Attainable Outside Investigational Setting**
Definition	The improvement must be attainable outside the investigational setting. When used under the usual conditions of medical practice, the technology should be reasonably expected to satisfy Criteria #3 and #4.

Application Benefit Classification(s)	• In-Network Inpatient • Out-of-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other • Emergency Care • Prescription Drugs
Description	This factor is used in the application of criteria to ensure outcomes are attainable.
Source(s) of Factor	• Internal Policies – Conducting a Technology Assessment: HCP 100.04; Technology Assessment Committee Meeting: HCP 100.09 • BlueCross BlueShield Association (BCBSA) MPS Assessment Criteria (formerly known as the TEC Criteria or "Technology Evaluation Center"
Evidentiary Standards and Applicable Thresholds	• Industry expert consultations • Independent review organization consultations • FDA guidelines • MCG care guidelines • ACOG recommendations • AAP recommendations • NIH recommendations • US Preventative Task Force evidence-based recommendations • CMS national and local coverage determinations • NIA Magellan recommendations • Cochrane Library • Peer-reviewed medical literature including: o BlueCross BlueShield Association - Evidence Street Positioning – o Criteria Sets - Milliman Care Guidelines (MCGs), Ambulatory Care Guidelines (ACGs), Local Coverage Determinations (LCDs) and National Coverage Determinations (NCDs). o Hayes Knowledge Center o UptoDate o National Comprehensive Cancer Network (NCCN) o PubMed o National Center for Biotechnology Information (NCBI) o U.S. National Library of Medicine (NLM)

A. Processes and Strategy

A review of internal policies and procedures outlines the below processes for conducting a technology assessment and the technology assessment committee (TAC) meetings. This process within written documentation is the same for both M/S and MH/SUD categorized devices, services, and prescriptions. Separate policies and procedures do not exist for M/S and MH/SUD, and the below process is followed for both M/S and MH/SUD.

Conducting a Technology Assessment *(HCP 100.04)*

Step	Action	Responsible Party
1	Receives external and internal requests by telephone, e-mail, postal mail, or fax to consider coverage of new technologies. Within CareFirst, a request to review a new technology may be submitted by the following departments: Provider or Member Services, Health Services, Government Affairs, Special Investigations Unit (SIU), and/or Legal. This list is not all inclusive. External Requests: External requests primarily originate from the provider community and companies in the healthcare technology industry. An assessment request may also be made by a member or community representative. Internal Requests: Incoming requests are prioritized based on clinical need, legislative demands, and impact to CareFirst membership. Technologies with support from local physicians that have shown strong evidence (e.g., peer reviewed literature) of safety and/or efficacy are prioritized for review.	**Lead/Senior Medical Policy Analyst; HCP Manager; Medical Director**
2	A technology assessment is completed for all technology topics presented to the Committee, for the purpose of providing information that supports the coverage decision made by the Committee. The technology assessment database within the Healthcare Policy SharePoint site is reviewed to determine if a file already exists for the technology which is to be evaluated. a. If a technology assessment review has been performed, the information and resources are assessed to determine if the clinical evidence is current and relevant to the requested topic. b. If no technology assessment review exists, or if the review is more than two years old, the technology assessment review process is initiated, and a provider or other recognized expert is consulted. c. Complete the Technology Assessment document (see template below) to outline the review findings which includes, but not limited to, the name and brief description of the technology, the findings from the literature review and the associated references. Prepare a reference sheet with all articles used in the review process in	**Lead Medical Policy Analyst**

	standard bibliography format. The evidence summary, including all research materials submitted by outside experts and all reports/presentation generated by expert consultants.	
3	Request a consultation from an experienced provider or other recognized expert. Specialty consultants, providers outside of CareFirst and/or subject matter experts in the field, may be called upon to offer guidance or an opinion regarding whether enough scientific studies have been performed to establish safety and efficacy. Consultation may be requested through an Independent Review Organization (IRO) or physicians who can offer insight based on their current experience in clinical practice, studies, or publications. The opinions of consultants are considered tools in the evaluation process and are not binding on the final determination to accept or reject a technology. Solicit and consider input from physicians or other recognized experts who attest that they are: a. Not employees of CareFirst; and • Are currently treating patients for the disease or condition being evaluated; and/or • Are board certified in the pertinent specialty or subspecialty area of the disease or condition being evaluated. • Are generally recognized by their peers to be authoritative resources in the clinical area being evaluated as evidenced by: i. Faculty appointments; and/or ii. Authorship of a significant body of peer-reviewed clinical literature in the pertinent specialty area; and/or iii. A demonstrated history of leadership in local, State, or national professional associations and nonprofit patient and community advocacy organizations that address the disease or condition and the specialty or subspecialty area in question; and/or	**Lead Medical Policy Analyst**

	• Have a demonstrated history of substantial experience and practical knowledge in the specialty or subspecialty area in question. b. If a physician or other recognized expert who meets the above criteria cannot be otherwise located, request an opinion from an individual who meets the above criteria through an Independent Review Organization (IRO).	
4	Conduct a search to determine if the technology is subject to approval by U.S. government regulators, such as the FDA. This would apply mainly to medical drugs, laboratory processes, radiological procedures, behavioral technology, and durable medical equipment. Approvals can be found at the FDA's Internet site at www.fda.gov/. If the technology is not subject to FDA approval, the criterion is considered met and no FDA review is applicable.	**Lead/Senior Medical Policy Analyst**
5	When conducting research, use the Research Resource Hierarchy, which outlines the research criteria to be used when establishing the coverage determination for the service, procedure, device, or medical drug associated with the policy/procedure based on the published literature. Review online resources for current study abstracts and articles related to the technology. Some of the resources include, but not limited to: PubMed, National Center for Biotechnology Information (NCBI), at the U.S. National Library of Medicine (NLM), located at the National Institutes of Health (NIH), Hayes© Technology Inc., UpToDate. Medical society guidelines are researched and taken under consideration. The literature supporting the technology is evaluated based on the merit of the scientific evidence. The most credible source of evidence is randomized double blinded control trials, followed by nonrandomized and/or non-controlled trials, meta-analyses, case series, case studies, individual case reports, and individual or consensus opinion.	**Lead/Senior Medical Policy Analyst**
6	Summarize the data and criteria used to evaluate the technology. In the evidence summary, specify the disease or condition for which the technology is appropriate. A treatment may be proven effective for one condition but may be investigational for another. If there are specific conditions where the technology is inappropriate, specify those conditions in the evidence summary.	**Lead/Senior Medical Policy Analyst**
7	The topics that will be reviewed by the Technology Assessment Committee (TAC) is sent, along with the TAC Meeting Agenda (see template below), to the committee participants in advance of the meeting.	**Lead Medical Policy Analyst**

	Note: If you are not responsible for facilitating the TAC meeting and have completed a technology assessment, please send the completed technology assessment form to the meeting facilitator to be added to the meeting documentation deck for distribution to the committee members.	
8	The technology and findings are presented at the TAC meeting. During the meeting, the HCP associate presents the key technology features, the research methodology, and the study results. The TAC members evaluate all research used to test the validity and reliability of each technology in order to reach an evidence-based decision.	**Lead Medical Policy Analyst and TAC members**
9	The Chief Medical Officer (or designee) and Medical Directors determine if the clinical benefits of the technology warrant approval and how the technology will be integrated into the existing clinical structure. CareFirst's decision to provide coverage for an emerging medical or behavioral health treatment shall result from the consensus of opinion from CareFirst's own analysis and the knowledge provided to CareFirst by clinical experts. TAC meeting minutes are recorded and uploaded on the Healthcare Policy SharePoint site for each meeting.	**Vice Present of Clinical Operations (or designee) and Medical Director(s)**
10	Communication of coverage decision determined at TAC sent to external providers and vendors. Typically delivered via email, but methods may vary.	**Lead Medical Policy Analyst**
11	After the CareFirst coverage decision has been made in the Technology Assessment Committee meeting, the Chief Medical Officer and Medical Directors determine whether a new medical policy is to be developed or an existing policy is to be revised. The medical policy is drafted and/or revised by the HCP associate, presented, and approved by the Medical Policy Committee, and reviewed annually through the periodic review process. Approved medical policies are publicly released and available on the https://www.carefirst.com. Provider notification occurs via the CareFirst provider newsletter. In the event the technology is not approved by the TAC, the HCP associate will contact the appropriate healthcare professional or vendor representing the technology to advise of CareFirst's decision. Not all decisions for non-coverage whether it be experimental and investigational, or not medically necessary will warrant the creation of a specific medical policy. This will be up to the discretion of the TAC based on the utility of having such a policy which varies with circumstances.	**Lead Medical Policy Analyst**

Technology Assessment Committee Meeting Process *(HCP 100.09)*

Proprietary and Confidential Information of CareFirst, Inc. and its affiliates and subsidiaries. This information shall only be disclosed as required by law.

Step	Action	Responsible Party
1	Topics might be suggested by medical directors, various areas within CareFirst, Inc. (especially within the Department of Health Services), or external providers and vendors.	**Lead Medical Policy Analyst**
2	When composing topics to be discussed by the TAC, an external speaker or member of the Healthcare Policy team can present the topics. If an external speaker requests to present a technology topic, the following steps must be completed before an external speaker can present to the TAC: a. The request must be received electronically, and a copy of the request must be uploaded to the Healthcare Policy SharePoint site, under the Technology Assessment Library folder. b. The HCP associate will send the requestor a Technology Assessment Committee Request for Evidence Letter, Technology Assessment Reviewer Verification Attestation Form and Evidence Submission Request Form. c. The requestor must complete and return all forms to the HCP associate in order to be allowed to present to the TAC. d. The meeting date and time is established, and communicated to the requestor, as well as scheduled by sending a meeting invitation to the TAC members and the requestor. All forms must be sent to the requestor 30 calendar days before the scheduled meeting. e. External speakers are scheduled to present for one hour at the TAC meeting. Meetings are scheduled for the third Thursday of the month, every other month. Adjustments to this schedule are permitted as a result of ad hoc requests. f. Complete a Technology Assessment for all technology topics presented to the Committee, for the purpose of providing information that supports the coverage decision made by the Committee. (See process above: Conducting a Technology Assessment)	**Lead Medical Policy Analyst**
3	The Technology Assessment Committee Meeting agenda is developed by compiling the topics to be discussed during the meeting. (see template below) Consideration of the complexity of topics should be considered, along with the anticipated amount of discussion about topics.	**Lead Medical Policy Analyst**
4	One week prior to the meeting, a meeting packet that contains the agenda and all relevant evaluations and/or code lists for the meeting is attached to the meeting invitation. The agenda and relevant meeting documentation are uploaded in the Healthcare Policy SharePoint site, under Technology Assessment Library folder.	**Lead Medical Policy Analyst**

5	On the day of the meeting, facilitate the meeting and take notes during the meeting, including highlights from the presenter's presentation to compile the meeting minutes.	**Lead Medical Policy Analyst**
6	After the meeting perform follow-up tasks: a. Type minutes from the meeting and send the Medical Director for review and approval within 5 business days after the meeting. Note: When completing the meeting attendee section, only capture the individuals who attended the meeting in the minutes, not all individuals who were invited to the meeting. Delete the names of the invitees from the minutes if they did not attend the meeting. b. The approved minutes are signed by the Chief Medical Officer or Designee (Lead Medical Director or Medical Director). The signed minutes are saved in PDF format and uploaded in the Healthcare Policy SharePoint site in the Technology Assessment Library folder The document should be saved with the following name convention: TAC Meeting Minutes - date of meeting (date format: MM-DD YYYY). c. Communication of coverage decision determined at TAC sent to the provider or vendor who presented at TAC will typically be delivered via email, but methods may vary. d. Prepare a report that summarizes TAC decisions and provide to the Utilization Management Committee for that LOB. e. Perform Medical Policy task(s) that resulted from the meeting, i.e., develop a new medical policy and/or revise an existing medical policy. Not all decisions for non-coverage whether it be E&I or not medically necessary will warrant the creation of a specific medical policy. This will be up to the discretion of the TAC based on the utility of having such a policy which varies with circumstances. f. Provide the Medical Policy number and name to be added to the MPC monthly presentation schedule after the TAC meeting	**Lead Medical Policy Analyst; Medical Director**

Technology Assessment Committee Meeting Members and Credentials

CareFirst Title	Qualifications
Vice President, Senior Medical Director	Medical Degree in primary care specialty from an accredited medical school, an American residency in a primary care specialty. Five years' clinical experience and five years administrative experience in a managed care setting. Current medical license and board certification in Maryland, DC, Virginia without restriction; and board certification. Previous experience as medical director for a health care company.

CareFirst Medical Director	Medical Degree from an accredited medical school, completion of an American residency program required with postgraduate training, eight years clinical practice experience, and three years care management experience. Board Certifications of current Medical Directors include Internal Medicine, Pediatrics, Obstetrics and Gynecology, Family Medicine, General Dentistry, Orthodontist, and Periodontist.
CareFirst Medical Director, Behavioral Health	Medical Degree from an accredited medical school, completion of an American residency program, minimum of five years clinical practice experience in the field of Psychiatry, and two years managed care experience with Accreditation experience. Board Certification includes American Board of Psychiatry & Neurology.
Medical Review and Appeals Director	Bachelor's degree in nursing, eight years clinical experience in care management, three years of experience leading in a managed care or health insurance environment with a focus on Clinical Medical Review and Appeals and Grievances.
Utilization Director	Bachelor's degree in nursing, eight years of clinical and/or utilization review experience, and three years of management experience.
Behavioral Health Services Director	Master's Degree Mental Health: education can be in one or more of the following areas: social work, psychology, nursing or counseling and eight years post master's clinical behavioral health/psychiatric experience with three years management experience or Licensed clinical professional counselor, Master of Arts in Counseling Psychology.
Dental Director	Medical Degree in Dentistry and eight years' experience in dental health care or medical management and three years management experience.
Healthcare Policy Manager	Bachelor's degree in nursing or other health related discipline, five years of experience in a health insurance environment, with focus on policy development and implementation; and/or claims operations/medical review experience. Three years Supervisory experience or demonstrated progressive leadership experience.
Lead Medical Policy Analyst	Bachelor's degree in nursing or healthcare Related Field, eight years varied clinical experience in a health care setting, and five years of experience with a health care payor organization.
Senior Medical Policy Analyst	Bachelor's degree in nursing, and five years varied clinical nursing experience in a health care setting.

Lead Clinical Appeals Nurse	Five years medical-surgical or similar clinical experience, three years of experience in Clinical Appeals and Analysis unit with one year as a Senior Appeals Specialist. BSN/MSN Degree, one to two years of experience in a CareFirst Care Management/Health Services Program.
Clinical Medical Review Supervisor	Five years acute clinical experience, previous case management, discharge planning or utilization review experience, and three years Clinical Review Nurse in the Clinical Medical Review area. BSN/MSN Degree, one to two years of experience in a CareFirst Care Management/Health Services Program.
Lead Clinical Medical Review Nurse	Five years acute clinical experience, previous case management, discharge planning or utilization review experience, and three years Clinical Review Nurse in the Clinical Medical Review area. BSN/MSN Degree, one to two years of experience in a CareFirst Care Management/Health Services Program.
Senior Medical Coding Specialist	Five years of experience in risk adjustment coding, ambulatory coding and/or CRC coding, experience in managed care; state or federal health care programs; or health insurance industry experience. CCS-Certified Coding Specialist, Certified Coder (CCS or CPC)-AHIMA or AAPC.
Utilization Management Specialist	Five years acute clinical experience, previous case management, discharge planning or utilization review experience, and three years clinical nursing experience. BSN/MSN Degree, one to two years of experience in a CareFirst Care Management/Health Services Program

B. Relationship Between Factors

No factors were considered and ultimately rejected. All considered factors were approved and applied as stated above.

III. Demonstration of Comparability and Stringency as Written

This section demonstrates that in each classification, under the terms of the plan as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying experimental/investigational determinations to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the experimental/investigational determinations with respect to M/S benefits. CareFirst has a new technology assessment process that applies to both MH/SUD services and M/S services (Technology Assessment; Policy Number 0.00.011). The written criteria and procedures are to ensure fair and consistent technology assessments regardless of whether the proposed treatment or prescription drug applies to M/S, MH/SUD, or both types of diagnoses.

CareFirst follows a five-step process when assessment new technologies. If a new technology is being considered and deemed beneficial by meeting the 5 criteria, a medical policy and reference manual is created for these services. Each service has its own unique medical policy that includes criteria, guidelines, descriptions, thresholds, and referenced peer-reviewed medical literature to support the policy and decisions.

A review of CareFirst's written policies and processes reveals the comparable application of the new technologies NQTL to M/S and MH/SUD services within the applicable benefit classifications. The Plan's new technology assessment policy development and application process is consistent between M/S and MH/SUD services. 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 undergoing new technology assessment for inclusion as a covered service.

Each year, CareFirst reviews the summary of total requests for coverage or review for both M/S and MH/SUD devices and treatments to ensure comparability between the M/S and MH/SUD review process and decisions. As shown below, in 2025, there were no requests for review of MH/SUD categorized devices or treatments. During 2025, the Technology Assessment Committee assessed 33 topics. Of those, 12 were determined to have a positive coverage decision. All TAC requests were categorized as Med/Surg; CareFirst did not receive any MH/SUD requests in 2025.

Since there were no MH/SUD categorized services reviewed by the TAC in 2025, CareFirst included a use-case for M/S and MH/SUD from a previous year to analyze for comparability.

2020-02 Deep Brain Stimulation (DBS) for Treatment of Obsessive Compulsive Disorder (OCD): Description

Deep brain stimulation involves placing electrodes intracranially. The deep brain stimulation system consists of three components: the implanted pulse generator (IPG), the lead, and the extension. The IPG generates electrical signals that are delivered via the electrodes to brain tissue. The signals serve the purpose of blocking nerve signals. The IPG can be implanted near the abdomen or the collarbone. It can be calibrated by a neurologist, nurse or trained technician to optimize symptom suppression and control side effects.

Obsessive compulsive disorder (OCD) affects about 2.3% of adults in the US at some point in their life. Most cases of OCD are successfully treated using pharmaceuticals and/or behavior therapy. However, a small percentage of cases are treatment-resistant and in those situations additional approaches are necessary. Surgical treatment has been beneficial for some patients with debilitating, refractory obsessive-compulsive disorder. Two surgical options have been used for treatment-resistant OCD: anterior capsulotomy and cingulotomy. A limitation of surgical approaches is their irreversibility.

Deep brain stimulation has positive results in some people with refractory OCD. Importantly, DBS is intended for patients with severe OCD who have failed three or more drug treatments and psychotherapy. DBS is considered to be a treatment option for refractory OCD and is not a cure.

1. The technology must have final approval from the appropriate government regulatory bodies:

On February 10, 2009 the Medtronic Reclaim™ Deep Brain Stimulation for OCD Therapy was approved by the FDA via a Humanitarian Device Exemption. HDE number: H050003. A Humanitarian Device Exemption facilitates the development and marketing Such exemptions facilitate the development and marketing of medical devices that treat or diagnose a disease or condition that affects fewer than 4000 people a year in the United States.

2. **The scientific evidence must permit conclusions concerning the effect on health outcomes:**

   The study that formed the basis for the HDE approval was authored by Greenberg et al. (2010). This study was conducted in four centers over a period of 8 years, with initial data being collected in 1998. A total of 24 patients enrolled in the study and eligibility criteria included a diagnosis of OCD for at least five years and a failure to obtain meaningful OCD improvement after conventional treatment.

   DBS leads were surgically implanted bilaterally in locations that allowed stimulation along the dorsal-ventral extent of the anterior capsule. DBS therapy was used as an adjunctive treatment during this study, and pharmacotherapy was permitted to occur concomitantly.

   The outcomes of greatest interest were the Yale-Brown Obsessive Compulsive Scale of OCD severity, functioning, adverse effect burden and effect on co-occurring non-OCD symptomatology. Of the 26 patients implanted, one died (due to recurrence of breast cancer 1 year after implantation). Stimulation was discontinued in three patients after 12 months due to inadequate improvement. One patient was judged a nonresponder after 12 months. Clinically significant symptom reductions and functional improvements were seen in over 60% of these highly treatment-resistant patients, within and across study sites. DBS was well tolerated overall, and the vast majority of adverse effects were transient. On average, OCD improved from severe illness at baseline to moderate severity during chronic DBS.

   Recent evidence suggests alleviation of specific symptoms of OCD may require region-specific application of DBS (Himanshu ey al., 2019). While this is an interesting finding, it highlights the fact that knowledge regarding the use of DBS to treat OCD is still evolving.

3. **The technology must improve the net health outcome:**

   No studies have documented the impact of DBS for OCD on net health outcome.

4. **The technology must be as effective as any established alternatives:**

   Alternative approaches for treatment-resistant OCD include cingulotomy and capsulotomy. Both of these approaches involve destruction of specific areas of brain tissue. Each of these approaches has had moderate success among treatment-resistant patients, with about half of treated patients showing an improvement following treatment. No studies have directly compared the efficacy of either of these treatments with TMS.

5. **The improvement must be attainable outside the investigational settings:**

   An improvement in net health outcome has not been demonstrated within investigational settings.

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Find this Mayberg article:

https://www.eurekalert.org/pub_releases/2019-10/tmsh-lsd100219.php

2020-04 Cunningham Panel: Description

The Cunningham Panel™ is a blood test which measures the levels of circulating autoantibodies associated with certain neurologic and psychiatric symptoms. Elevated levels indicate that symptoms may be due to an infection-driven autoimmune problem, rather than a neuropsychiatric disorder. This test is proposed to be appropriate when a clinical diagnosis of an autoimmune neuropsychiatric disorder is made or suspected.

Offered exclusively by Moleculara Labs, this immune panel is composed of five analytes: calcium calmodulin dependent kinase II activation (CamKII activation) and enzyme-linked immunosorbent assays (ELISAs) to measure anti-dopamine receptor D1, anti-dopamine receptor D2, anti-tubulin, and anti-lysoganglioside-GM1. These analytes were initially combined in a panel to study Sydenham's chorea, which is the neurological manifestation of rheumatic fever. The rationale behind including each analyte in the panel is a known correlation with symptoms of neuropsychiatric behavior. Calcium calmodulin dependent protein kinase II (CaMKII) enzyme is a multifunctional enzyme that is highly concentrated in the brain. It controls neurotransmission and neuronal excitability and regulates catecholamine and glutamate neurotransmission. Dopamine receptors are highly

concentrated on neurons and their normal functioning is responsible for many neurologic processes. Tubulin is an internal scaffolding protein located within all cells. Lysoganglioside-GM1 is concentrated in the central nervous system and is associated with membranes of nerve cells.

1. **The technology must have final approval from the appropriate government regulatory bodies:**

   Moleculera is the sole testing laboratory for the Cunningham Panel and is not part of any governmental or insurance plans. Moleculera Labs is accredited by CLIA (Clinical Laboratory Improvement Amendment) and COLA (Commission on Laboratory Accreditation). The technology for these tests is exclusively licensed from the University of Oklahoma and was validated and made clinically available in April 2013 through Moleculera Labs.

2. **The scientific evidence must permit conclusions concerning the effect on health outcomes:**

   The relationship between Cunningham Panel results and patient symptoms remains uncertain as there are no well-designed prospective clinical trials using this testing method. In addition, how Cunningham Panel results are interpreted and used is controversial and in need of further investigation.

   Connery et al (2018) performed a study to evaluate whether biomarkers of autoimmunity could predict a treatment response. The study included 80 patients who were diagnosed with Autism Spectrum Disorder. The Cunningham panel was considered to be is positive only when one of the four autoantibody titers was positive in the ELISA AND at the same time autoantibody-mediated CaMKII activation was positive. This criteria for a positive panel result was unique to this study rather than an absolute method for interpreting Cunningham Panel test results. The Cunningham Panel was positive in 44 of the 77 patients for which it was performed. For patients who received IVIG therapy, the dosing schedules were highly variable between patients. Outcomes included parent-reported improvements in their child's communication and/or behavior. Results of the study were interpreted as the Cunningham panel predicted response to IVIG treatment with an accuracy of 81% with a sensitivity of 90% and a specificity of 67% based on the ABC scores;

   Bejerot and Hasselmark (2019) highlight flaws in the Connery et al. study. Despite complete data sets only being collected from 16 of 31 children studies, the Connery study concludes the Cunningham panel predicts response to IVIG treatment with good accuracy. The reason this conclusion is questionable is the Connery study did not treat all patients with IVIG. Therefore, it is possible all treatment groups would have improved from IVIG treatment.

3. **The technology must improve the net health outcome:**

   No studies been conducted to examine the impact of the Cunningham panel on net health outcome.

4. **The technology must be as effective as any established alternatives:**

   The Cunningham Panel is a tool that is proposed to aid in the diagnosis and treatment of infection-triggered autoimmune neuropsychiatric disorders. It is designed to supplement the diagnosis procedure. Studies examining the accuracy of diagnoses with and without use of the Cunningham Panel do not exist.

5. **The improvement must be attainable outside the investigational settings:**

Improvement in patient outcomes has not been adequately addressed in investigational settings. Therefore, it is not possible to determine an expected improvement in outcomes outside the investigational setting.

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The Deep Brain Stimulation (DBS) for treatment-resistant obsessive-compulsive disorder (OCD) use case and the Cunningham Panel use case demonstrate that CareFirst applies the same technology assessment process to M/S and MH/SUD. Although the technologies differ in clinical purpose—DBS is a device-based behavioral health treatment for refractory OCD, while the Cunningham Panel is a laboratory test proposed to support diagnosis and treatment of autoimmune neuropsychiatric conditions—the assessment structure used for both is the same. In each case, CareFirst applied the same factors, sources, and standards to determine if the services were experimental/investigational/unproven. These cases applies the five technology assessment criteria described above: final regulatory approval or applicable accreditation status; whether the scientific evidence permits conclusions about health outcomes; whether the technology improves net health outcomes; whether the technology is at least as beneficial as established alternatives; and whether the improvement is attainable outside investigational settings.

The DBS review followed the stated process by first describing the technology, identifying the applicable patient population, and evaluating regulatory status through FDA Humanitarian Device Exemption approval. The review then assessed the available scientific evidence, including the Greenberg et al. study and other published literature, to determine whether conclusions could be drawn about clinical outcomes. It further evaluated whether DBS improved net health outcomes, whether it was comparable to established alternatives such as cingulotomy and capsulotomy, and whether any improvement was attainable outside investigational settings. These steps mirror the written technology assessment process described above, including regulatory review, literature review, consideration of clinical outcomes, comparison to alternatives, and assessment of generalizability beyond investigational settings.

The Cunningham Panel review followed the same sequence. The review began with a description of the technology, its analytes, proposed diagnostic use, and affected clinical population. It then evaluated the applicable regulatory/accreditation status, noting CLIA and COLA accreditation and clinical availability through Moleculera Labs. The review next considered the scientific evidence, including published studies and critiques of those studies, to determine whether the evidence permitted conclusions regarding patient outcomes. The analysis then assessed whether the test improved net health outcomes, whether it was as effective as established diagnostic alternatives, and whether any improvement could be expected outside investigational settings. As with DBS, the Cunningham Panel analysis applied the same evidentiary standards and the same questions concerning safety, efficacy, clinical utility, alternatives, and generalizability.

These two use cases therefore demonstrate comparability in practice. Both reviews used the same decision framework, the same core factors, and the same types of sources, including regulatory or accreditation information, peer-reviewed literature, clinical outcome data, expert or published clinical interpretation, and comparison to available alternatives. Both reviews followed the same process and reached the same result: the technologies were not covered because they did not satisfy all required technology assessment criteria. This demonstrates that the process is the same as written and in operation and is applied comparably across M/S and MH/SUD technologies.

CareFirst's written technology assessment policies and TAC meeting procedures apply the same process to both M/S and MH/SUD categorized devices in the Inpatient in-network, Inpatient out-of-network, Outpatient in-network, Outpatient out-of-network, and emergency care benefit classifications, and to both M/S and MH/SUD categorized services in the Inpatient in-network, Inpatient out-of-network, Outpatient in-network, Outpatient out-of-network, and emergency care benefit classifications, and to both M/S and MH/SUD categorized prescriptions in the Inpatient in-network, Inpatient out-of-network, and emergency care benefit classifications. The same review steps, responsible parties, evidentiary standards, regulatory or accreditation considerations, literature review hierarchy, expert consultation process, clinical outcome criteria, and TAC decision-making process are used regardless of whether the technology is classified as M/S or MH/SUD. Although no MH/SUD technologies were reviewed by TAC in 2025, the prior-year DBS and Cunningham Panel use cases demonstrate that the same five technology assessment criteria were applied in operation to behavioral health and medical/surgical examples. Both reviews used comparable sources and standards and reached non-coverage determinations where the technologies did not satisfy all required criteria. This supports the conclusion that the Experimental/Investigational/Unproven (EIU) Treatments NQTL is applied comparably and no more stringently to MH/SUD benefits than to M/S benefits, both as written and in operation.

IV. Demonstration of Comparability and Stringency In Operation

This section demonstrates that in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying experimental/investigational determinations to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying experimental/investigational determinations with respect to M/S benefits.

A. Explanation of how the CareFirst Evaluates Comparability

Below is a comprehensive explanation of how CareFirst evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying experimental/investigational determinations to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying experimental/investigational determinations with respect to M/S benefits.

B. Documentation of Outcomes

1. Evaluation of Relevant Data

a. In-Network Outpatient Claim Denials as Experimental/Investigational

In-Network Outpatient	M/S Outpatient Office	M/S Outpatient Other
Total # of Claims	722,981	512,944
Total # of Claims Denials Based on Exp/Inv	35	42
Percentage of Claims Denied Based on Exp/Inv	0.0%	0.0%

In-Network Outpatient	MH Outpatient Office	MH Outpatient Other	SUD Outpatient Office	SUD Outpatient Other
Total # of Claims	87,355	144,309	3,195	5,932
Total # of Claims Denials Based on Exp/Inv	0	0	0	0
Percentage of Claims Denied Based on Exp/Inv	0.0%	0.0%	0.0%	0.0%

b. Out-of-Network Outpatient Claim Denials as Experimental/Investigational

Out-of-Network Outpatient	M/S Outpatient Office	M/S Outpatient Other
Total # of Claims	27,778	31,265
Total # of Claims Denials Based on Exp/Inv	0	0
Percentage of Claims Denied Based on Exp/Inv	0.0%	0.0%

Out-of-Network Outpatient	MH Outpatient Office	MH Outpatient Other	SUD Outpatient Office	SUD Outpatient Other
Total # of Claims	8,833	11,328	320	1,552
Total # of Claims Denials Based on Exp/Inv	0	0	0	0
Percentage of Claims Denied Based on Exp/Inv	0.0%	0.0%	0.0%	0.0%

c. In-Network Inpatient Claim Denials as Experimental/Investigational

In-Network Inpatient	M/S General Hospital	M/S Specialty Hospital	M/S Inpatient Hospice	M/S Skilled Nursing Facility
Total # of Claims	48,093	275	133	709
Total # of Claims Denials Based on Exp/Inv	0	0	0	0
Percentage of Claims Denied Based on Exp/Inv	0.0%	0.0%	0.0%	0.0%

In-Network Inpatient	MH General Hospital	MH Specialty Psychiatric Hospital	MH Residential Treatment Facility	SUD General Hospital	SUD Specialty Psychiatric Hospital	SUD Residential Treatment Facility
Total # of Claims	1,947	642	528	549	9	448
Total # of Claims Denials Based on Exp/Inv	0	0	0	0	0	0
Percentage of Claims Denied Based on Exp/Inv	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%

d. Out-of-Network Inpatient Claim Denials as Experimental/Investigational

Out-of-Network Inpatient	M/S General Hospital	M/S Specialty Hospital	M/S Inpatient Hospice	M/S Skilled Nursing Facility
Total # of Claims	2,449	3	5	234
Total # of Claims Denials Based on Exp/Inv	0	0	0	0
Percentage of Claims Denied Based on Exp/Inv	0.0%	0.0%	0.0%	0.0%

Out-of-Network Inpatient	MH General Hospital	MH Specialty Psychiatric Hospital	MH Residential Treatment Facility	SUD General Hospital	SUD Specialty Psychiatric Hospital	SUD Residential Treatment Facility
Total # of Claims	265	27	394	189	0	136
Total # of Claims Denials Based on Exp/Inv	0	0	0	0	0	0
Percentage of Claims Denied Based on Exp/Inv	0.0%	0.0%	0.0%	0.0%	#DIV/0!	0.0%

e. Outpatient Appeals and Outcomes

Appeals												
Outpatient												
Vendor Name	INN M/S Overturned	INN M/S Upheld	INN M/S Partial Overturned	INN MH/SUD Overturned	INN MH/SUD Upheld	INN MH/SUD Partial Overturned	OON M/S Overturned	OON M/S Upheld	OON M/S Partial Overturned	OON MH/SUD Overturned	OON MH/SUD Upheld	OON MH/SUD Partial Overturned
Carelon	7	60	0	0	0	0	2	53	0	0	0	0
CVS Drug	396	395	0	26	18	0	0	0	0	0	0	0
CVS Drug Medical	78	17	0	3	0	0	0	0	0	0	0	0
CVS NCCN	1	2	0	0	0	0	0	0	0	0	0	0
eviCore	76	51	0	0	0	0	0	0	0	0	0	0
CareFirst Clinical Appeals	191	191	5	6	14	0	14	6	1	2	0	0
Total	749	716	5	35	32	0	16	59	1	2	0	0

f. Inpatient Appeals and Outcomes

Appeals												
Inpatient												
Vendor Name	INN M/S Overturned	INN M/S Upheld	INN M/S Partial Overturned	INN MH/SUD Overturned	INN MH/SUD Upheld	INN MH/SUD Partial Overturned	OON M/S Overturned	OON M/S Upheld	OON M/S Partial Overturned	OON MH/SUD Overturned	OON MH/SUD Upheld	OON MH/SUD Partial Overturned
Carelon	0	0	0	0	0	0	0	0	0	0	0	0
CVS Drug	0	0	0	0	0	0	0	0	0	0	0	0
CVS Drug Medical	0	0	0	0	0	0	0	0	0	0	0	0
CVS NCCN	0	0	0	0	0	0	0	0	0	0	0	0
eviCore	0	0	0	0	0	0	0	0	0	0	0	0

CareFirst Clinical Appeals	9	9	0	1	0	0	0	0	0	0	0	0
Total	9	9	0	1	0	0	0	0	0	0	0	0

2. Justification and Analysis

Review of CareFirst's internal experimental and investigational denial data for Virginia fully insured risk business for the period January 1, 2025 through December 31, 2025 shows that denials based on experimental or investigational criteria were rare and were not applied more stringently to MH/SUD benefits than to M/S benefits. The data applies the benefit classifications using diagnosis category and place-of-service codes for claims, and diagnosis category with authorization type name for authorizations. The analysis therefore evaluates the NQTL within inpatient and outpatient benefit classifications and across in-network and out-of-network categories.

For inpatient services, the claims data reflects no experimental/investigational denials for either M/S or MH/SUD benefits in any reported in-network or out-of-network service category. In-network M/S inpatient services included 48,093 general hospital claims, 275 specialty hospital claims, 133 inpatient hospice claims, and 709 skilled nursing facility claims, with no claims denied based on experimental or investigational criteria. Out-of-network M/S inpatient services similarly reflected no experimental/investigational denials across 2,449 general hospital claims, three specialty hospital claims, five inpatient hospice claims, and 234 skilled nursing facility claims. MH/SUD inpatient services also reflected no experimental/investigational claims denials across all reported in-network and out-of-network categories, including general hospital, specialty psychiatric hospital, and residential treatment facility services for both MH and SUD. Because no inpatient M/S or MH/SUD claims were denied on this basis, the inpatient claims experience does not indicate that the experimental/investigational NQTL was applied more stringently to MH/SUD inpatient benefits.

For outpatient services, the data reflects a small number of experimental/investigational denials for M/S in-network services and no such denials for MH/SUD services. M/S in-network outpatient office services had 722,981 total claims and 35 experimental/investigational denials, representing approximately 0.005% of claims. M/S in-network outpatient other services had 512,944 total claims and 42 experimental/investigational denials, representing approximately 0.008% of claims. There were no experimental/investigational denials for M/S out-of-network outpatient office or outpatient other services. By comparison, MH/SUD outpatient services had no experimental/investigational claims denials in any reported category, including MH outpatient office, MH outpatient other, SUD outpatient office, and SUD outpatient other services, both in-network and out-of-network. These results show that the limited outpatient denials based on experimental or investigational criteria occurred only within M/S in-network outpatient services and do not show more stringent application to MH/SUD benefits.

The appeals data likewise does not show more stringent treatment of MH/SUD benefits. For inpatient appeals, the data reflects one M/S in-network upheld appeal reason associated with experimental/investigational criteria and no MH/SUD inpatient experimental/investigational appeal outcomes. For outpatient appeals, experimental/investigational appeal reasons were reported only for M/S in-network appeals, including 83 overturned, 53 upheld, and one partially overturned appeal. No MH/SUD in-network or out-of-network appeals were identified as denied for experimental/investigational reasons in the reported appeal reason fields. Although the M/S outpatient appeal volume is higher than the MH/SUD appeal volume, the relevant experimental/investigational appeal reason data does not indicate that MH/SUD requests or claims were upheld, denied, or otherwise treated less favorably on this basis.

V. Findings and Conclusions

The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply the experimental/investigational determinations to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the experimental/investigational determinations to M/S benefits; and (2) CareFirst complies with the relevant data requirements under the MHPAEA Final Rules.

CareFirst has a written new technology assessment process that applies to both MH/SUD services and M/S services (Technology Assessment; Policy Number 0.00.011). The written criteria and procedures are to ensure fair and consistent technology assessments regardless of whether the proposed treatment or prescription drug applies to M/S, MH/SUD, or both types of diagnoses.

CareFirst follows a five-step process when assessment new technologies. If a new technology is being considered and deemed beneficial by meeting the 5 criteria, a medical policy and reference manual is created for these services. Each service has its own unique medical policy that includes criteria, guidelines, descriptions, thresholds, and referenced peer-reviewed medical literature to support the policy and decisions.

A review of CareFirst's written policies and processes reveals the comparable application of the new technologies NQTL to M/S and MH/SUD services within the applicable benefit classifications. 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 undergoing new technology assessment for inclusion as a covered service.

Operationally, the data supports a finding that CareFirst's experimental/investigational NQTL is applied in a comparable and no more stringent manner for MH/SUD benefits than for M/S benefits, as written and in operation. Inpatient claims showed no experimental/investigational denials for either M/S or MH/SUD services. Outpatient claims showed limited experimental/investigational denials only for M/S in-network services, with no MH/SUD outpatient denials reported. Appeals data also showed experimental/investigational appeal reasons only in M/S categories and did not identify adverse MH/SUD appeal outcomes on this basis. Accordingly, the available data does not identify a parity concern and supports the conclusion that the experimental/investigational review process complies with MHPAEA's comparative analysis standard because it is not designed or applied more stringently to MH/SUD benefits than to M/S benefits within the same benefit classifications.

VI. Required Certification

CareFirst certifies that the foregoing comparative analysis of the Experimental or Investigational: Evaluation of New Technologies NQTL was prepared for the Virginia fully insured coverage identified in this report and was reviewed by individuals with appropriate knowledge of the plan terms, policies, procedures, factors, evidentiary standards, operational practices, supporting documentation, and relevant data addressed in the analysis. The analysis applies to the CareFirst entities identified in this report as NAIC 53007 and NAIC 9602 to the extent the NQTL is designed and administered as described in this analysis.

To the best of CareFirst's knowledge and based on the information, documentation, and data reviewed as of the report's version date, this comparative analysis is accurate and complete in all material respects and demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the Experimental or Investigational: Evaluation of New Technologies NQTL to mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, those used to design and apply the NQTL to medical/surgical benefits, as written and in operation. CareFirst will maintain supporting documentation and will update or supplement the analysis if a material change, newly identified data limitation, or corrective action affects this conclusion.

TREATMENT PLAN REQUIREMENT

Overview

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the treatment plan requirement to mental health or substance use disorder ("MH/SUD") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the treatment plan requirement to medical surgical ("M/S") benefits.

I. Description of the Treatment Plan Requirement NQTL

CareFirst requires providers to maintain treatment plans, as clinically indicated, for certain M/S services. For MH/SUD benefits, ABA is the MH/SUD-specific service subject to a treatment plan requirement; treatment plans may also apply to services available across benefit types, as reflected below. These requirements are based on applicable law, guidance, and clinical standards governing the medical management of services.

A. Identification of the NQTL

i. Plan/Coverage Terms Regarding Treatment Plan Requirements

The Plan document contains the following sections regarding treatment plans (also identified as 'plans of treatment' in plan documents). Treatment plan requirements apply to both certain M/S benefits and certain MH/SUD benefits. The treatment plan requirements are the same for both M/S and MH/SUD benefits that require a treatment plan.

- Definitions
- Utilization Management Requirements
- Schedule of Benefits

(*Source:* Plan EOC)

ii. Policies/Guidelines/Other Documents Describing Treatment Plan Requirements

Treatment Plans appear or are described in the following documents:

- CareFirst Medical Policy Reference Manual

iii. Identification of All MH/SUD Benefits and M/S Benefits to Which the Treatment Plan Requirement NQTL Applies by Benefit Classification

The Plan requires a treatment plan for certain M/S services, and certain MH/SUD services, as follows. Emergency services and prescription drugs are not subject to treatment plans.

List of M/S Services that Require a Treatment Plan (or a 'Plan of Treatment')	List of MH/SUD Services that Require a Treatment Plan (or a 'Plan of Treatment')
Inpatient M/S Services (In-Network and Out-of-Network)	**Inpatient MH/SUD Services (In-Network and Out-of-Network)**
N/A- No inpatient M/S services are subject to a treatment plan requirement.	N/A- No inpatient MH/SUD services are subject to a treatment plan requirement.
Outpatient M/S Services (In-Network and Out-of-Network)	**Outpatient MH/SUD Services (In-Network and Out-of-Network)**
M/S Services for which CareFirst must approve a Plan of Treatment: • Controlled Clinical Trial Patient Cost coverage • Habilitative Services • Rehabilitative Services • Home Health Care • Hospice Care • Infertility Services • Private Duty Nursing • MRI, CT Scan • Durable Medical Equipment (DME) • Radiology Services • Surgery	MH/SUD Services for which CareFirst must approve a Plan of Treatment: • Controlled Clinical Trial Patient Cost coverage • ABA Therapy • Habilitative Services • Rehabilitative Services • Home Health Care • Private Duty Nursing • MRI, CT Scan

II. Identification and Definition of the Factors and Evidentiary Standards Used to Design and Apply the Treatment Plan Requirement

Factor 1	Supports Optimal Clinical Outcomes
Definition	The application of a treatment plan supports optimal clinical outcomes as determined by internal clinical experts based on evidence-based guidelines.
Application Benefit Classification(s)	• In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other

Description	This factor is used in the design of treatment plan requirements to determine whether maintaining a treatment plan would optimize a patient's treatment.

Source(s) of Factor	• Clinical evidence (scientifically based) E.g.:
	  ○ FDA
	  ○ Hayes
	  ○ Cochrane Library
	  ○ Centers for Medicare & Medicaid Services
	  ○ National Institute of Health U.S. National Library of Medicine
	  ○ MCG, ACG, LCDs, NCDs
	  ○ NCCN
	  ○ PubMed
	  ○ UpToDate
	• Systematic reviews
	• Trials (randomized, controlled)
	• Studies (comparative, cohort, cross-sectional, retrospective, surveillance)
	• Case reviews
	• Editorials
	• Professional and association opinions

Evidentiary Standards and Applicable Thresholds	CareFirst utilizes appropriate criteria based on the service type to decide on whether a treatment plan requirement applies to a particular service. The process does not differ from M/S or MH/SUD, though appropriate criteria is applied to its corresponding service type. There is no specific threshold as this follows standard guidelines and professional recommendations. CareFirst ensures application in parity by utilizing industry appropriate criteria and guidelines.

Source(s) of Evidentiary Standards	• Clinical evidence (scientifically based) E.g.:
	  ○ FDA
	  ○ Hayes
	  ○ Cochrane Library
	  ○ Centers for Medicare & Medicaid Services
	  ○ National Institute of Health U.S. National Library of Medicine
	  ○ MCG, ACG, LCDs, NCDs
	  ○ NCCN
	  ○ PubMed
	  ○ UpToDate
	• Systematic reviews
	• Trials (randomized, controlled)

	• Studies (comparative, cohort, cross-sectional, retrospective, surveillance) • Case reviews • Editorials • Professional and association opinions

Factor 2	**State and Federal Guidance**
Definition	Applicable state and federal guidance regarding the medical management of services and requirement to create and maintain a Plan of Treatment for specific services.
Application Benefit Classification(s)	• In-Network Outpatient Office • In-Network Outpatient Other • Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	This factor is used in the design of the treatment plan requirement to determine whether a treatment plan is required by law in a particular jurisdiction.
Source(s) of Factor	• DC 22-A53 • 12 VAC 30-150-50 • 12 VAC35-105-810
Evidentiary Standards and Applicable Thresholds	Treatment plans are required for services where the regulatory and clinical guidelines recommend maintaining a treatment plan as best practice or required by law.
Source(s) of Evidentiary Standards	• DC 22-A53 • 12 VAC 30-150-50 • 12 VAC35-105-810

A. Processes

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 peer-reviewed literature. Policies are reviewed by CareFirst's chief medical officer, senior medical directors, and behavioral health medical director. The criteria are always used together with an assessment of the individual patient's needs. CareFirst's medical and behavioral health policies are available on web.carefirst.com.

The internal and external criteria used for both M/S and MH/SUD are authorized by the CareFirst Criteria Review Committee. Internal 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 must hold an active RN license in Maryland, Virginia, or the District of Columbia and have 7–10 years of clinical experience, or hold an active license as a Licensed Clinical Social Worker (LCSW), Licensed Certified Social Worker-Clinical (LCSW-C), or Licensed Clinical Professional Counselor (LCPC) and have 7–10 years of clinical experience. For both M/S and MH/SUD benefits, medical-necessity denials may be issued only by physicians. Physicians issuing M/S denials must have an MD degree and at least five years of clinical experience; physicians issuing MH/SUD denials must be psychiatrists with at least five years of clinical experience.

When appropriate, providers may be asked to maintain treatment plans including the goals of treatment, patient progress and coordination of care. When submitting requests for services that require authorization, providers include clinical information relevant to the request. For services with treatment plans, the treatment plan is an essential part of relevant clinical information.

Utilization Management Staff and their Responsibilities:

CareFirst Title	Qualifications
Medical Director/Chief Medical Officer	Board certified Medical Doctor responsible for the development and implementation of UM processes, criteria, and program outcomes. Oversees the operations of the UM department and is a liaison to the medical community regarding UM program operations. Clinical consultant for UM decisions: approves and denies care according to medical criteria and policies and procedures. Reports to Executive Vice President of Health Services and supervises all other medical directors (e.g., Behavioral Health Medical Director, Radiology/Cardiology Medical Director, etc.). Chairs the UM Committee.
Medical Director, Behavioral Health	Board-certified physician in psychiatry who reviews behavioral health UM cases and makes medical-necessity determinations using evidence-based UM criteria, policies, and procedures. Serves as a liaison to the behavioral health practitioner and provider communities and provides information and expertise to behavioral health UM staff. Reports to the Medical Director and is a member of the UM Committee.
Director of Utilization Management	A Registered Nurse who is responsible for intake, precertification, concurrent review, and retrospective review activities of the department. Develops and maintains policies and procedures for assigned areas. Approves requested care per UM criteria and policies and procedures. May deny care based on benefits or contract issues. Supervises all RN, LPN staff and UM coordinators, and is responsible for department operations. Reports to the Clinical Director of Government Programs with a dotted line to the Chief Medical Officer.

Utilization Management Manager/Supervisor	Assists UM director with day-to-day operations, oversees completion of reviews by UR Reviewers, problem- solves, conducts audits, prepares documents for weekly UM Meetings. Reports to the Director of Utilization Management.
Utilization Management Reviewer	A licensed nurse who conducts UM review activities. Monitors and coordinates care with participating practitioners, enrollees, and provider organizations using established criteria. Collects data for precertification, concurrent review, and retrospective review. Approves requested care under UM criteria, policies, and procedures. May deny authorization requests based on administrative criteria, such as benefit or contractual limitations. If medical-necessity criteria are not met, the reviewer submits the authorization request to a physician for the medical-necessity determination.
Vice President of Pharmacy and Therapeutics	The Doctor of Pharmacy is responsible for developing and maintaining the formulary and formulary policies and procedures. Researches, approves and denies requests for drugs consistent with formulary policies and procedures and UM criteria. Reports to the Medical Director/CMO and is a member of the P & T Committee. Provides support to the P & T Committee and manages the MCO's relationship with the Pharmacy Benefits Manager (PBM).
Physician Advisors	Board-certified physicians who are available to review UM cases, including appeals. They research the request and either approve or deny it in accordance with UM criteria, policies, and procedures.

B. Strategy

CareFirst uses internal clinical policies in the CareFirst Medical Policy Reference Manual for M/S and MH/SUD benefits. These policies are developed using external clinical criteria, peer-reviewed literature, clinical trials, professional opinions, and publications from professional societies or government agencies. Appropriately qualified clinical staff review authorization requests using evidence-based clinical guidelines. Qualified staff may approve coverage under applicable criteria; only physicians may issue medical-necessity denials. Providers and members are notified of adverse benefit determinations in accordance with applicable state, federal, and NCQA requirements, and applicable appeal rights are provided.

If internal criteria are not sufficient to support an approval determination, CareFirst uses appropriate evidence-based external clinical criteria for M/S and MH/SUD benefits. These may include the Modified Appropriateness Evaluation Protocol (AEP) Criteria for M/S inpatient services; Apollo Managed Care criteria for physical, occupational, and speech therapy and rehabilitation; the applicable edition of MCG guidelines for behavioral health, ambulatory care, inpatient and surgical care, and home care; and American Society of Addiction Medicine (ASAM) criteria for SUD services.

CareFirst requires providers to maintain treatment plans, as clinically indicated, for certain M/S services. For MH/SUD benefits, ABA is the MH/SUD-specific service subject to a treatment plan requirement; treatment plans may also apply to services available across benefit types, as reflected in the service table above. The requirements are based on applicable state guidance and service-specific clinical standards.

C. Relationship Between Factors

All factors in the analyses are considered equally and there is no factor that carries more weight than another.

III. Demonstration of Comparability and Stringency as Written

This section demonstrates that in each classification, under the terms of the plan as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the treatment plan requirement to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying treatment plan requirement with respect to M/S benefits.

CareFirst recognizes a responsibility to demonstrate a commitment of superior clinical quality service that is member centric, high touch, clinically appropriate, cost effective, data driven and culturally competent. This is achieved through an organization-wide, systematic, and coordinated approach that involves input from and coordination with both internal and external stakeholders. These stakeholders include members, providers, state entities, CMS, business units, department, and staff members. The UM program, including treatment plan requirements, 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.

A review of CareFirst's written policies and processes reveals the comparable application of the Treatment Plan Requirement NQTL to M/S and MH/SUD services within the applicable benefit classifications. The Plan's 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.

IV. Demonstration of Comparability and Stringency In Operation

This section demonstrates that in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the treatment plan requirement to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the treatment plan requirement with respect to M/S benefits.

A. Explanation of How CareFirst Evaluates Comparability

Below is a comprehensive explanation of how CareFirst evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the treatment plan requirement to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the treatment plan requirement with respect to M/S benefits.

B. Documentation of Outcomes

1. Evaluation of Relevant Data

a. In-Network Outpatient Denial Rates for Lack of or Insufficient Treatment Plan

In-Network Outpatient	M/S Outpatient Office	M/S Outpatient Other
Total # of Claims	722,981	512,944
Total # of Claims Denials Based on Treatment Plan	2	51
Percentage of Claims Denied Based on Lack of or Insufficient Treatment Plan	0.00%	0.01%

In-Network Outpatient	MH Outpatient Office	MH Outpatient Other	SUD Outpatient Office	SUD Outpatient Other
Total # of Claims	87,355	144,309	3,195	5,932
Total # of Claims Denials Based on Treatment Plan	13	18	0	0
Percentage of Claims Denied Based on Lack of or Insufficient Treatment Plan	0.01%	0.01%	0.00%	0.00%

**Inpatient services are not subject to a treatment plan requirement. Therefore, inpatient data tables are not included here.*

b. Out-of-Network Outpatient Denial Rates for Lack of or Insufficient Treatment Plan

Out-of-Network Outpatient	M/S Outpatient Office	M/S Outpatient Other
Total # of Claims	27,778	31,265
Total # of Claims Denials Based on Treatment Plan	1	1
Percentage of Claims Denied Based on Lack of or Insufficient Treatment Plan	0.00%	0.00%

Out-of-Network Outpatient	MH Outpatient Office	MH Outpatient Other	SUD Outpatient Office	SUD Outpatient Other
Total # of Claims	8,833	11,328	320	1,552

Total # of Claims Denials Based on Treatment Plan	0	3	0	0
Percentage of Claims Denied Based on Lack of or Insufficient Treatment Plan	0.00%	0.03%	0.00%	0.00%

**Inpatient services are not subject to a treatment plan requirement. Therefore, inpatient data tables are not included here.*

2. Justification and Analysis

Review of CareFirst's internal treatment plan denial data for Virginia fully insured risk business for the period January 1, 2025, through December 31, 2025, shows that treatment plan-related denials were rare across the reported outpatient classifications. The displayed data uses diagnosis category and place-of-service codes to compare in-network and out-of-network outpatient office and outpatient other services. As noted above, inpatient services are not subject to the treatment plan requirement and therefore are not included in the data tables.

For outpatient services, the data reflects a small number of treatment plan denials across both M/S and MH/SUD categories, with denial rates remaining very low in all classifications. M/S in-network outpatient office services had 722,981 total claims and two treatment plan denials, representing approximately 0.0003% of claims. M/S in-network outpatient other services had 512,944 total claims and 51 treatment plan denials, representing approximately 0.0099% of claims. M/S out-of-network outpatient office and outpatient other services each had one treatment plan denial, representing approximately 0.0036% and 0.0032% of claims, respectively. By comparison, MH in-network outpatient office services had 87,355 claims and 13 treatment plan denials, representing approximately 0.0149% of claims, and MH in-network outpatient other services had 144,309 claims and 18 treatment plan denials, representing approximately 0.0125% of claims. SUD in-network outpatient office and outpatient other services had no treatment plan denials. Out-of-network MH outpatient other services had three treatment plan denials across 11,328 claims, representing approximately 0.0265% of claims, while out-of-network MH outpatient office and all reported out-of-network SUD outpatient categories had no treatment plan denials. Although certain MH outpatient categories show slightly higher percentages than the corresponding M/S categories, the absolute volume of denials is low and does not, by itself, establish that the treatment plan requirement was applied more stringently to MH/SUD benefits in operation.

V. Findings and Conclusions

The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply the treatment plan requirement to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the treatment plan requirement to M/S benefits; and (2) CareFirst complies with the relevant data requirements under the MHPAEA Final Rules.

CareFirst's treatment plan requirement is supported by neutral clinical and regulatory factors and is administered through comparable processes for M/S and MH/SUD benefits. As written, the requirement is grounded in evidence-based clinical standards, applicable state and federal guidance, and uniform UM governance processes that apply across benefit types. In operation, the data shows limited variation among outpatient categories. Accordingly, the written and operational findings support the conclusion that the treatment plan requirement NQTL is comparable and is applied no more stringently to MH/SUD benefits than to M/S benefits.

VI. Required Certification

CareFirst certifies that the foregoing comparative analysis of the Treatment Plan Requirement NQTL was prepared for the Virginia fully insured coverage identified in this report and was reviewed by individuals with appropriate knowledge of the plan terms, policies, procedures, factors, evidentiary standards, operational practices, supporting documentation, and relevant data addressed in the analysis. The analysis applies to the CareFirst entities identified in this report as NAIC 53007 and NAIC 9602 to the extent the NQTL is designed and administered as described in this analysis.

To the best of CareFirst's knowledge and based on the information, documentation, and data reviewed as of the report's version date, this comparative analysis is accurate and complete in all material respects and demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the Treatment Plan Requirement NQTL to mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, those used to design and apply the NQTL to medical/surgical benefits, as written and in operation. CareFirst will maintain supporting documentation and will update or supplement the analysis if a material change, newly identified data limitation, or corrective action affects this conclusion.

CREDENTIALING (PROVIDER AND FACILITY)

Overview

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the credentialing requirement to mental health or substance use disorder ("MH/SUD") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the credentialing requirement to medical surgical ("M/S") benefits.

I. Description of the Credentialing NQTL

CareFirst applies credentialing standards to ensure all providers and facilities within the CareFirst network meet and continue to maintain the qualifications and standards to operate in compliance with state and federal laws, NCQA standards, and to validate that a provider or facility may join or remain in the network by confirmation that all qualifications are met. At this time, CareFirst does not use Artificial Intelligence (AI) to make decisions regarding credentialing decisions.

A. Identification of the NQTL

i. Plan/Coverage Terms Regarding Credentialing

The Plan document contains the following sections regarding credentialing requirements. These credentialing sections apply to both M/S benefits and MH/SUD benefits, and do not differentiate between M/S and MH/SUD benefits:

- Definitions
- General Provisions
- Inter-Plan Arrangements Disclosure

(*Source: Plan EOC*)

ii. Policies/Guidelines/Other Documents Describing Credentialing

Credentialing appears or is described in the following documents:

- Compensation and Premium Disclosure Statement, pp. 2-3
- CareFirst Provider Manual, pp. 59-68
- Provider Scorecard Methodology

iii. Identification of All MH/SUD Benefits and M/S Benefits to which Credentialing Requirements Apply

All M/S and MH/SUD in-network providers and facilities are subject to credentialing.

Proprietary and Confidential Information of CareFirst, Inc. and its affiliates and subsidiaries. This information shall only be disclosed as required by law.

II. Identification, Definition, and Application of the Factors and Evidentiary Standards Used to Design and Apply Credentialing Requirements

A. Factors and Evidentiary Standards for Credentialing

Factor 1	**Completed Application and Attestation**
Definition	The provider/facility submits a completed application and attestation to the ability to perform the essential functions of a clinical practitioner and lack of present illegal drug use. CareFirst validation and ongoing monitoring of information provided within the application. (Recredentialing every 3 years).
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other
Description	The credentialing process begins when a provider/facility applies and submits an attestation requesting to join the CareFirst network.
Source(s) of Factor	• State law and federal requirements
Evidentiary Standards and Applicable Thresholds	CareFirst follows state and federal requirements and NCQA standards to ensure appropriate requirements are met before credentialing providers and facilities.
Source(s) of Evidentiary Standards	• Receipt and review of documents for accuracy • CareFirst BCBS provider manual • CAQH application. facility application, or state application, as applicable • CareFirst questionnaire • Attestation • Required documentation • OIG • State licensing boards

Factor 2	**Licensure**
Definition	The 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.

Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst reviews state and federal licensing to ensure the prospective provider or facility meets the appropriate state and federal law licensing requirements.
Source(s) of Factor	• State law licensing requirements • Federal law licensing requirements
Evidentiary Standards and Applicable Thresholds	CareFirst follows state and federal licensing requirements.
Source(s) of Evidentiary Standards	• State law licensing rules • Federal law licensing rules • DEA registration • CDS registration

Factor 3	**Education and Training**
Definition	The provider (or providers within a facility) has appropriate education and training to be credentialed.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst reviews education and training of prospective providers to determine whether they meet state law requirements.
Source(s) of Factor	• State law
Evidentiary Standards and Applicable Thresholds	CareFirst follows state and federal education and training requirements.
Source(s) of Evidentiary Standards	• State law

Factor 4	Board Certification
Definition	The provider or facility as the appropriate board certification (as applicable).
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst reviews board certification records to determine whether an applicant meets the board certification criteria and requirements.
Source(s) of Factor	• State law licensing requirements
Evidentiary Standards and Applicable Thresholds	CareFirst follows state board certification requirements.
Source(s) of Evidentiary Standards	• Board certification records

Factor 5	Liability Claims
Definition	Acceptable history of professional liability claims.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst reviews applicants' professional liability claims history to determine the risk of adding the applicant to the network.
Source(s) of Factor	• NCQA guidelines
Evidentiary Standards and Applicable Thresholds	The applicant's malpractice history cannot have any cases that settled with totals exceeding $3,000,000.00 in the past 10 years or have any case resulting in death within the past 10 years. For recredentialing, the provider cannot have more than 5 complaints in the prior credentialing cycle.
Source(s) of Evidentiary Standards	• NCQA guidelines • Liability claims review

Factor 6	Appropriate Malpractice Insurance
Definition	Applicant maintains current malpractice insurance coverage at or exceeding the minimum liability limits.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst must obtain a copy of the applicant's medical malpractice insurance policy to review and confirm minimum liability limits are in place.
Source(s) of Factor	• NCQA guidelines
Evidentiary Standards and Applicable Thresholds	See chart below for medical malpractice insurance requirements.
Source(s) of Evidentiary Standards	• NCQA guidelines • Provider insurance review

Number of practitioners in practice	Medical practices primary layer	Medical practices excess layer	Mid-level behavioral primary layer	Mid-level behavioral excess layer	PT/OT/ST primary layer only
1	$1M/$3M Individual	N/A	$.5M/$1.5M Individual	N/A	$1M/$3M Shared (up to 24)
2–5	$1M/$3M Shared	N/A	$.5M/$1.5M Shared	N/A	$1M/$3M Shared (up to 24)
6–10	$2M/$6M Shared	N/A	$1M/$3M Shared	N/A	$1M/$3M Shared (up to 24)
11-24	$2M/$6M Shared	$5M Shared	$1M/$3M Shared	$3.5M Shared	$1M/$3M Shared (up to 24)
	$1M/$3M Shared	$10M Shared	$.5M/$1.5M Shared	$7.5M Shared	
25-50	$2M/$6M Shared	$10M Shared	$1M/$3M Shared	$5M Shared	Individual Consideration
	$1M/$3M Shared	$15M Shared	$.5M/$1.5M Shared	$10M Shared	

51+	Individual Consideration

Factor 7	**Accreditation**
Definition	Appropriate accreditation from proper accrediting bodies (as applicable).
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst review applicants' accreditations and confirms them against records held by accrediting bodies.
Source(s) of Factor	• State law accreditation requirements • Federal law accreditation requirements • Requirements of accreditation body
Evidentiary Standards and Applicable Thresholds	See below chart with institutional and ancillary credentialing requirements.

Source(s) of Evidentiary Standards	**Accreditation Bodies:** • AAAASF—American Association for Accreditation of Ambulatory Surgery Facilities • AAAHC—Accreditation Association for Ambulatory Health Care • AAPSF—Accreditation Association for Podiatric Surgical Facilities • ABC—American Board for Certification in Orthotics & Prosthetics, Inc. • ACHC—Accreditation Commission for Health Care, Inc. • BOC—Board of Orthotists/Prosthetist Certification • CABC—Commission for Accreditation of Birthing Centers • CARF—Commission on Accreditation of Rehabilitation Facilities • CHAP—Community Health Accreditation Program • CMS—Centers for Medicare and Medicaid Services • CON—Certificate of Need; exemption letter from State Licensing Agency (must accompany CON) DNV Healthcare Inc. • HQAA—HealthCare Quality Association on Accreditation • NABP—National Association of Boards of Pharmacy • NBAOS—The National Board of Accreditation for Orthotic Suppliers • State/District Site Survey— Survey Documentation conducted at State or District Level • TJC—The Joint Commission • The Compliance Team

Provider Types	State Licensure	GL Certificate	CMS Certification	OIG Exclusions	Accreditation Required	Acceptable Accreditation Bodies
Medical						
Birthing Center	Yes	$1M Occ / $3M Agg	No	None	Yes	CABC, AAAHC, or TJC
Freestanding ASC	Yes (MD, D.C., DE) VA – As required by Virginia Department of Health	$1M Occ / $3M Agg	Yes (MD, D.C., DE) VA – if State license is required	None	Yes	AAASF, AAAHC, AAPSF, or TJC

Provider Types	State Licensure	GL Certificate	CMS Certification	OIG Exclusions	Accreditation Required	Acceptable Accreditation Bodies
Freestanding Dialysis	Yes except for D.C. and VA	$1M Occ / $3M Agg	Yes	None	N/A	CMS Certification
Home Health Agencies	Yes; except D.C.; VA requires a license or license exemption letter.	$1M Occ / $3M Agg	Yes, but waived if TJC or ACHC accredited	None	Yes	ACHC (Home health accreditation), CHAP, TJC, or state/district site survey
Hospice	Yes, except in D.C.	$1M Occ / $3M Agg	Yes	None	Yes	ACHC, CHAP, TJC, or state/district site survey
Hospital	Yes	$1M Occ / $3M Agg	Yes	None	Yes	TJC or DNV Healthcare, Inc.
Rehabilitation Hospital	Yes	$1M Occ / $3M Agg	Yes	None	Yes	CARF or TJC
Skilled Nursing Facility	Yes	$1M Occ / $3M Agg	Yes	None	Yes	CARF, TJC, or state/district site survey
Lithotripsy	Yes	$1M Occ / $3M Agg	No	None	N/A	State license
Behavioral						
Ambulatory	Yes	$1M Occ / $3M Agg	No	None	Yes	CARF, TJC, or state/district site survey
Residential or Inpatient	Yes	$1M Occ / $3M Agg	No	None	Yes	CARF, TJC, or state/district site survey
Eating Disorder	Yes	$1M Occ / $3M Agg	No	None	Yes	CARF, TJC, or state/district site survey
Alcohol and Drug Rehabilitation						

Provider Types	State Licensure	GL Certificate	CMS Certification	OIG Exclusions	Accreditation Required	Acceptable Accreditation Bodies
Ambulatory	Yes	$1M Occ / $3M Agg	No	None	Yes	CARF, TJC, or state/district site survey
Residential or Inpatient	Yes	$1M Occ / $3M Agg	No	None	Yes	CARF, TJC, or state/district site survey
Durable Medical Equipment (DME)						
Prosthetics and Orthotics	Virginia—permit required. D.C.—an out-of-state business requires a certificate of authority or registration to transact business within D.C. No MD requirement.	$1M Occ / $2M Agg	Yes	None	Yes	ABC, ACHC, BOC, CARF, CHAP, HQAA, NABP, NBAOS, TJC, The Compliance Team
Mail Order	Yes, from the state shipping from unless otherwise notified of a state exemption.	$1M Occ / $2M Agg	Yes	None	Yes	ABC, ACHC, BOC, CARF, CHAP, HQAA, NABP, NBAOS, TJC, The Compliance Team
Pharmacy (not specialty pharmacy)	Yes, as required by their state to operate a business.	$1M Occ / $2M Agg	Yes	None	Yes	ABC, ACHC, BOC, CARF, CHAP, HQAA, NABP, NBAOS, TJC, The Compliance Team

Provider Types	State Licensure	GL Certificate	CMS Certification	OIG Exclusions	Accreditation Required	Acceptable Accreditation Bodies
All Other Types	Yes, as required by their state to operate a business.	$1M Occ / $2M Agg	Yes	None	None	ABC, ACHC, BOC, CARF, CHAP, HQAA, NABP, NBAOS, TJC, The Compliance Team

A. Processes

For new providers and facilities, the process begins with the provider/facility application. Providers submit a CAQH profile, facility-based application, or state application, as applicable. CareFirst BCBS will validate education, licensing, experience, and other requirements. Validation is consistent with NCQA standards and applicable state and federal requirements. When the Medical Director determines that an application is complete and meets credentialing requirements, it is referred to the Credentialing Advisory Committee (CAC) for approval. An application that does not meet credentialing requirements may be denied. If an application is denied, appeal rights are provided. Continued monitoring of network providers occurs to identify issues with licensing or sanctions. Recredentialing occurs every 3 years.

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. The medical director 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

CareFirst's 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 that are no longer 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.

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.

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.

B. <u>Strategy</u>

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 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 to assess if 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.

Requirements for Professional Providers:

- Valid, current, unrestricted licensure
- Prescribers only (MD, NP): Valid, current, Drug Enforcement Agency and Controlled Dangerous Substance registration, if and as applicable, for each state where the practitioner practices
- Appropriate education and training in a relevant field
- Board certification, if applicable
- Review of work history
- M/S MD's only: Active, unrestricted, admitting privileges at a participating network hospital, except as otherwise agreed to by CareFirst in its sole discretion
- At least 20 office hours per week to see patients
- Acceptable history of professional liability claims
- Acceptable history of previous or current state sanctions, Medicare/Medicaid sanctions, restrictions on licensure, hospital privileges and/or limitations on scope of practice
- Attestation to ability to perform the essential functions of a clinical practitioner and lack of present illegal drug use.
- Current malpractice insurance coverage with minimum limits as indicated above

Requirements for Institutional Providers/Facilities:

- A completed Request for Information (RFI) Application and a Facility Data Sheet for each location along with all required credentialing documents for professional providers.
- Institutional and ancillary providers are required to have a physical location in the CareFirst service area, meet all credentialing requirements.

- Institutions requesting to participate in CareFirst's provider network need to have both State Licensure and CMS certification

C. Relationship Between Factors

All factors in the analyses are considered equally and no single factor carries more weight than another. Additionally, no factors were considered but rejected. Lastly, all factors apply to both M/S and MH/SUD classified services.

III. Demonstration of Comparability and Stringency as Written

This section demonstrates that in each classification, under the terms of the plan as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying credentialing requirements to MH/SUD providers and facilities are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the credentialing requirement with respect to M/S providers and facilities.

While there is variation in the accreditation bodies for facilities and board certifications for providers, this is purely due to different accreditation and regulatory bodies overseeing these reviews and approvals for the various M/S and MH/SUD specialties. For example, CARF is responsible for accreditation of rehabilitation facilities, including MH/SUD drug and alcohol rehabilitation facilities, whereas ABC is responsible for accreditation of services tied to durable medical equipment (DME).

As evidenced in the charts above, the malpractice insurance requirements are lower (less stringent) for MH/SUD facilities when compared to the amounts required for M/S facilities. This differentiation acknowledges the inherent differences in the services provided and reduces this barrier of entry for MH/SUD facilities. The review process for professional liability claims applies to both M/S and MH/SUD providers and the requirements of settled totals less than $3M in claims in 10 years and no cases resulting in death in the past 10 years are identical for M/S and MH/SUD providers. Furthermore, the requirements for the application, licensure, education and training, and board certifications are all determined by state and federal law for both M/S and MH/SUD providers and facilities.

In sum, there are no factors, evidentiary standards, or sources applied to MH/SUD providers or facilities which are not also applied to M/S providers or facilities. Accordingly, CareFirst finds that the credentialing requirement is no more stringently applied to MH/SUD facilities and practitioners, than to M/S facilities and practitioners, in writing.

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IV. Demonstration of Comparability and Stringency In Operation

This section demonstrates that in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying credentialing requirements to MH/SUD providers and facilities are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying credentialing requirements with respect to M/S providers and facilities.

A. Explanation of how CareFirst Evaluates Comparability

Below is a comprehensive explanation of how CareFirst evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the credentialing requirement to MH/SUD providers and facilities are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the credentialing requirement with respect to M/S providers and facilities.

B. Documentation of Outcomes

1. Evaluation of Relevant Data

a. PPO Credentialing Rates

Credentialing Data Point	M/S Facility	MH/SUD Facility
Mean number of days from first submission of an application to the later of the effective date or date of execution of contract	4	6
Median number of days from first submission of an application to the later of the effective date or date of execution of contract	3	3
Number of providers that submitted an initial application	153	19
Number of providers that submitted an initial application, but withdrew before completing the credentialing process, or failed to complete the credentialing process by not responding	0	0
Number of providers that submitted an initial application that were denied/rejected due to a full network	0	0
Number of providers that submitted an initial application that were denied/rejected based on other reasons other than their withdrawal, failure to respond, or a full network (e.g., ineligible, incorrect licensure, already participating)	0	0
Number of providers that submitted a complete application and did not subsequently withdraw	153	19
Number of providers who submitted a complete application, but declined the offer of a contract from the carrier	0	0
Number of providers that completed the process and executed a contract	153	19
Percentage of providers that submitted an initial application, but withdrew before completing the credentialing process, or failed to complete the credentialing process by not responding	0%	0%

Credentialing Data Point	M/S Facility	MH/SUD Facility
Percentage of providers that submitted an initial application that were rejected due to a full network	0%	0%
Percentage of providers that submitted an initial application, but were denied/rejected for any other reasons other than their withdrawal, failure to respond, or a full network	0%	0%
Percentage of providers that submitted an initial application and completed the process	100%	100%
Percentage of providers who submitted a complete application, but declined the offer of a contract from the carrier	0%	0%
Percentage of providers that completed the process and executed a contract	100%	100%

Credentialing Data Point	M/S Physician	MH/SUD Physician (Psychiatrist)	M/S Non-Physician Provider	MH/SUD Non-Physician Provider
Mean number of days from first submission of an application to the later of the effective date or date of execution of contract	34	35	32	35
Median number of days from first submission of an application to the later of the effective date or date of execution of contract	32	27	31	33
Number of providers that submitted an initial application	9,382	385	2,726	7,794
Number of providers that submitted an initial application, but withdrew before completing the credentialing process, or failed to complete the credentialing process by not responding	1,045	37	254	445
Number of providers that submitted an initial application that were denied/rejected due to a full network	0	0	0	0
Number of providers that submitted an initial application that were denied/rejected based on other reasons other than their withdrawal, failure to respond, or a full network (e.g., ineligible, incorrect licensure, already participating)	713	66	195	370
Number of providers that submitted a complete application and did not subsequently withdraw	8,337	348	2,472	7,349
Number of providers who submitted a complete application, but declined the offer of a contract from the carrier	0	0	0	0
Number of providers that completed the process and executed a contract	7,622	282	2,477	6,948
Percentage of providers that submitted an initial application, but withdrew before completing the credentialing process, or failed to complete the credentialing process by not responding	11%	10%	9%	6%

Credentialing Data Point	M/S Physician	MH/SUD Physician (Psychiatrist)	M/S Non-Physician Provider	MH/SUD Non-Physician Provider
Percentage of providers that submitted an initial application that were rejected due to a full network	0%	0%	0%	0%
Percentage of providers that submitted an initial application, but were denied/rejected for any other reasons other than their withdrawal, failure to respond, or a full network	8%	17%	7%	5%
Percentage of providers that submitted an initial application and completed the process	89%	90%	91%	94%
Percentage of providers who submitted a complete application, but declined the offer of a contract from the carrier	0%	0%	0%	0%
Percentage of providers that completed the process and executed a contract	81%	73%	84%	89%

b. HMO Credentialing Rates

Credentialing Data Point	M/S Facility	MH/SUD Facility
Mean number of days from first submission of an application to the later of the effective date or date of execution of contract	4	6
Median number of days from first submission of an application to the later of the effective date or date of execution of contract	3	3
Number of providers that submitted an initial application	153	19
Number of providers that submitted an initial application, but withdrew before completing the credentialing process, or failed to complete the credentialing process by not responding	0	0
Number of providers that submitted an initial application that were denied/rejected due to a full network	0	0
Number of providers that submitted an initial application that were denied/rejected based on other reasons other than their withdrawal, failure to respond, or a full network (e.g., ineligible, incorrect licensure, already participating)	0	0
Number of providers that submitted a complete application and did not subsequently withdraw	153	19
Number of providers who submitted a complete application, but declined the offer of a contract from the carrier	0	0
Number of providers that completed the process and executed a contract	153	19
Percentage of providers that submitted an initial application, but withdrew before completing the credentialing process, or failed to complete the credentialing process by not responding	0%	0%

Credentialing Data Point	M/S Facility	MH/SUD Facility
Percentage of providers that submitted an initial application that were rejected due to a full network	0%	0%
Percentage of providers that submitted an initial application, but were denied/rejected for any other reasons other than their withdrawal, failure to respond, or a full network	0%	0%
Percentage of providers that submitted an initial application and completed the process	100%	100%
Percentage of providers who submitted a complete application, but declined the offer of a contract from the carrier	0%	0%
Percentage of providers that completed the process and executed a contract	100%	100%

Credentialing Data Point	M/S Physician	MH/SUD Physician (Psychiatrist)	M/S Non-Physician Provider	MH/SUD Non-Physician Provider
Mean number of days from first submission of an application to the later of the effective date or date of execution of contract	34	35	31	35
Median number of days from first submission of an application to the later of the effective date or date of execution of contract	33	27	30	33
Number of providers that submitted an initial application	9,203	382	2,670	7,736
Number of providers that submitted an initial application, but withdrew before completing the credentialing process, or failed to complete the credentialing process by not responding	1,021	36	255	429
Number of providers that submitted an initial application that were denied/rejected due to a full network	0	0	0	0
Number of providers that submitted an initial application that were denied/rejected based on other reasons other than their withdrawal, failure to respond, or a full network (e.g., ineligible, incorrect licensure, already participating)	704	66	193	370
Number of providers that submitted a complete application and did not subsequently withdraw	8,182	346	2,415	7,307
Number of providers who submitted a complete application, but declined the offer of a contract from the carrier	0	0	0	0
Number of providers that completed the process and executed a contract	7,476	280	2,222	6,906
Percentage of providers that submitted an initial application, but withdrew before completing the credentialing process, or failed to complete the credentialing process by not responding	11%	9%	10%	6%

Credentialing Data Point	M/S Physician	MH/SUD Physician (Psychiatrist)	M/S Non-Physician Provider	MH/SUD Non-Physician Provider
Percentage of providers that submitted an initial application that were rejected due to a full network	0%	0%	0%	0%
Percentage of providers that submitted an initial application, but were denied/rejected for any other reasons other than their withdrawal, failure to respond, or a full network	8%	17%	7%	5%
Percentage of providers that submitted an initial application and completed the process	81%	73%	83%	89%
Percentage of providers who submitted a complete application, but declined the offer of a contract from the carrier	0%	0%	0%	0%
Percentage of providers that completed the process and executed a contract	81%	73%	83%	89%

2. Justification and Analysis

CareFirst reviewed provider and facility credentialing data at the network level for both PPO and HMO products to assess whether M/S and MH/SUD providers and facilities are credentialed using comparable operational processes and outcomes. The review considered facility credentialing outcomes separately from practitioner credentialing outcomes and, for practitioners, further distinguished between physicians and non-physician providers to account for differences in credentialing pathways and provider types.

For facilities, the PPO and HMO data show comparable outcomes across M/S and MH/SUD facilities. In both networks, the mean number of days from first submission of an application to the later of the effective date or contract execution was 4 days for M/S facilities and 6 days for MH/SUD facilities, while the median was 3 days for both M/S and MH/SUD facilities. Facility application volume was higher for M/S facilities than MH/SUD facilities, but completion and contracting outcomes were identical: 153 of 153 M/S facilities and 19 of 19 MH/SUD facilities completed the process and executed a contract in both the PPO and HMO data. No facilities withdrew, failed to respond, were denied due to a full network, were denied for other reasons, or declined an offered contract. CareFirst maintains an open network; therefore, no facilities were denied access on the basis of the network being “full.”

For practitioners, the current PPO and HMO data provide a new breakout between physicians and non-physician providers. In the PPO data, the mean credentialing timeframe was 34 days for M/S physicians, 35 days for MH/SUD physicians, 32 days for M/S non-physician providers, and 35 days for MH/SUD non-physician providers. Median timeframes were also comparable: 32 days for M/S physicians, 27 days for MH/SUD physicians, 31 days for M/S non-physician providers, and 33 days for MH/SUD non-physician providers. In the HMO data, the mean credentialing timeframe was 34 days for M/S physicians, 35 days for MH/SUD physicians, 31 days for M/S non-physician providers, and 35 days for MH/SUD non-physician providers. Median timeframes were 33 days for M/S physicians, 27 days for MH/SUD physicians, 30 days for M/S non-physician providers, and 33 days for MH/SUD non-physician providers. These results show that MH/SUD physician timeframes are substantially comparable

to M/S physician timeframes, and MH/SUD non-physician provider timeframes are substantially comparable to M/S non-physician provider timeframes.

The approval and contracting outcomes also support comparability and demonstrate that the credentialing process is not applied more stringently to MH/SUD providers. In the PPO data, 73% of MH/SUD physicians and 89% of MH/SUD non-physician providers completed the process and executed a contract, compared to 81% of M/S physicians and 84% of M/S non-physician providers. In the HMO data, 73% of MH/SUD physicians and 89% of MH/SUD non-physician providers completed the process and executed a contract, compared to 81% of M/S physicians and 83% of M/S non-physician providers. Although MH/SUD physicians had a higher denial/rejection rate for other reasons than M/S physicians in both PPO and HMO data, MH/SUD non-physician providers had lower withdrawal, denial/rejection, and higher completed-contract rates than M/S non-physician providers. No practitioners were denied because of a full network, and no practitioners who submitted a complete application declined an offered contract. Overall, the data does not indicate that CareFirst applies credentialing requirements more stringently to MH/SUD providers or facilities than to comparable M/S providers or facilities in operation.

The “In-Network MH/SUD Providers and Facilities Data Collection Table” reports the following record exactly as presented: In-Network MH/SUD Providers and Facilities Data Collection; Classification / Sub-classification Entity Type Total MH/SUD Providers or Facilities Identified Number In-Network Percentage In-Network Data Period Data Source / System Methodology, Definitions, and Notes; Outpatient, Office (Professional) Professional providers 18,050 12,582 69.7% PDMES Definition of provider; distinct provider counting method; practitioner identifier used; duplicate and multi-location handling; applicable network/product; exclusions.; Outpatient, All Other (Professional) Professional providers 18,050 12,582 69.7% Included specialties and services; distinct provider counting method; practitioner identifier used; duplicate and multi-location handling; applicable network/product; exclusions.; Outpatient, All Other (Facility) Facilities 9 9 100.0% Included facility types; facility identifier used; individual location versus organizational entity counting method; applicable network/product; exclusions.; Subacute Inpatient (Professional) Professional providers 18,050 12,582 69.7% Included practitioner types; definition of subacute services; distinct provider counting method; practitioner identifier used; applicable network/product; exclusions.; Acute Inpatient (Professional) Professional providers 18,050 12,582 69.7% Included practitioner types; definition of acute inpatient services; distinct provider counting method; practitioner identifier used; applicable network/product; exclusions.; Subacute Inpatient (Facility) Facilities 70 19 27.1% Included facility types; definition of subacute inpatient facility; facility identifier and location counting method; applicable network/product; exclusions.; Acute Inpatient (Facility) Facilities 9 9 100.0% Included facility types; definition of acute inpatient facility; facility identifier and location counting method; applicable network/product; exclusions.; Total, if an unduplicated aggregate is requested Providers and facilities 18,129 12,610 69.6% Do not sum classification rows unless duplicates across classifications have been removed. Document the unduplicated aggregate methodology.. These MH/SUD provider and facility results describe the evidence used to assess the design and operation of the Network Adequacy NQTL; counts and percentages are network-composition measures and are not treated as access or adequacy outcomes unless the table expressly identifies them as such. The M/S information stated in this section supplies comparator evidence only for the common measures expressly reported. The reported geographic or access measures are evaluated on their stated terms and are not converted into an unstated standard. Any adequacy determination is confined to the threshold or standard expressly stated in the record. The documented limitation confines the inference that can be drawn from the data. The table shows a warning sign or material disparity only if its stated comparison expressly identifies one; no disparity is inferred from counts alone.

V. Findings and Conclusions

The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply the credentialing requirements to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the credentialing requirements to M/S benefits; and (2) CareFirst complies with the relevant data requirements under the MHPAEA Final Rules.

Under the terms of the plan as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying credentialing requirements to MH/SUD providers and facilities are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the credentialing requirement with respect to M/S providers and facilities. While there is variation in the accreditation bodies for facilities and board certifications for providers, this is purely due to different accreditation and regulatory bodies overseeing these reviews and approvals for the various M/S and MH/SUD specialties and therefore is not more stringent for MH/SUD specialties. Furthermore, the requirements for the application, licensure, education and training, and board certifications are all determined by state and federal law for both M/S and MH/SUD providers and facilities. In sum, there are no factors, evidentiary standards, or sources applied to MH/SUD providers or facilities which are not also applied to M/S providers or facilities.

Operationally, the current PPO and HMO data support comparability across M/S and MH/SUD facilities and practitioners. For facilities, M/S and MH/SUD outcomes were substantially comparable in both networks. The mean timeframe was 4 days for M/S facilities and 6 days for MH/SUD facilities, and the median timeframe was 3 days for both M/S and MH/SUD facilities. In both PPO and HMO data, 153 of 153 M/S facilities and 19 of 19 MH/SUD facilities completed the process and executed a contract, with no withdrawals, non-responses, full-network denials, other denials, or declined contracts.

For practitioners, the revised data further supports comparability when physicians and non-physician providers are evaluated separately. In the PPO data, mean credentialing timeframes were 34 days for M/S physicians, 35 days for MH/SUD physicians, 32 days for M/S non-physician providers, and 35 days for MH/SUD non-physician providers. In the HMO data, mean credentialing timeframes were 34 days for M/S physicians, 35 days for MH/SUD physicians, 31 days for M/S non-physician providers, and 35 days for MH/SUD non-physician providers. Median timeframes were also comparable across categories, with MH/SUD physician median timeframes lower than M/S physician median timeframes in both networks and MH/SUD non-physician provider median timeframes closely aligned with M/S non-physician provider median timeframes.

The contracting outcomes likewise do not indicate more stringent application to MH/SUD providers. In both PPO and HMO data, no practitioners were denied because of a full network and no practitioners who submitted a complete application declined an offered contract. MH/SUD non-physician providers had higher completed-contract rates than M/S non-physician providers in both networks. Although MH/SUD physicians had a higher denial/rejection rate for reasons other than withdrawal, failure to respond, or full network than M/S physicians, the overall timeframe and contracting data, including the separate non-physician provider results, do not demonstrate that the credentialing requirement is applied more stringently to MH/SUD providers in operation.

Integrated with the as-written terms and in-operation evidence in this Network Adequacy section, the table does not identify an operational outcome demonstrating that a network adequacy process, strategy, evidentiary standard, or other factor is applied more stringently to MH/SUD than to M/S. This conclusion is confined to the M/S comparator and common measures expressly stated in the section and does not extend beyond the table's scope. It is also confined to the geographic or access measures actually reported and does not substitute counts for a different member-access outcome.

VI. Required Certification

CareFirst certifies that the foregoing comparative analysis of the Credentialing—Provider and Facility NQTL was prepared for the Virginia fully insured coverage identified in this report and was reviewed by individuals with appropriate knowledge of the plan terms, policies, procedures, factors, evidentiary standards, operational practices, supporting documentation, and relevant data addressed in the analysis. The analysis applies to the CareFirst entities identified in this report as NAIC 53007 and NAIC 9602 to the extent the NQTL is designed and administered as described in this analysis.

To the best of CareFirst's knowledge and based on the information, documentation, and data reviewed as of the report's version date, this comparative analysis is accurate and complete in all material respects and demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the Credentialing—Provider and Facility NQTL to mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, those used to design and apply the NQTL to medical/surgical benefits, as written and in operation. CareFirst will maintain supporting documentation and will update or supplement the analysis if a material change, newly identified data limitation, or corrective action affects this conclusion.

IN-NETWORK REIMBURSEMENT (PROVIDER AND FACILITY)

Overview

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the network reimbursement requirement to mental health or substance use disorder ("MH/SUD") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the network reimbursement requirement to medical surgical ("M/S") benefits.

I. Description of the In-Network Reimbursement NQTL

CareFirst applies standard methodologies to establish reimbursement rates for participating network providers and facilities. For all provider types, participating providers agree to accept a plan allowance (also called an 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. For facility reimbursement, CareFirst provides several methods dependent upon the respective Hospital's Participation Agreement. These include:

- 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

CareFirst determines reimbursement for Limited Licensed Providers (LLPs), including Board Certified Behavior Analysts (BCBAs), at a percentage of the base physician fee schedule. This reimbursement policy applies to all CareFirst provider contracts.

LLP Types	**Related Percentages**
Nurse midwife	90%
Nurse practitioner	85%
Board certified behavior analyst (BCBA)	75%
Dietician/nutritionist	75%
Licensed professional counselor, licensed marriage and family therapist, licensed alcohol and drug therapist	75%
Naturopathic provider	75%
Psychiatric nurse	75%
Licensed clinical social worker	75%
Lactation consultant	75%
Athletic Trainers	75%
Music Therapists	75%

At this time, CareFirst does not use Artificial Intelligence (AI) to make decisions regarding reimbursement rates.

A. Identification of the NQTL

i. Plan/Coverage Terms Regarding In-Network Reimbursement

The Plan document contains the following sections regarding in-network reimbursement. These in-network reimbursement sections apply to both M/S benefits and MH/SUD benefits, and do not differentiate between M/S and MH/SUD benefits:

- Definitions
- General Provisions
- Inter-Plan Arrangements Disclosure Amendment

Proprietary and Confidential Information of CareFirst, Inc. and its affiliates and subsidiaries. This information shall only be disclosed as required by law.

(*Source:* Plan EOC)

ii. Policies/Guidelines/Other Documents Describing In-Network Reimbursement

Network reimbursement appears or is described in the following documents:

- Compensation and Premium Disclosure Statement, pp. 2-3
- CareFirst Provider Manual, pp. 59-68
- Description of Covered Services, pg. B-32
- Provider Scorecard Methodology

iii. Identification of All MH/SUD Benefits and M/S Benefits to In-Network Reimbursement Rates Apply

All M/S and MH/SUD in-network benefits are subject to in-network reimbursement rates.

II. Identification and Definition of the Factors and Evidentiary Standards Used in the Design and Application of In-Network Reimbursement Rates

A. Factors and Evidentiary Standards for Standard Fee Schedules (Facilities)

Factor 1	**Reimbursement Laws**
Definition	Any state established reimbursement requirements.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Other
Description	Where applicable, CareFirst follows state laws regarding required reimbursement rates for covered services.
Source(s) of Factor	• 12 VAC 30 (30-8-30 and 30-70)
Evidentiary Standards and Applicable Thresholds	State reimbursement laws.
Source(s) of Evidentiary Standards	• 12 VAC 30 (30-8-30 and 30-70)

Factor 2	**Relative Value Units**
Definition	The Relative Value Units (RVUs) as established by CMS.

Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Other
Description	CareFirst relies upon industry standard RVUs and per diem rates as established by CMS when determining reimbursement rates.
Source(s) of Factor	• CMS RVUs • CMS Per Diem Rates
Evidentiary Standards and Applicable Thresholds	CMS RVUs:(Work RVU x work GPCI) + (PE RVU x PE GPCI) + (MP RVU x MP GPCI) x CF = CMS benchmark rate. The work RVU = relative time and intensity associated with furnishing services. The Practice Expense (PE) RVU = the costs of maintaining a practice. The Malpractice (MP) RVU = 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. The calculation is followed as opposed to a specific threshold.
Source(s) of Evidentiary Standards	• CMS Guidelines

Factor 3	**Market Rates per Geographic Region**
Definition	Applicable market rates for the services based on geographic region as defined by CMS.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Other
Description	CareFirst relies upon the geographic market rates as defined by CMS to determine reimbursement rates.
Source(s) of Factor	• External market rates i.e., Truven Health Analytics • CMS rates as defined by Medicare geographic region (MPFS or MAC for local jurisdictions)

Evidentiary Standards and Applicable Thresholds	CareFirst covers three distinct service areas (DC, Baltimore Metro, and Rural MD). These service areas match the CMS localities (see the locality list by county below for further details).
Source(s) of Evidentiary Standards	• CMS rates by CMS established region • Internal claims data

Factor 4	**Competitive Intelligence**
Definition	Information about industry reimbursement rates or evidence of cost of care as provided by industry benchmarking data or provider application.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Other
Description	CareFirst relies upon industry benchmarking to set reimbursement rates.
Source(s) of Factor	• Industry benchmarking data i.e., Truven, IDB Watson
Evidentiary Standards and Applicable Thresholds	Provider application and 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 (IDB Watson and Truven).
Source(s) of Evidentiary Standards	• Provider application and correspondence • Industry benchmarking data

B. Factors and Evidentiary Standards for Standard Fee Schedules (Providers)

Factor 1	**Medicare Reimbursement Rates**
Definition	Medicare reimbursement rates are the basis for the standard fee schedule.
Application Benefit Classification(s)	• In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst uses published Medicare reimbursement rates to establish standard fee schedules annually.
Source(s) of Factor	• CMS rates as defined by Medicare geographic region (MPFS or MAC for local jurisdictions)
Evidentiary Standards and Applicable Thresholds	Reimbursement is based on Medicare reimbursement rates. Behavioral health services: Should be no less than Medicare when possible. At a minimum, the percentage of Medicare used for these services should be no less than the methodology used for E/M office visits codes (99202-99215). The work RVU = relative time and intensity associated with furnishing services. The Practice Expense (PE) RVU = the costs of maintaining a practice. The Malpractice (MP) RVU = 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.
Source(s) of Evidentiary Standards	• CMS rates

Factor 2	**Competitive Intelligence**
Definition	Awareness of industry benchmarking data and market evidence of reimbursement rates, including any additional specialized service need or unique market demand. Competitive Intelligence is generally applied when information is submitted by providers through market validation. This factor relies on the provider landscape and member needs, and could be impacted by geography, abundance or lack of providers able to handle specialized services, or member needs and accessibility.
Application Benefit Classification(s)	• In-Network Outpatient Office • In-Network Outpatient Other

Description	CareFirst relies upon industry standard RVUs and per diem rates as established by CMS when determining reimbursement rates.
Source(s) of Factor	• Industry benchmarking data i.e., Truven, IDB Watson
Evidentiary Standards and Applicable Thresholds	Provider application and 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 (IDB Watson and Truven).
Source(s) of Evidentiary Standards	• Provider application and correspondence • Industry benchmarking data

Factor 3	**Market Rates per Geographic Region**
Definition	Applicable market rates for the services based on geographic region as defined by CMS.
Application Benefit Classification(s)	• In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst relies upon the geographic market rates as defined by CMS to determine reimbursement rates.
Source(s) of Factor	• External market rates i.e., Truven Health Analytics • CMS rates as defined by Medicare geographic region (MPFS or MAC for local jurisdictions)
Evidentiary Standards and Applicable Thresholds	CareFirst covers three distinct service areas (DC, Baltimore Metro, and Rural MD). These service areas match the CMS localities (see the locality list by county below for further details). The percentage of Medicare used for MH/SUD services should be no less than the methodology used for E/M office visit codes (99202–99215).
Source(s) of Evidentiary Standards	• CMS rates by CMS established region • Internal claims data

Factor 4	**Network Type**
Definition	Whether the network type is a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO).
Application Benefit Classification(s)	• In-Network Outpatient Office • In-Network Outpatient Other

Description	The type of network determines whether members can seek claim payment for non-emergency covered services from an out-of-network provider.
Source(s) of Factor	• CareFirst Internal Policy
Evidentiary Standards and Applicable Thresholds	HMO and PPO plans have rate differentials due to contracting. The rate differentials are the same among HMO and PPO for M/S and MH/SUD services. There is on average a 5% difference in these rates when comparing HMO and PPO network options.
Source(s) of Evidentiary Standards	• Contracting arrangements

Factor 5	**Training, Expertise, and Licensure**
Definition	Assessment of provider specialty, license type (MD or non-MD), training, education, board certification, and experience.
Application Benefit Classification(s)	• In-Network Outpatient Office • In-Network Outpatient Other
Description	Providers' level of training and experience influence reimbursement rates in line with CMS guidelines.
Source(s) of Factor	• CMS Guidelines
Evidentiary Standards and Applicable Thresholds	Provider specialty, license type (MD or non-MD), training, education, board certification, and experience affect reimbursement rates. CareFirst follows industry standards for differences in these rates. There is no threshold because industry standards are followed.
Source(s) of Evidentiary Standards	• CMS guidelines • Industry benchmarking data • Provider application • Medicare reductions for limited licensed provider

C. Factors and Evidentiary Standards for Negotiated Rates (Providers and Facilities)

All factors, evidentiary standards, and sources listed above that apply to develop standard fee schedules for facilities and providers apply to negotiated reimbursement rates and re-negotiated rates. Additionally, the below factors, evidentiary standards, and sources apply to the design and application of reimbursement rate negotiations and renegotiations beyond the established standard fee schedule.

Factor 1	**Network Need**
Definition	An identified network gap demonstrates a need to negotiate more aggressively for the given specialty or expertise. Any additional specialized service need or unique market demand is applied when information is submitted by providers through market validation. Network need relies on the provider landscape and member needs and could be impacted by geography, abundance or lack of providers able to handle specialized services, or member needs and accessibility.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Other
Description	CareFirst relies upon regular network adequacy reporting to identify potential coverage gaps and address them through ongoing reimbursement negotiation.
Source(s) of Factor	• Geo-access reporting such as time/access/distance standards • Network adequacy reports • Provider submitted market demand data/reports
Evidentiary Standards and Applicable Thresholds	Established network need is identified through reporting and internal analysis. This includes any gaps identified by members, internally, or by regulatory bodies. CareFirst follows time, access, and distance standards established by the MIA, as well as industry benchmarks such as NCQA standards. Any gaps identified through these processes are promptly addressed, and higher reimbursement rates are typically offered to fill identified gaps. For example, four CPT codes allow higher reimbursement for in-network psychiatrists to incentivize more providers to join the network. This rate increase was implemented because the number of nonparticipating providers in this specialty was larger than in other specialties. **Thresholds:** • CareFirst aims to maintain a 98% in-network claim percentage. If that number drops below 98%, CareFirst increases recruiting and contracting efforts. • Through member complaints, CareFirst identifies network inadequacies and works to add providers and facilities to ensure members have access to care. • Upon receiving CAHPS survey results, network adequacy feedback is forwarded to the CareFirst Contracting team to research and recruit providers.

	• On a quarterly basis, a network disruption report is generated to highlight gaps in network adequacy. Once providers are identified, the report is sent to the CareFirst Contracting team for outreach and recruitment into the CareFirst network. • After 10 claims and/or two or more Single Case Agreements (SCAs) are received within three months, CareFirst will contact the provider to begin discussions about network participation. CareFirst will conduct outreach by phone, mail, and email. If the provider does not respond, CareFirst will make up to 10 attempts. In addition, if an SCA is received after outreach has been attempted, CareFirst will use that communication as another opportunity to encourage the provider to join the network.
Source(s) of Evidentiary Standards	• Geo-access reporting such as time/access/distance standards • NCQA Network Adequacy standards • Member complaints specific to network adequacy or access concerns

Factor 2	**Facility or Provider Volume Capabilities**
Definition	When a facility or provider has capacity to serve a large number of members, size will be considered.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Other
Description	Potential volume of the facility in areas facing network shortages is considered to create the greatest accessibility increase for members.
Source(s) of Factor	• Geo-access reporting such as time/access/distance standards • Network adequacy reports
Evidentiary Standards and Applicable Thresholds	Provider or facility size/capacity can be a negotiation factor based on network need. If the facility serves a larger portion of the member population, it is taken into consideration as a negotiation factor. CareFirst can negotiate higher reimbursement rates for providers that fulfill a specific need/services and practices in rural areas. In these instances, we negotiate on average 10% higher than our standard rates. CareFirst will do this to increase access to care to members that need to be served.
Source(s) of Evidentiary Standards	• Geo-access reporting such as time/access/distance standards • Network adequacy reports

Factor 3	**Special Investigations Unit (SIU) Activity**

Definition	Whether a provider or facility has a case or history with SIU (i.e., fraud or abuse) is considered before engaging in re-negotiations.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Other
Description	Facilities with SIU history are not inherently excluded from re-negotiation, but past cases are considered when determining whether a provider or facility have proper protocols in place to reduce fraud, waste, and abuse.
Source(s) of Factor	• SIU activity of fraud/waste/abuse
Evidentiary Standards and Applicable Thresholds	CareFirst utilizes Special Investigations Unit (SIU) activity to determine fraud waste and abuse cases or history with the specific facility or provider. This information is considered when deciding to engage in re-negotiation. **Threshold:** Any SIU activity (1 case or more).
Source(s) of Evidentiary Standards	• Fraud Waste and Abuse activity as identified by SIU

Factor 4	**Quality Outcomes Data**
Definition	Quality outcome scores in the provider or facility scorecard.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Other
Description	Provider or facility quality outcome scores are reviewed during re-negotiation to maintain high-quality provider and facilities and remove low-quality providers and facilities.
Source(s) of Factor	• CareFirst quality data
Evidentiary Standards and Applicable Thresholds	Provider and Facility Quality Outcomes are collected via provider scorecards. These scorecards are developed from CareFirst quality data. There are no thresholds because the scoring methodology is the same for M/S and MH/SUD.
Source(s) of Evidentiary Standards	• CareFirst quality data • Provider and Facility scorecards

Factor 5	**Enhanced Access Needs**

Definition	An identified enhanced-access need may warrant more aggressive negotiation for a given specialty or area of expertise. An enhanced-access need exists when an area has limited options for a specific specialty or expertise and additional access is necessary to support a member's right to choose.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Other
Description	This factor is considered when a provider or facility has not participated in the network for at least one year.
Source(s) of Factor	• Geo-access reporting such as time/access/distance standards • Network adequacy reports
Evidentiary Standards and Applicable Thresholds	If the provider serves certain areas eligible for enhanced access, such as rural areas, less populated areas, or areas where only 1 provider exists for a specific service CareFirst can negotiate higher reimbursement rate. CareFirst negotiates on average 10% higher than our standard rates.
Source(s) of Evidentiary Standards	• Geo-access reporting such as time/access/distance standards • Network adequacy reports • Single Case Agreement (SCA) data

A. Processes

On an annual basis, CareFirst evaluates In-Network provider professional reimbursement and facility reimbursement for M/S and MH/SUD, as compared to CMS benchmarks, to determine if fee schedule adjustments are needed. Reimbursement is maintained by geographic region and utilizes the provider's primary location for each practice affiliation. Fee schedules are updated periodically, in response to market research, and/or in response to industry benchmark changes, such as changing CMS rates. When changes occur, CareFirst will notify the impacted providers in accordance with contractual agreements. M/S and MH/SUD providers and facilities are reimbursed at 100% of agreed upon contracted rates and fee schedules using current procedural terminology (CPT) codes or healthcare common procedure coding system (HCPCS) codes. M/S and MH/SUD Emergency services are always reimbursed as in-network at 100% of the fee schedule, unless state or federal mandated amount supersedes.

Participating hospitals that are not located in Maryland are reimbursed for approved inpatient services using a methodology similar to Medicare's diagnostic-related group (DRG) payment method. This method uses the principal and secondary diagnoses and the principal and secondary procedures, in addition to the member's age, gender and discharge status to assign a DRG. Reimbursement is calculated using the DRG and the standard average length of stay. Facilities under the purview of Maryland's HSCRC, including acute care facilities and private psychiatric hospitals, would be reimbursed according to the HSCRC model.

B. Strategy

CareFirst develops and maintains a standard fee schedule for use with M/S and MH/SUD providers, applied to both INN and OON providers. The fee schedule is updated through ongoing evaluation and maintenance, (e.g., AMA code additions/deletions), with adjustments/modifications made

typically once per year. In evaluating the standard fee schedule, CareFirst relies on Medicare rates as the primary source. Medicare RVUs incorporate the provider's location, specialty, license type, board certification, education, relevant training, and services.

Reimbursement analysis includes ensuring that the percentage of CMS reimbursement for M/S does not exceed the percentage of CMS reimbursement for MH/SUD. This analysis is performed by a CareFirst Reimbursement Analyst and confirmed by the Manager of Provider Reimbursement; both are part of the Health Services Division Network Operations Team. Additionally, external market rates are used to ensure that CareFirst rates are consistent with reimbursement in the provider's geographic area. The Manager of Provider Reimbursement and the Contracting team work together with the analysts before finalizing rates. The Provider Reimbursement team includes certified professional coders and individuals who have been involved in rate-setting decisions since at least 2009.

CareFirst performs annual audits of reimbursement rates and compares medical and surgical specialties to mental health and substance use disorder specialties. Reimbursement data for the 2024 plan year is not finalized until end of July. Therefore, the most recent analysis was performed in 2024 for reimbursement data from 2023. As noted below, the 2024 analysis showed that some M/S and MH/SUD rates were lower than Medicare rates which led CareFirst to institute a policy to reimburse all MH/SUD providers at or above 100% of Medicare whenever possible. If it is not possible, the reimbursement rate should be increased to be at least the same percentage of Medicare as a M/S counterpart/equivalent. As indicated in the data below, both M/S and MH/SUD services are below 100% of Medicare. Therefore, there is not a significant parity concern. However, CareFirst improved reimbursement rates in 2024 and continues to evaluate and adjust rates to ensure that there is no question of parity in reimbursement rates.

If an M/S or MH/SUD provider does not accept the standard fee schedule, additional factors may be considered in negotiating contract terms upward. CareFirst’s network demand for the given specialty/services, the size of the provider group, and the number of members served may be considered. In negotiations, the provider is often able to share a desired fee schedule arrangement, based on competitive rates offered to them. This competitive market data is considered by CareFirst. If a contracted provider wishes to re-negotiate their contract, in addition to the above methodologies, CareFirst will also evaluate the provider's SIU activity (Fraud, Waste, and Abuse), and provider quality results.

C. Relationship Between Factors

All factors in the analyses are considered equally, and no single factor carries more weight than another. Additionally, no factors were considered but rejected. Lastly, all factors apply to both M/S and MH/SUD classified services.

III. Demonstration of Comparability and Stringency as Written

This section demonstrates that in each classification, under the terms of the plan as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying in-network reimbursement to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the in-network reimbursement with respect to M/S benefits.

In all fee schedule scenarios, whether setting standard contract rates, negotiating, or in re-negotiating a continuing contract, the same factors, evidentiary standards, and sources are used for M/S and MH/SUD, as shared in steps one through three. Additionally, CareFirst now has a Community and Standard fee schedule. Community is defined as those providers with no negotiated rates as part of their contractual agreement.

Standard is defined as those providers who have negotiated rates as part of their contractual agreement. This applies to all specialties in the same manner.

CareFirst applies the HSCRC rate methodology to inpatient-acute and other facilities as required under Maryland law (see §15-604 of MD Insurance Art.). When a facility is contracted via HSCRC, no additional factors are applied in determining reimbursement, and no negotiations occur. For facilities outside of Maryland that are not contracted via HSCRC, the same factors, evidentiary standards, and sources apply for both M/S and MH/SUD. In many circumstances, the facility provides both M/S and MH/SUD services, and the contracts would be negotiated using the same methodology. When a facility provides only M/S or MH/SUD services, the same factors, evidentiary standards, and sources still apply, using CMS relatives as well as third-party market rates, to ensure comparability.

In sum, there are no factors, evidentiary standards, or sources applied to MH/SUD which are not also applied to M/S. Both provider and facility types follow the same hierarchy; if an HSCRC facility, payment methodology would follow the HSCRC requirements. If not an HSCRC facility, or if a provider, the shared factors, evidentiary standards, and sources would be applied in setting standard rates, as well as in negotiating contracts. Accordingly, CareFirst finds that in-network reimbursement is no more stringently applied to MH/SUD in-network reimbursement, than to M/S in-network reimbursement, in writing.

IV. Demonstration of Comparability and Stringency In Operation

This section demonstrates that in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying in-network reimbursement to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying in-network reimbursement with respect to M/S benefits.

A. Explanation of how CareFirst Evaluates Comparability

Below is a comprehensive explanation of how CareFirst evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying in-network reimbursement to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying in-network reimbursement with respect to M/S benefits. In developing fee schedules, CareFirst analyzes many sources of data including Medicare changes and allowances, provider complaints and correspondence, industry benchmarking data, and competitive research.

CareFirst evaluates professional reimbursement 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. Reimbursement amounts are maintained by geographic region. There are three geographic regions in place for pricing services covered under CareFirst products: The District of Columbia metropolitan area (which includes parts of Northern Virginia), the Baltimore metropolitan area, and rural Maryland. Application of a geographic pricing region is based on the location of the practitioner’s primary location for each practice affiliation. The table below outlines the states and counties for each region:

Applicable Geographic Region	State and County	
District of Columbia	**D.C. and Maryland Counties:** Montgomery, Prince George	**Virginia Counties:** Alexandria City, Arlington, Fairfax City, Fairfax, Falls Church City, Fauquier, Loudoun, Manassas City, Manassas Park City, Prince William, Spotsylvania, Stafford

B. Documentation of Outcomes

1. Evaluation of Relevant Data

a. In-Network Outpatient PPO Reimbursement Rates

Specialty	CPT Code	Avg. Plan Rate for DC PPO	Medicare Rate for DC PPO	Plan Rate as a Percentage of Medicare
Cardiologists	99203	$165.49	$122.83	135%
Cardiologists	99213	$99.07	$100.28	99%
Chiropractor	99203	$95.57	$122.83	78%
Chiropractor	99213	$74.94	$100.28	75%
Dermatologists	99203	$106.61	$122.83	87%
Dermatologists	99213	$77.70	$100.28	77%
Endocrinologists	99203	$132.43	$122.83	108%
Endocrinologists	99213	$84.99	$100.28	85%
Gastroenterologist	99203	$149.44	$122.83	122%
Gastroenterologist	99213	$97.24	$100.28	97%
Internists MD	99203	$143.00	$122.83	116%
Internists MD	99213	$100.25	$100.28	100%
LCSW	90791	$139.42	$136.58	102%
LCSW	90832	$68.62	$64.45	106%
Neurologists	99203	$138.46	$122.83	113%
Neurologists	99213	$95.46	$100.28	95%
Occupational Therapy	97165	$116.82	$113.16	103%
Occupational Therapy	97166	$104.49	$113.16	92%
Occupational Therapy	97167	$103.13	$113.16	91%
Occupational Therapy	97168	$74.74	$78.68	95%
Orthopedic Surgery	99203	$147.07	$122.83	120%

Specialty	CPT Code	Avg. Plan Rate for DC PPO	Medicare Rate for DC PPO	Plan Rate as a Percentage of Medicare
Orthopedic Surgery	99213	$99.31	$100.28	99%
Pediatrician	99203	$149.45	$122.83	122%
Pediatrician	99213	$103.53	$100.28	103%
Physical Therapy	97161	$96.08	$110.07	87%
Physical Therapy	97162	$101.00	$110.07	92%
Physical Therapy	97163	$101.67	$110.07	92%
Physical Therapy	97164	$65.24	$76.38	85%
Podiatrists	99203	$107.59	$122.83	88%
Podiatrists	99213	$78.58	$100.28	78%
Psychiatrist	99203	$122.57	$122.83	100%
Psychiatrist	99213	$91.60	$100.28	91%
Psychologists	90791	$193.40	$182.11	106%
Psychologists	90832	$96.05	$85.93	112%

b. In-Network Outpatient HMO Reimbursement Rates

Specialty	CPT Code	Avg. Plan Rate for DC HMO	Medicare Rate for DC HMO	Plan Rate as a Percentage of Medicare
Cardiologists	99203	$148.85	$122.83	121%
Cardiologists	99213	$87.77	$100.28	88%
Chiropractor	99203	$90.97	$122.83	74%
Chiropractor	99213	$71.30	$100.28	71%
Dermatologists	99203	$99.50	$122.83	81%
Dermatologists	99213	$72.92	$100.28	73%
Endocrinologists	99203	$124.26	$122.83	101%
Endocrinologists	99213	$82.14	$100.28	82%
Gastroenterologist	99203	$138.96	$122.83	113%
Gastroenterologist	99213	$89.50	$100.28	89%
Internists MD	99203	$134.79	$122.83	110%
Internists MD	99213	$92.88	$100.28	93%
LCSW	90791	$134.28	$136.58	98%
LCSW	90832	$67.63	$64.45	105%
Neurologists	99203	$135.52	$122.83	110%

Specialty	CPT Code	Avg. Plan Rate for DC HMO	Medicare Rate for DC HMO	Plan Rate as a Percentage of Medicare
Neurologists	99213	$85.49	$100.28	85%
Occupational Therapy	97165	$105.21	$113.16	93%
Occupational Therapy	97166	$96.90	$113.16	86%
Occupational Therapy	97167	$94.30	$113.16	83%
Occupational Therapy	97168	$67.98	$78.68	86%
Orthopedic Surgery	99203	$138.65	$122.83	113%
Orthopedic Surgery	99213	$94.28	$100.28	94%
Pediatrician	99203	$141.06	$122.83	115%
Pediatrician	99213	$97.70	$100.28	97%
Physical Therapy	97161	$86.46	$110.07	79%
Physical Therapy	97162	$89.88	$110.07	82%
Physical Therapy	97163	$90.69	$110.07	82%
Physical Therapy	97164	$59.42	$76.38	78%
Podiatrists	99203	$100.49	$122.83	82%
Podiatrists	99213	$73.76	$100.28	74%
Psychiatrist	99203	$119.51	$122.83	97%
Psychiatrist	99213	$90.38	$100.28	90%
Psychologists	90791	$192.82	$182.11	106%
Psychologists	90832	$96.55	$85.93	112%

c. Standard vs. Negotiated Rates

In-Network Professional	M/S Provider	MH/SUD Provider
MD Professionals with Standard Rate	75%	80%
Non-MD Professionals with Standard Rate	75%	80%
Percent of Professionals with Standard Rate	75%	80%
MD Professionals with Negotiated Rate	25%	20%
Non-MD Professionals with Negotiated Rate	25%	20%
Percent of Professionals with Negotiated Rate	25%	20%

In-Network Facility	M/S Facility	MH/SUD Facility
Inpatient Facilities with Standard Rate	0%	0%
Outpatient Office Facilities with Standard Rate	0%	0%
Outpatient Other Facilities with Standard Rate	0%	0%
Emergency Facilities with Standard Rate	0%	0%
Percent Facilities with Standard Rate	0%	0%
Inpatient Facilities with Negotiated Rate	100%	100%
Outpatient Office Facilities with Negotiated Rate	100%	100%
Outpatient Other Facilities with Negotiated Rate	100%	100%
Percent Facilities with Negotiated Rate	100%	100%

2. Justification and Analysis

CareFirst develops reimbursement rates based on set geographic locations that match CMS localities for comparison purposes. M/S and MH/SUD reimbursement rates are comparable when evaluated as a percentage of Medicare and compared to providers with similar education, training, and/or certifications for similar services for participating providers enrolled in the PPO and/or HMO network. Providers that specialize in MH/SUD care include LCSWs, Psychologists, and Psychiatrists. The requisite education requirements for these provider types are master's degree, doctoral degree, and medical degree respectively. CareFirst compares these reimbursement rates to M/S specialties with the same education level requirements, including occupational therapists, chiropractors, and neurologists. CareFirst also considers outliers in the data sets given the variety of M/S specialties, including medical-degree specialties with rates above 100% of Medicare, such as orthopedic surgeons, and specialties with rates below 100% of Medicare, such as dermatologists and podiatrists.

Within the PPO network in the DC locality, LCSWs are reimbursed at 102% of the Medicare rate for CPT code 90791 and 106% of the Medicare rate for CPT code 90832. Psychologists are reimbursed at 106% of the Medicare rate for CPT code 90791 and 112% of the Medicare rate for CPT code 90832. Psychiatrists are reimbursed at 100% of the Medicare rate for CPT code 99203 and 91% of the Medicare rate for CPT code 99213. While the psychiatrist rate for CPT code 99213 is below the goal of reimbursing at the prevailing Medicare rate when possible, comparison to M/S specialties with similar education, training, and certification requirements does not indicate a parity concern. Occupational Therapists' reimbursement rates ranged from 91% to 103% of Medicare compared to 102% to 106% for LCSWs. Chiropractor reimbursement rates ranged from 75% to 78% of Medicare compared to 106% to 112% for Psychologists. Neurologist reimbursement rates ranged from 95% to 113% of Medicare

compared to 91% to 100% for Psychiatrists. Within the specialties requiring medical degrees, other M/S rates also varied, with dermatologists reimbursed at 77% to 87% of Medicare and orthopedic surgeons reimbursed at 99% to 120% of Medicare.

Within the HMO network in the DC locality, LCSWs are reimbursed at 98% of the Medicare rate for CPT code 90791 and 105% of the Medicare rate for CPT code 90832. Psychologists are reimbursed at 106% of the Medicare rate for CPT code 90791 and 112% of the Medicare rate for CPT code 90832. Psychiatrists are reimbursed at 97% of the Medicare rate for CPT code 99203 and 90% of the Medicare rate for CPT code 99213. While certain MH/SUD rates are below the goal of reimbursing at the prevailing Medicare rate when possible, comparison to M/S specialties with similar education, training, and certification requirements does not indicate a parity concern. Occupational Therapists' reimbursement rates ranged from 83% to 93% of Medicare compared to 98% to 105% for LCSWs. Chiropractor reimbursement rates ranged from 71% to 74% of Medicare compared to 106% to 112% for Psychologists. Neurologist reimbursement rates ranged from 85% to 110% of Medicare compared to 90% to 97% for Psychiatrists. Within the specialties requiring medical degrees, other M/S rates also varied, with dermatologists reimbursed at 73% to 81% of Medicare and orthopedic surgeons reimbursed at 94% to 113% of Medicare. Taken together, the DC PPO and DC HMO data show that MH/SUD reimbursement is generally comparable to or higher than similarly situated M/S comparator specialties, and that any rates below Medicare are not applied more stringently to MH/SUD than to M/S.

Additionally, CareFirst compared the top CPT, HCPCS, and revenue codes using the average billed amount, average allowed amount, and percentage of the billed amount paid. If a provider type had fewer than 10 billed codes, all available codes were included. The updated analysis combines the HMO and PPO results by taking an unweighted average of the plan-level values; claim-volume weights were not available in the workbook. Providers were grouped as physicians (psychiatrists and cardiologists) and nonphysicians (psychologists, social workers, and physical therapists) to support comparisons across generally similar levels of education and training.

The common physician codes for the Inpatient In-Network Provider classification were 99232 and 99233. For code 99232, psychiatrists had a combined average billed amount of $271.89 and average allowed amount of $158.18 (57.5% of billed charges), compared with cardiologists at $189.46 billed and $113.37 allowed (59.8%). For code 99233, psychiatrists averaged $230.02 billed and $128.50 allowed (55.9%), compared with cardiologists at $260.54 billed and $155.24 allowed (59.6%). Across each specialty's reported top inpatient codes, the simple average percentage of billed charges paid was approximately 56.9% for psychiatrists and 61.9% for cardiologists. The results show modest variation by code and plan type, but no consistent pattern of materially lower MH/SUD reimbursement.

The non-physician categories did not share a common top code across MH/SUD and M/S providers. Based on the available HMO and PPO results, psychologists were paid approximately 66% of billed charges and social workers approximately 70% on a simple plan-level basis. The workbook did not report inpatient physical therapist results, so a direct M/S non-physician comparison could not be completed. Subject to that data limitation and the absence of claim-volume weighting, the available inpatient INN professional data does not identify a reimbursement parity concern.

In the Outpatient Office INN Provider classification, the shared physician codes were 99213, 99214, and 99215. For 99213, psychiatrists averaged $158.61 billed and $95.96 allowed (60.5%), compared with cardiologists at $194.83 billed and $118.28 allowed (60.7%). For 99214, psychiatrists averaged $229.79 billed and $156.37 allowed (68.1%), compared with cardiologists at $275.95 billed and $162.26 allowed (58.8%). For 99215, psychiatrists averaged $405.35 billed and $209.23 allowed (51.6%), compared with cardiologists at $399.63 billed and $270.85 allowed (67.8%).

Results therefore vary by code: psychiatrist reimbursement is stronger for 99214, essentially equivalent for 99213, and lower as a percentage of billed charges for 99215. The prior discussion of historical rate increases is not used as a current-period assumption because the workbook reports observed reimbursement results rather than the underlying fee-schedule history.

The non-physician categories did not have a common top code that supported direct MH/SUD-to-M/S code matching. Across the reported top codes, psychologists were paid approximately 55.6% of billed charges and social workers approximately 50.6% on a simple combined-plan basis. The M/S categories generally showed lower percentages for many dermatology, chiropractic, and physical therapy services, although results varied by code and provider type. Average allowed amounts for MH/SUD non-physician services were also generally higher than those for chiropractic and physical therapy services. On balance, the current outpatient office INN data does not show a systematic reimbursement disadvantage for MH/SUD providers.

In the Outpatient Other INN Provider classification, the outpatient other physician code sets provide little direct overlap. In the PPO data, code 99215 appeared for both psychiatrists and cardiologists: psychiatrists averaged $255.72 billed and $143.13 allowed (56.0%), while cardiologists averaged $391.95 billed and $224.75 allowed (57.3%). The HMO cardiology top-code set did not include 99215, so a combined HMO/PPO matched-code comparison is not available for that service. The remaining physician results are directionally similar but involve different services, limiting a parity inference based on code-level reimbursement alone.

The non-physician outpatient other results are sparse and do not support broad matched-code comparisons. Psychologists and social workers generally show allowed-to-billed percentages within or above the ranges reported for the limited M/S categories, but physical therapist data is absent and dermatology and chiropractic results are limited. The available results do not indicate a systematic MH/SUD reimbursement disadvantage.

In the Emergency Services classification, CareFirst compared the reported emergency CPT or revenue codes using average billed amount, average allowed amount, and percentage of billed charges paid. For code 99285, which appears in both MH/SUD and M/S results across HMO and PPO, MH/SUD services averaged $464.47 billed and $298.02 allowed (65.0%), compared with M/S services at $435.51 billed and $309.12 allowed (70.5%). Other emergency codes are not consistently shared across the two classifications. This matched code shows a somewhat lower allowed-to-billed percentage for MH/SUD but a similar dollar-level allowed amount; in isolation, it does not establish a systematic reimbursement disparity.

Land ambulance results are identical between MH/SUD and M/S within each plan for the reported mileage and base-service comparisons, which supports parity for those services. The combined HMO/PPO percentage paid was approximately 66.8% for A0425, 67.0% for the $750 base-service comparison, and 68.6% for the $950 base-service comparison. The workbook reports no MH/SUD claims for air or water ambulance services and no reported reimbursement values for mobile crisis response, regional crisis stabilization unit (RCSU), or crisis receiving center services. Those categories therefore cannot be evaluated.

In the Inpatient Facilities classification, combined MH/SUD results were: revenue code 0126, $3,484.68 billed and $848.42 allowed (24.4%); 0128, $2,164.00 billed and $775.06 allowed (35.8%); 1001, $2,395.13 billed and $1,242.51 allowed (51.4%); and 1002, $3,688.52 billed and $647.49 allowed (17.5%). For the primary M/S comparators, combined results included 0110 at $575.94 billed and $321.44 allowed (54.0%), 0191 at $530.01 billed and $275.44 allowed (52.9%), 0192 at $1,957.52 billed and $391.12 allowed (20.0%), and 0194 at $700.37 billed and $701.03 allowed (approximately 100%). Therapy-related codes 0420, 0430, and 0440 are reported in the workbook but are not used as the primary specialty-facility comparators under the current methodology.

The MH/SUD codes generally have higher average allowed dollar amounts than the primary M/S specialty-facility codes, while percentages of billed charges paid vary widely by revenue code. Because the services and revenue codes are not directly matched, the data cannot support a strong parity conclusion based solely on percentage paid. Applying the workbook's current methodology and limitations, the available inpatient INN facility results do not identify a clear reimbursement parity concern.

In the Outpatient Facilities classification, Across the four reported MH/SUD outpatient facility code combinations, the combined HMO/PPO values were approximately: $1,050.63 billed and $298.17 allowed (28.4%); $913.43 billed and $204.22 allowed (22.4%); $1,698.61 billed and $417.54 allowed (24.6%); and $1,897.40 billed and $595.27 allowed (31.4%). These results reflect the workbook's PHP and IOP revenue-code groupings; because the table presentation associates multiple facility labels and formatted revenue-code variants with the same rows, the analysis uses the reported combinations without reassigning them to a different facility category.

The M/S outpatient facility tables contain ambulatory surgical center and ESRD results, but the reported codes and services are not directly comparable to PHP and IOP. Allowed-to-billed percentages vary substantially by code, including very low percentages for certain ESRD drug or supply revenue codes and higher percentages for many ambulatory surgical services. Under the workbook's current methodology, those therapy, drug, and supply results should not be used to create a broad blended comparison with MH/SUD specialty-facility reimbursement.

Because the M/S and MH/SUD facility services use different code sets and reflect different levels and types of care, the updated workbook does not permit a reliable like-for-like rate comparison. However, the available results do not identify a clear systemic MH/SUD reimbursement disadvantage.

Finally, The Negotiations data shows different contracting patterns for in-network professionals and facilities, but no material difference in the use of standard versus negotiated rates between M/S and MH/SUD providers. Among professionals, 75% of both MD and non-MD M/S providers are reimbursed at standard rates, compared with 80% of both MD and non-MD MH/SUD providers. Correspondingly, negotiated rates apply to 25% of M/S professionals and 20% of MH/SUD professionals. The five-percentage-point difference indicates that MH/SUD professionals are somewhat more likely to be reimbursed under standard rates and somewhat less likely to have negotiated rates than M/S professionals. For facilities, all reported M/S and MH/SUD inpatient, outpatient office, and outpatient other facilities use negotiated rates, while none use standard rates. Emergency facilities are also reported at 0% standard rates. Overall, the data reflects comparable negotiation practices across the two classifications and does not identify a material disparity in the availability or application of negotiated reimbursement arrangements for MH/SUD providers or facilities.

V. Findings and Conclusions

The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply the in-network reimbursement requirement to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the in-network reimbursement requirement to M/S benefits; and (2) CareFirst complies with the relevant data requirements under the MHPAEA Final Rules.

In all fee schedule scenarios, whether setting standard contract rates, negotiating, or in re-negotiating a continuing contract, the same factors, evidentiary standards, and sources are used for M/S and MH/SUD. Additionally, CareFirst now has a Community and Standard fee schedule.

Community is defined as those providers with no negotiated rates as part of their contractual agreement. Standard is defined as those providers who have negotiated rates as part of their contractual agreement. This applies to all specialties in the same manner.

CareFirst applies the HSCRC rate methodology to inpatient-acute and other facilities as required under Maryland law (see §15-604 of MD Insurance Art.). When a facility is contracted via HSCRC, no additional factors are applied in determining reimbursement, and no negotiations occur. For facilities outside of Maryland that are not contracted via HSCRC, the same factors, evidentiary standards, and sources apply for both M/S and MH/SUD. In many circumstances, the facility provides both M/S and MH/SUD services, and the contracts would be negotiated using the same methodology. When a facility provides only M/S or MH/SUD services, the same factors, evidentiary standards, and sources still apply, using CMS relatives as well as third-party market rates, to ensure comparability.

Operationally, CareFirst develops reimbursement rates based on set geographic locations that match CMS localities for comparison purposes. The data analyzed above supports a finding that provider and facility reimbursement rates do not present a parity concern.

VI. Required Certification

CareFirst certifies that the foregoing comparative analysis of the In-Network Reimbursement—Provider and Facility NQTL was prepared for the Virginia fully insured coverage identified in this report and was reviewed by individuals with appropriate knowledge of the plan terms, policies, procedures, factors, evidentiary standards, operational practices, supporting documentation, and relevant data addressed in the analysis. The analysis applies to the CareFirst entities identified in this report as NAIC 53007 and NAIC 9602 to the extent the NQTL is designed and administered as described in this analysis.

To the best of CareFirst's knowledge and based on the information, documentation, and data reviewed as of the report's version date, this comparative analysis is accurate and complete in all material respects and demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the In-Network Reimbursement—Provider and Facility NQTL to mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, those used to design and apply the NQTL to medical/surgical benefits, as written and in operation. CareFirst will maintain supporting documentation and will update or supplement the analysis if a material change, newly identified data limitation, or corrective action affects this conclusion.

OUT-OF-NETWORK REIMBURSEMENT (PROVIDER AND FACILITY)

Overview

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the out-of-network reimbursement requirement to mental health or substance use disorder ("MH/SUD") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the out-of-network reimbursement requirement to medical surgical ("M/S") benefits.

I. Description of the Out-of-Network Reimbursement NQTL

It is CareFirst practice to reimburse out-of-network provider and facility services at 100% of the in-network reimbursement rate, or according to a fee schedule using CPT or HCPCS codes for M/S and MH/SUD. Out-of-network reimbursement rates are established in the same manner as in-network reimbursement rates using geographic region, provider location, market data, and industry benchmarks to determine rates. The list of CPT codes eligible for payment in an Ambulatory Surgery Center (ASC) will be periodically reviewed and updated. Based on the review process, additional CPT codes may be added to the list or deleted from the list.

A. Identification of the NQTL

i. Plan/Coverage Terms Regarding Out-of-Network Reimbursement

The Plan document contains the following sections regarding out-of-network reimbursement. These out-of-network reimbursement sections apply to both M/S benefits and MH/SUD benefits, and do not differentiate between M/S and MH/SUD benefits:

- Definitions
- General Provisions
- Utilization Management Requirements
- Schedule of Benefits
- Emergency Services and Urgent Care
- Inter-Plan Arrangements Disclosure

(*Source:* Plan EOC)

ii. Policies/Guidelines/Other Documents Describing Out-of-Network Reimbursement

Out-of-Network reimbursement appears or is described in the following documents:

- CareFirst Provider Manual, pp. 59-68
- Description of Covered Services, pg. B-32

iii. Identification of All MH/SUD and M/S Benefits to Which Out-of-Network Reimbursement Rates Apply

All M/S and MH/SUD out-of-network benefits are subject to out-of-network reimbursement rates.

II. Identification and Definition of the Factors and Evidentiary Standards Used in the Design or Application of Out-of-Network Reimbursement Rates

A. Factors and Evidentiary Standards for Standard Fee Schedules (Facilities)

Factor 1	**Reimbursement Laws**
Definition	Any state established reimbursement requirements.
Application Benefit Classification(s)	• Out-of-Network Inpatient • Out-of-Network Outpatient Other
Description	Where applicable, CareFirst follows state laws regarding required reimbursement rates for covered services.
Source(s) of Factor	• 12 VAC 30 (30-8-30 and 30-70)
Evidentiary Standards and Applicable Thresholds	State reimbursement laws.

Source(s) of Evidentiary Standards	• 12 VAC 30 (30-8-30 and 30-70)

Factor 2	**Relative Value Units**
Definition	The Relative Value Units (RVUs) as established by CMS.
Application Benefit Classification(s)	• Out-of-Network Inpatient • Out-of-Network Outpatient Other
Description	CareFirst relies upon industry standard RVUs and per diem rates as established by CMS when determining reimbursement rates.
Source(s) of Factor	• CMS RVUs • CMS Per Diem Rates
Evidentiary Standards and Applicable Thresholds	CMS RVUs: [(Work RVU × Work GPCI) + (PE RVU × PE GPCI) + (MP RVU × MP GPCI)] × CF = CMS benchmark rate. The work RVU = relative time and intensity associated with furnishing services. The Practice Expense (PE) RVU = the costs of maintaining a practice. The Malpractice (MP) RVU = 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 dollar amount by which the sum of the geographically adjusted RVUs is multiplied. The calculation is applied rather than a specific threshold.
Source(s) of Evidentiary Standards	• CMS Guidelines

Factor 3	**Market Rates per Geographic Region**
Definition	Applicable market rates for the services based on geographic region as defined by CMS.
Application Benefit Classification(s)	• Out-of-Network Inpatient • Out-of-Network Outpatient Other

Description	CareFirst relies upon the geographic market rates as defined by CMS to determine reimbursement rates.
Source(s) of Factor	• External market rates i.e., Truven Health Analytics • CMS rates as defined by Medicare geographic region (MPFS or MAC for local jurisdictions)
Evidentiary Standards and Applicable Thresholds	CareFirst considers market rates in the region for out-of-network reimbursement based on the CMS region locality. The threshold used is 1%. For example, if the out-of-network reimbursement rate for M/S is 1% higher than MH/SUD, CareFirst will adjust the out-of-network reimbursement rate to make the percentage equal to or higher than M/S for MH/SUD services. The threshold for change is when any rate falls below 100% of the corresponding Medicare rate.
Source(s) of Evidentiary Standards	• CMS rates by CMS established region • Internal claims data

Factor 4	Competitive Intelligence
Definition	Information about industry reimbursement rates or evidence of cost of care as provided by industry benchmarking data or provider application.
Application Benefit Classification(s)	• Out-of-Network Inpatient • Out-of-Network Outpatient Other
Description	CareFirst relies upon industry benchmarking to determine out-of-network reimbursement rates.
Source(s) of Factor	• Industry benchmarking data i.e., Truven, IDB Watson
Evidentiary Standards and Applicable Thresholds	Provider application and 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 (IDB Watson and Truven). Any rate differential, even a 1% difference is reviewed for possible competition purposes.
Source(s) of Evidentiary Standards	• Provider application and correspondence • Industry benchmarking data

B. Factors and Evidentiary Standards for Standard Fee Schedules (Providers)

Factor 1	Medicare Reimbursement Rates
Definition	Medicare reimbursement rates are the basis for the standard fee schedule.
Application Benefit Classification(s)	• Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	CareFirst uses published Medicare reimbursement rates to establish standard fee schedules annually.
Source(s) of Factor	• CMS rates as defined by Medicare geographic region (MPFS or MAC for local jurisdictions)
Evidentiary Standards and Applicable Thresholds	Conversion Factor (CF) = the sum of the geographically adjusted RVUs by a CF in dollars.
Source(s) of Evidentiary Standards	• CMS rates

Factor 2	**Competitive Intelligence**
Definition	Awareness of industry benchmarking data and market evidence of reimbursement rates, including any additional specialized service need or unique market demand. Competitive Intelligence is generally applied when information is submitted by providers through market validation. This factor relies on the provider landscape and member needs, and could be impacted by geography, abundance or lack of providers able to handle specialized services, or member needs and accessibility.
Application Benefit Classification(s)	• Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	CareFirst relies on industry benchmarking data and provider-submitted market information when evaluating out-of-network reimbursement rates.
Source(s) of Factor	• Industry benchmarking data i.e., Truven, IDB Watson
Evidentiary Standards and Applicable Thresholds	Provider application and 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 (IDB Watson and Truven). Any rate differential, even a 1% difference is reviewed for possible competition purposes.
Source(s) of Evidentiary Standards	• Provider application and correspondence • Industry benchmarking data

Factor 3	**Market Rates per Geographic Region**
Definition	Applicable market rates for the services based on geographic region as defined by CMS.
Application Benefit Classification(s)	• Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	CareFirst relies upon the geographic market rates as defined by CMS to determine reimbursement rates.
Source(s) of Factor	• External market rates i.e., Truven Health Analytics • CMS rates as defined by Medicare geographic region (MPFS or MAC for local jurisdictions)
Evidentiary Standards and Applicable Thresholds	CareFirst considers market rates in the region for out-of-network reimbursement based on the CMS region locality. The threshold used is 1%. For example, if the out-of-network reimbursement rate for M/S is 1% higher than MH/SUD, CareFirst will adjust the out-of-network reimbursement rate to make the percentage equal to or

	higher than M/S for MH/SUD services. The threshold for change is when any rate falls below 100% of the corresponding Medicare rate.
Source(s) of Evidentiary Standards	• CMS rates by CMS established region • Internal claims data

Factor 4	**Network Type**
Definition	Whether the network type is a Health Maintenance Organization (HMO) or Preferred Provider Organization (PPO).
Application Benefit Classification(s)	• Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	The type of network determines whether members can seek claim payment for non-emergency covered services from an out-of-network provider.
Source(s) of Factor	• CareFirst Internal Policy
Evidentiary Standards and Applicable Thresholds	HMO and PPO plans have rate differentials due to contracting. The rate differentials are the same among HMO and PPO for M/S and MH/SUD services. There is on average a 5% difference in these rates when comparing HMO and PPO network options.
Source(s) of Evidentiary Standards	• Contracting arrangements

Factor 5	**Training, Expertise, and Licensure**
Definition	Assessment of provider specialty, license type (MD or non-MD), training, education, board certification, and experience.
Application Benefit Classification(s)	• Out-of-Network Outpatient Office • Out-of-Network Outpatient Other
Description	Providers' level of training and experience influence reimbursement rates in line with CMS guidelines.

Source(s) of Factor	• CMS Guidelines
Evidentiary Standards and Applicable Thresholds	Provider specialty, license type (MD or non-MD), training, education, board certification, and experience affect reimbursement rates. CareFirst follows industry standards for differentials in these rates. There is no separate quantitative threshold because the applicable industry standards are followed.
Source(s) of Evidentiary Standards	• CMS guidelines • Industry benchmarking data • Provider application • Medicare reductions for limited licensed provider

A. Processes

CareFirst strives to reimburse out-of-network M/S and MH/SUD providers and facilities at the same rate as in-network M/S and MH/SUD providers and facilities. For additional details on the processes deployed to ensure parity in reimbursement rates, please see the In-Network Reimbursement NQTL.

B. Strategy

CareFirst strives to reimburse out-of-network M/S and MH/SUD providers and facilities at the same rate as in-network M/S and MH/SUD providers and facilities. For additional details on the strategies deployed to ensure parity in reimbursement rates, please see the In-Network Reimbursement NQTL.

C. Relationship Between Factors

All factors in the analyses are considered equally, and no single factor carries more weight than another. Additionally, no factors were considered but rejected. Lastly, all factors apply to both M/S and MH/SUD classified services.

III. Demonstration of Comparability and Stringency as Written

This section demonstrates that in each classification, under the terms of the plan as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying out-of-network reimbursement to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the out-of-network reimbursement with respect to M/S benefits.

CareFirst strives to reimburse out-of-network providers and facilities at in-network rates. The factors, evidentiary standards, and sources applied to in-network reimbursement rates are therefore applicable to out-of-network reimbursement rates. Accordingly, CareFirst finds that out-of-network reimbursement is no more stringently applied to MH/SUD out-of-network reimbursement, than to M/S out-of-network reimbursement, in writing. For additional details on how in-network reimbursement rates demonstrate parity in writing, see the In-Network Reimbursement NQTL.

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IV. Demonstration of Comparability and Stringency In Operation

This section demonstrates that in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying out-of-network reimbursement to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying out-of-network reimbursement with respect to M/S benefits.

A. Explanation of how CareFirst Evaluates Comparability

Below is a comprehensive explanation of how CareFirst evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying out-of-network reimbursement to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying out-of-network reimbursement with respect to M/S benefits.

Out-of-network reimbursement amounts are maintained by geographic region. There are three geographic regions used to price services covered under CareFirst products: the District of Columbia metropolitan area (which includes parts of Northern Virginia), the Baltimore metropolitan area, and rural Maryland. Application of a geographic pricing region is based on the location of the practitioner's primary location for each practice affiliation. The table below identifies the Virginia counties included in the District of Columbia region; corresponding detail for the Baltimore metropolitan and rural Maryland regions is not included in the available table.

Geographic Region	State and County
District of Columbia	**Virginia Counties:** Alexandria City, Arlington, Fairfax City, Fairfax, Falls Church City, Fauquier, Loudoun, Manassas City, Manassas Park City, Prince William, Spotsylvania, Stafford

B. Documentation of Outcomes

1. Evaluation of Relevant Data

a. Out-of-Network Outpatient Reimbursement Rates for the PPO Network

Specialty	CPT Code	Avg. Plan Rate for DC PPO	Medicare Rate for DC PPO	Plan Rate as a Percentage of Medicare
Cardiologists	99213	$113.85	$100.28	114%
Chiropractor	99203	$128.00	$122.83	104%
Chiropractor	99213	$73.95	$100.28	74%
Dermatologists	99203	$128.84	$122.83	105%
Dermatologists	99213	$98.27	$100.28	98%

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Specialty	CPT Code	Avg. Plan Rate for DC PPO	Medicare Rate for DC PPO	Plan Rate as a Percentage of Medicare
Endocrinologists	99203	$117.46	$122.83	96%
Endocrinologists	99213	$94.87	$100.28	95%
Gastroenterologist	99203	$129.79	$122.83	106%
Gastroenterologist	99213	$74.24	$100.28	74%
Internists MD	99203	$206.80	$122.83	168%
Internists MD	99213	$114.65	$100.28	114%
LCSW	90791	$165.46	$136.58	121%
LCSW	90832	$83.98	$64.45	130%
Neurologists	99203	$94.04	$122.83	77%
Neurologists	99213	$94.03	$100.28	94%
Occupational Therapy	97165	$134.80	$113.16	119%
Occupational Therapy	97166	$108.72	$113.16	96%
Occupational Therapy	97167	$125.56	$113.16	111%
Occupational Therapy	97168	$86.06	$78.68	109%
Orthopedic Surgery	99203	$121.78	$122.83	99%
Orthopedic Surgery	99213	$77.85	$100.28	78%
Pediatrician	99203	$107.92	$122.83	88%
Pediatrician	99213	$114.70	$100.28	114%
Physical Therapy	97161	$90.02	$110.07	82%
Physical Therapy	97162	$95.69	$110.07	87%
Physical Therapy	97163	$98.67	$110.07	90%
Physical Therapy	97164	$62.07	$76.38	81%
Podiatrists	99203	$88.00	$122.83	72%
Podiatrists	99213	$78.81	$100.28	79%
Psychiatrist	99203	$122.88	$122.83	100%
Psychiatrist	99213	$93.67	$100.28	93%
Psychologists	90791	$186.50	$182.11	102%
Psychologists	90832	$88.33	$85.93	103%

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b. Out-of-Network Outpatient Reimbursement Rates for the HMO Network

Specialty	CPT Code	Avg. Plan Rate for D.C. HMO	Medicare Rate for D.C. HMO	Plan Rate as a Percentage of Medicare
Cardiologists	99203	$89.34	$122.83	73%
Cardiologists	99213	$74.51	$100.28	74%
Chiropractor	99203	$94.30	$122.83	77%
Chiropractor	99213	$80.20	$100.28	80%
Dermatologists	99203	$109.21	$122.83	89%
Dermatologists	99213	$86.60	$100.28	86%
Endocrinologists	99203	$94.04	$122.83	77%
Endocrinologists	99213	$82.25	$100.28	82%
Gastroenterologist	99203	$95.65	$122.83	78%
Gastroenterologist	99213	$87.85	$100.28	88%
Internists MD	99203	$58.91	$122.83	48%
Internists MD	99213	$66.76	$100.28	67%
LCSW	90791	$141.91	$136.58	104%
LCSW	90832	$78.01	$64.45	121%
Neurologists	99203	$94.04	$122.83	77%
Neurologists	99213	$72.78	$100.28	73%
Occupational Therapy	97165	$136.54	$113.16	121%
Occupational Therapy	97166	$133.56	$113.16	118%
Occupational Therapy	97167	$75.32	$113.16	67%
Occupational Therapy	97168	$53.63	$78.68	68%
Orthopedic Surgery	99203	$119.72	$122.83	97%
Orthopedic Surgery	99213	$92.91	$100.28	93%
Pediatrician	99203	$95.18	$122.83	77%
Pediatrician	99213	$86.47	$100.28	86%
Physical Therapy	97161	$79.94	$110.07	73%
Physical Therapy	97162	$83.31	$110.07	76%
Physical Therapy	97163	$83.78	$110.07	76%
Physical Therapy	97164	$52.11	$76.38	68%
Podiatrists	99203	$95.77	$122.83	78%
Podiatrists	99213	$75.20	$100.28	75%
Psychiatrist	99203	$111.56	$122.83	91%

Specialty	CPT Code	Avg. Plan Rate for D.C. HMO	Medicare Rate for D.C. HMO	Plan Rate as a Percentage of Medicare
Psychiatrist	99213	$89.78	$100.28	90%
Psychologists	90791	$181.52	$182.11	100%
Psychologists	90832	$80.64	$85.93	94%

2. Justification and Analysis

CareFirst develops out-of-network reimbursement rates with the goal of matching in-network reimbursement rates. Out-of-network M/S and MH/SUD reimbursement rates are comparable when evaluated as a percentage of Medicare and compared to providers with similar education, training, and/or certifications for similar services for participating providers enrolled in the PPO and/or HMO network. Providers that specialize in MH/SUD care include LCSWs, Psychologists, and Psychiatrists. The requisite education requirements for these provider types are master's degree, doctoral degree, and medical degree respectively. CareFirst compares these out-of-network reimbursement rates to M/S specialties with the same education level requirements including occupational therapists, chiropractors, and neurologists. CareFirst also considers the outliers in the data sets given the variety of M/S specialties. These include specialties with medical degree requirements like orthopedic surgeons with rates above 100% of Medicare and dermatologists with rates below 100% of Medicare.

For the PPO network in the D.C. locality, reimbursement was reviewed using the plan rate as a percentage of the applicable Medicare rate. For MH/SUD specialties, LCSWs were reimbursed at 121% of Medicare for CPT code 90791 and 130% for CPT code 90832. Psychologists were reimbursed at 102% of Medicare for CPT code 90791 and 103% for CPT code 90832. Psychiatrists were reimbursed at 100% of Medicare for CPT code 99203 and 93% for CPT code 99213. These PPO results are comparable to, and in several instances higher than, M/S specialties with similar education, training, licensure, or service characteristics. Occupational Therapy reimbursement ranged from 96% to 119% of Medicare, compared to 121% to 130% for LCSWs. Chiropractor reimbursement ranged from 74% to 104% of Medicare, compared to 102% to 103% for Psychologists. Neurologist reimbursement ranged from 77% to 94% of Medicare, compared to 93% to 100% for Psychiatrists. The broader PPO data also includes M/S specialties both above and below 100% of Medicare, including Cardiologists at 114%, Dermatologists at 98% to 105%, Endocrinologists at 95% to 96%, Gastroenterologists at 74% to 106%, Internists at 114% to 168%, Orthopedic Surgery at 78% to 99%, Pediatricians at 88% to 114%, Physical Therapy at 81% to 90%, and Podiatrists at 72% to 79%. Against this range, PPO MH/SUD reimbursement is not an outlier indicating greater stringency.

For the HMO network in the D.C. locality, reimbursement was also reviewed using the plan rate as a percentage of Medicare. For MH/SUD specialties, LCSWs were reimbursed at 104% of Medicare for CPT code 90791 and 121% for CPT code 90832. Psychologists were reimbursed at 100% of Medicare for CPT code 90791 and 94% for CPT code 90832. Psychiatrists were reimbursed at 91% of Medicare for CPT code 99203 and 90% for CPT code 99213. These HMO results are comparable to M/S specialties with similar education, training, licensure, or service characteristics. Occupational Therapy reimbursement ranged from 67% to 121% of Medicare, compared to 104% to 121% for LCSWs. Chiropractor reimbursement ranged from 77% to 80% of Medicare, compared to 94% to 100% for Psychologists. Neurologist reimbursement ranged from 73% to 77% of Medicare, compared to 90% to 91% for Psychiatrists. The broader HMO data also reflects M/S reimbursement rates both below and above 100% of

Medicare, including Cardiologists at 73% to 74%, Dermatologists at 86% to 89%, Endocrinologists at 77% to 82%, Gastroenterologists at 78% to 88%, Internists at 48% to 67%, Orthopedic Surgery at 93% to 97%, Pediatricians at 77% to 86%, Physical Therapy at 68% to 76%, and Podiatrists at 75% to 78%. Against this range, HMO MH/SUD reimbursement is comparable to, and generally more favorable than, similarly situated M/S comparison specialties.

Additionally, CareFirst compared the top CPT, HCPCS, and revenue codes using the average billed amount, average allowed amount, and percentage of the billed amount paid. If a provider type had fewer than 10 billed codes, all available codes were included. The updated analysis combines the HMO and PPO results by taking an unweighted average of the plan-level values; claim-volume weights were not available in the workbook. Providers were grouped as physicians (psychiatrists and cardiologists) and non-physicians (psychologists, social workers, and physical therapists) to support comparisons across generally similar levels of education and training.

In the Inpatient Out-of-Network, the Outpatient Office Out-of-Network, and the Outpatient Other Out-of-Network classifications, the available MH/SUD and M/S code sets do not provide a consistent like-for-like comparison, and several reported MH/SUD codes are neurodiagnostic services rather than codes shared with the M/S comparator. Accordingly, the data is insufficient to support a reliable comparative reimbursement conclusion for OON professional services.

In the Inpatient Out-of-Network classification, MH/SUD results are reported for revenue codes 0126, 0128, and 1002, while the M/S results contain only a small number of populated codes and materially different service categories. For example, combined MH/SUD results were approximately $5,495 billed and $1,097.97 allowed for 0126, and $4,495 billed and $762.90 allowed for 0128 where PPO data was available; HMO values were absent for some codes. Because the observations are sparse, unbalanced across plan types, and not directly comparable, no parity conclusion can be drawn for inpatient OON facility reimbursement, but there are no red flags indicating any parity concerns.

In the Outpatient Out-of-Network classification, data were limited for both MH/SUD and M/S services. Reported MH/SUD PHP/IOP combinations include allowed amounts ranging from approximately $312.61 to $908.67 by plan and code grouping. M/S results are concentrated in ambulatory surgical center, ESRD, and on-campus outpatient hospital codes that are not comparable to PHP/IOP. Given the sparse observations, missing values, and different code mixes, the OON outpatient facility data does not support a full comparative parity analysis, but there are no red flags indicating any parity concerns.

V. Findings and Conclusions

The analysis above demonstrates that, for the provider reimbursement comparisons supported by the available data, the processes, strategies, evidentiary standards, and other factors used to design and apply out-of-network reimbursement to MH/SUD benefits are comparable to and are applied no more stringently than those used for M/S benefits. The facility data are too sparse and dissimilar to support a reliable comparative conclusion and should be supplemented before a comprehensive operational conclusion is made.

CareFirst strives to reimburse out-of-network providers and facilities at in-network rates. The factors, evidentiary standards, and sources applied to in-network reimbursement rates are therefore applicable to out-of-network reimbursement rates. Accordingly, CareFirst finds that out-of-network

reimbursement is no more stringently applied to MH/SUD out-of-network reimbursement, than to M/S out-of-network reimbursement, in writing. For additional details on how in-network reimbursement rates demonstrate parity in writing, see the In-Network Reimbursement NQTL.

Operationally, CareFirst develops reimbursement rates using geographic areas aligned with CMS localities for comparison purposes. The provider data analyzed above do not indicate that MH/SUD reimbursement is applied more stringently than M/S reimbursement. The available facility data are insufficient for a definitive operational parity conclusion.

VI. Required Certification

CareFirst certifies that the foregoing comparative analysis of the Out-of-Network Reimbursement—Provider and Facility NQTL was prepared for the Virginia fully insured coverage identified in this report and was reviewed by individuals with appropriate knowledge of the plan terms, policies, procedures, factors, evidentiary standards, operational practices, supporting documentation, and relevant data addressed in the analysis. The analysis applies to the CareFirst entities identified in this report as NAIC 53007 and NAIC 9602 to the extent the NQTL is designed and administered as described in this analysis.

To the best of CareFirst's knowledge and based on the information, documentation, and data reviewed as of the report's version date, this comparative analysis is accurate and complete in all material respects and demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the Out-of-Network Reimbursement—Provider and Facility NQTL to mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, those used to design and apply the NQTL to medical/surgical benefits, as written and in operation. CareFirst will maintain supporting documentation and will update or supplement the analysis if a material change, newly identified data limitation, or corrective action affects this conclusion.

PROVIDER DIRECTORIES

Overview

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the network adequacy requirement to mental health or substance use disorder ("MH/SUD") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the network adequacy requirement to medical surgical ("M/S") benefits.

I. Description of the Provider Directory NQTL

A. Identification of the NQTL

i. Plan/Coverage Terms Regarding Provider Directories

The Plan document contains the following sections regarding provider directories. These sections apply to both M/S benefits and MH/SUD benefits, and do not differentiate between M/S and MH/SUD benefits:

- Link to network directory

(*Source:* Plan EOC)

ii. Policies/Guidelines/Other Documents Describing Provider Directories

Network reimbursement appears or is described in the following documents:

- *Directory Listings Policy PIC 202.00*
- *SOP SRV 205.00*
- *Directory Suppress Report Policy PIC 310.00*
- *Provider Directory Policy OP.PR.15*
- *No Surprises Act*
- *Institutional Credentialing Database Policy PIC 329.00*
- *Provider Directory Data Support Policy CC NMDT 300.00*
- *Credentialing and Recredentialing File Audit Process CO QA 320.01*
- *Provider Data Accuracy Data Support Policy MA NMDT 400.00*

iii. Identification of All MH/SUD Benefits and M/S Benefits which Provider Directories Apply

All M/S and MH/SUD in-network benefits are subject to the provider directory NQTL.

II. Identification and Definition of the Factors and Evidentiary Standards Used in the Design and Application of Provider Directories

A. Factors and Evidentiary Standards for Provider Directories

Factor 1	**Provider contracting and updates to provider information**
Definition	When a new provider is contracted, their information will be added to the system within the above-mentioned timeframes. The provider updates CareFirst regarding any changes to provider information including new provider information and any changes during the credentialing/recredentialling process. This also includes the removal of providers who are no longer credentialed with CareFirst.

Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst updates the directory as contracting receives updates.

Source(s) of Factor	• Provider amendments
	• Internal policies:
	  o PIC 202.00
	  o PIC 310.00
	• Credentialing/recredentialing requirements including:
	  o NCQA accreditation standards
	  o Federal, state, and local credentialing regulations (MD Insurance Art. §15-112)
	  o CareFirst credentialing and recredentialing policies
	  o CareFirst Provider Manual

Evidentiary Standards and Applicable Thresholds	Provider Information & Credentialing (PI&C) updates the information in the provider file system within 15 working days (or within 19 calendar days) after receipt of written notification of the update from the provider. The provider directory is updated daily so the information in the provider file system is reflected in the directory one day later. NCQA accreditation standards include:
	• Organization has a web-based directory that includes the following information:
	  o Name
	  o Gender
	  o Specialty
	  o Hospital affiliation
	  o Medical group affiliation
	  o Board certification
	  o Accepting new patients
	  o Languages spoken by physician and clinical staff
	  o Office locations and phone numbers
	• The organization updates its web-based physician directory within 30 calendar days of receiving new information from the physician.
	• The organization uses valid methodology, the organization performs an annual evaluation of its directories and reports accuracy for (see below steps for more information):
	  o Accuracy of office locations and phone numbers
	  o Accuracy of hospital affiliations
	  o Accuracy of accepting new patients

	○ Awareness of physician office staff of physicians participation in network. • Based on results of the analysis performed in Element C, at least annually, the organization: ○ Identifies opportunities to improve the accuracy of the information in its physician directories. ○ Takes action to improve the accuracy of the information in its physician directories. • The organization has a web-based hospital directory that includes the following information: ○ Hospital name. ○ Hospital location and phone number. ○ Hospital accreditation status. ○ Hospital quality data from recognized sources. • The organization evaluates its web-based physician and hospital directories for understandability and usefulness to members and prospective members at least every 3 years, and considers the following: ○ Reading level. ○ Intuitive content organization. ○ Ease of navigation. ○ Directories in additional languages, if applicable to the membership. • The organization makes web-based physician and hospital directory information available to members and prospective members through alternative media, including: ○ Print. ○ Telephone.
Source(s) of Evidentiary Standards	• Physician notification • Annual audit and evaluations • Quarterly review and report by NMDA • Internal policies • Contracting documents • Credentialing/recredentialing requirements including: ○ NCQA accreditation standards document: HP 2024 NET Standards (ncqa.org) ○ Federal, state, and local credentialing regulations (MD Insurance Art. §15-112) ○ CareFirst credentialing and recredentialing policies ○ CareFirst Provider Manual

Factor 2	**Annual Evaluation**

Definition	CareFirst performs an annual evaluation of its provider directories to evaluate the accuracy of the information displayed. Based on results of the annual evaluation, CareFirst identifies opportunities to improve the accuracy of the information in its provider directories and takes action to improve it.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst performs annual evaluation for accuracy testing.

Source(s) of Factor	• NCQA accreditation requirements
	• Internal policies:
	  ○ PIC 202.00
	  ○ PIC 310.00

Evidentiary Standards and Applicable Thresholds	CareFirst performs an annual evaluation and internal audit as part of its NCQA accreditation and requirements that ensures: • Accuracy of office locations and phone numbers. • Accuracy of all directory facing data elements indicated in response 1(a). • Accuracy of hospital affiliations. • Accuracy of accepting new patients. • Awareness of physician office staff of physician's participation in CareFirst's networks.

Source(s) of Evidentiary Standards	• Annual evaluation:
	  ○ Annual audit and evaluations and corresponding results
	  ○ NCQA requirements document: HP 2024 NET Standards (ncqa.org)

Factor 3	**Quarterly Review**
Definition	At the conclusion of each quarter, PI&C requests a report of practitioner and provider records that are directory suppressed (not displayed in the provider directory) from Networks Management Data & Analytics (NMDA). NMDA delivers the report to PI&C and the records are reviewed by specialty and provider type and corrected as necessary. Discrepancies on the report are investigated, documented, and corrected prior to the beginning of the next quarter.

Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst performs quarterly reviews of records for directory accuracy.

Source(s) of Factor	• NCQA accreditation requirements
	• Internal policies:
	  ○ PIC 202.00
	  ○ PIC 310.00

Evidentiary Standards and Applicable Thresholds	Reviews of information accuracy are done quarterly and updated by the start of the following quarter.
Source(s) of Evidentiary Standards	• Quarterly Reviews: ○ Quarterly reviews and corresponding results

Factor 4	**User-Friendliness**
Definition	CareFirst aims to maintain user-friendliness of their directory through: • Font size • Reading level • Intuitive content organization • Ease of navigation • Additional language(s) if applicable
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst applies user-friendliness criteria to ensure accessibility.
Source(s) of Factor	• User-feedback • User-friendliness testing • Marketing and Branding strategy
Evidentiary Standards and Applicable Thresholds	User-friendliness is reviewed annually to ensure the website is accessible to all members.

Source(s) of Evidentiary Standards	• Annual user-friendliness review • User feedback or requests

A. Processes

It is the policy of CareFirst to produce and maintain accurate, current, and easily accessible provider network directories both in online and paper formats so that members can find providers to meet their health care needs.

The online provider directory is available to members and prospective members at www.carefirst.com. Hard copy directories are printed annually in the Fall and are available to any member or prospective member upon request.

(Directory Listings Policy PIC 202.00, pg. 2; SOP SRV 205.00)

Directory Notice of Availability of PCPs

The provider directory includes a notice regarding the availability of practitioners listed in the directory:

> *Enrolling in [product name] does not guarantee services by a provider on this list. If you wish to receive care from specific providers listed, you should contact those providers to be sure that they are accepting additional patients for [product name].*

(Directory Listings Policy PIC 202.00, pg. 2)

The CareFirst provider directory displays information to members about the criteria it uses to select hospitals and practitioners for participation in all plan networks and provides information to help members and prospective members choose physicians and hospitals. (CareFirst does not use quality measures, member experience measures, or cost-related measures when selecting practitioners/facilities for our networks.)

(Directory Listings Policy PIC 202.00, pg. 2)

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Directory Assessment

Annual Evaluation:

Notwithstanding timely updates made as noted above, CareFirst performs an annual evaluation of its provider directories to evaluate the accuracy of the information displayed, including 13 key provider directory data elements (including NCQA required elements in **bold**):

- Practitioner Name;
- Practitioner Title/Degree;
- **Practitioner Location Address** (practitioner schedules appointments and sees patients; <=3 locations);
- **Practitioner Location Phone Numbers** (all practice location phone numbers);
- **Practitioner Accepting New Patients;**
- Practitioner Gender;
- Practitioner Specialty;
- Practitioner Language(s);
- Practitioner Board Certification;
- Practitioner Training/Education;
- **Practitioner Hospital Affiliation;**
- Practitioner Medical Group Affiliation;
- **Provider's Awareness of Network Participation**

Based on results of the annual evaluation, CareFirst identifies opportunities to improve the accuracy of the information in its provider directories and takes action to improve it. *(PIC 202.00)*

Additional information located on the provider directory includes:

- Awards & Recognition
- Plans accepted

(See: *Directory*)

Directory Search Mapping

The directory has mapping of terms built in which allows members to search for service types. These service types were compiled from the standard list provided by the provider directory vendor, specialty codes mapping, and clinical team input. There are hundreds of terms and services that are searchable which will map the member to an appropriate provider. M/S and MH/SUD services and search terms are present.

Quarterly Reviews:

Quarterly reviews are also conducted as part of the maintenance for accuracy of the directory as to providers and facilities available to CareFirst members. At the conclusion of each quarter, Provider Information & Credentialing (PI&C) requests a report of provider records from the Networks Management Data Team (NMDT). These reports are reviewed by specialty and provider types. Any discrepancies in the reports are investigated, documented, and corrected respectively prior to the beginning of the next quarter. *(Directory Suppress Report Policy PIC 310.00, pg. 2;Provider Directory Policy OP.PR.15, pg. 2; No Surprises Act)*

Weekly Reviews of Credentialing Database:

The Institutional Credentialing Database, which contains all the credentialing information for all acute and non-acute institutional facility types in the CareFirst network, is reviewed once weekly by a PI&C Business Analyst. This review looks for any missing or expired documents to ensure that credentials are current and valid based upon the license and certification dates maintained in the database. Requests for any missing or renewed documents are scheduled to be mailed every other week by the PI&C Analyst, in addition to telephone and email outreach. The database is then updated upon receipt of the requested documents.

If a provider does not respond after three attempts of the biweekly outreach, the provider is referred to the Provider Contracting team for possible termination. *(Institutional Credentialing Database Policy PIC 329.00, pg. 2)*

Day-to-Day Provider Data Extraction Process:

Day-to-day provider data extraction processes are conducted by the Provider IT Department, which manages and monitors the Company's provider IT systems on a regular basis. NMDT supports the provider directory process by reviewing the Data Extract Error Review Report for any items that are identified as possible errors. If there are any data accuracy issues identified in the provider directory, NMDT triages the issues and sends them to the Provider Data Accuracy (PDA) team, which is responsible for researching these reported discrepancies and making any required updates to the provider file system. *(Provider Directory Data Support Policy CC NMDT 300.00, pp. 2-3)*

Updates to Provider Information

PI&C is the Department responsible for initialing credentialing of new applicants for network participation and recredentialing for continued network participation, provider data maintenance, and provider directory production. PI&C updates the information in the provider file system within 15 working days (or within 19 calendar days) after receipt of written notification of the update from the provider or facility.

(Directory Listings Policy PIC 202.00, pg. 2; SOP SRV 205.00)

In addition, the ongoing credentialing and recredentialing processes allow for validation or updating of practitioner, hospital, and facility information in the directory. *(Provider Directory Policy OP.PR.15, pg. 2)*

Every three years, or when there are significant changes to either the design of the Provider Directory or the demographics of the membership, CareFirst evaluates the online directory for usability by applying the following criteria:

- Font size

- Reading level
- Intuitive content organization
- Ease of navigation
- Directories in additional language(s) when requested

If opportunities for improvement are identified through the usability test, the Provider Relations and Solutions Departments develop action plans to improve the ease of use for members. *(Provider Directory Policy OP.PR.15, pg. 3)*

Adding New Providers

New providers are added to the CareFirst directories:

- If the provider is new to the CareFirst network, the directory is updated following the completion of the contract and credentialing process.
- If the provider is joining a new group, the new provider is added to the CareFirst directory when the contracts are signed by the new group and counter-signed by CareFirst and all providers that will participate with the new group have completed the credentialing process.
- If the new provider is joining an existing group, the provider is added to the CareFirst directory when the provider completes the credentialing process.
- The timeline for the directory additions can take up to 120 calendar days due to the requirement to complete the contracting and credentialing process.

Removing Providers

Providers are removed from the CareFirst directories:

- When a provider terminates their participation with CareFirst. This applies to the following policy:

  "The PI&C updates the information in the provider file system within 15 working days (or within 19 calendar days) after receipt of written notification of the termination from the group practice".

- When a provider request to be removed from the CareFirst directory is received by CareFirst. The provider may need to take a temporary leave of absence due to illness, etc.

- When PI&C receive notification that a provider information may be inaccurate or the provider may be subject to sanctioned/disciplinary action.

Directory Data Elements, Searchability, and Selection of Providers

CareFirst makes determinations of which specialties and facility types will be displayed in the directory and searchable based on the following:

- Taxonomy codes
- Provider certifications

- CMS/NCQA recommendations
- PI&C data
- Provider contracting data
- Industry standards

Practitioners listed in the directory include and are searchable using any of the following information:

1. Name.
2. Gender.
3. Specialty.
4. Hospital affiliations.
5. Medical group affiliations.
6. Board certification.
7. Accepting new patients.
8. Languages spoken by the practitioner or clinical staff.
9. Office locations and phone numbers.

Hospitals listed in the directory include the following information:

1. Hospital name
2. Hospital location and phone number (including distance from zip code/location)
3. Hospital accreditation status
4. Hospital quality data from recognized sources

(Provider Directory Policy OP.PR.15, pg. 2)

Members are able to filter their search by entering search criteria in multiple search fields. For example, the online directory provides a search by the following categories:

- Primary Care
- Medical Specialties
- Urgent Care Center
- Smart Shopper Rewards
- Procedure Costs
- Opioid Treatment

The online directory also facilitates a member's search by providing a list of common searches which includes:

- Behavioral Health

- CloseKnit
- Specialist
- Colonoscopy
- Mammogram

Additionally, the directory provides the following searchability:

- All Out-of-Pocket Costs
- In-Network: Lowest Out-of-Pocket Costs
- Patient Ratings

(See: *Directory*)

If a member has questions or requires additional assistance with finding a provider, a phone number to call and speak with a representative is provided. Further, if using the online directory, there is a tab to connect them with a Customer Service Representative.

For each physician and hospital listed in its directory, CareFirst specifies the source of each piece of information, the frequency of validation, and the limitations of each source (i.e., self-reported information such as hospital affiliation). Each affiliation (practitioner level) should only have one specialty in the credentialing process. Due to this, the directory is currently only searchable by main specialty. This is a search area that CareFirst will consider expanding to in the future if systems allow. *(SOP Title: Credentialing and Recredentialing File Audit Process SOP # Identifier: CO QA 320.01)*

Members can also submit any inaccuracies by utilizing the 'Report an Issue' function that is available in the online provider directory tool. *(PIC 202.00; Directory)*

The Provider Information & Credentialing (PI&C) team is responsible for updates to provider demographic information and other details in the provider file system. The provider file source system data captures the data and sends it via an automated process to the Provider Directory.

- The Provider Data Accuracy (PDA) team is responsible for researching reported provider data discrepancies and making required updates to the provider file system. The PDA team provides routine internal auditing and testing oversight of their processes for data validation, to identify any errors before they are added to the Provider Directory
- Day-to-day provider data extraction processes are handled directly by Provider IT. NMDT is responsible for ensuring that the mapping rules for the data extraction are approved, and if changes to the mapping rules are required, NMDT supplies that information to Provider IT.
- NMDT provides support to the provider data accuracy process in the form of reviewing the data extract error review report and checking to ensure that data items that are identified as errors during the data extraction process are reviewed and updated.
- If there are provider data accuracy issues identified in the provider directory, NMDT performs triage to determine if it is an issue with the vendor, an issue with the data source, or a different issue, and sends the issues/questions to the appropriate areas for correction.

(Provider Data Accuracy Data Support Policy MA NMDT 400.00, pp. 2-3)

B. Strategy

CareFirst applies the Provider Network Directory NQTL the same to M/S and MH/SUD providers by following the same process when checking for and ensuring accuracy of directory records. Updates, corrections, and evaluations of the directory are done simultaneously among M/S and MH/SUD providers and facilities using the same processes. As noted above under Step 1(a), CareFirst has implemented several levels of checkpoints and reviews such as quarterly reviews for maintaining the accuracy of the directory for both M/S and MH/SUD providers and facilities. These checkpoints include triaging and verifying any identified discrepancies and making any needed updates. CareFirst also performs annual internal audits to ensure accuracy of their network directories. This audit is performed by a third-party to ensure objectivity in the reporting. *(Directory Listings Policy PIC 202.00, pg. 2; (Provider Directory Policy OP.PR.15).* Details regarding these audits, checks, and analyses are below.

Provider Contracting and Updates to Provider Information

- **Provider File System Updates Following Notification**

Per CareFirst policy, PI&C updates information within the provider file system which supports the accuracy of the provider directory. These updates to the file system are made within 15 working days or 19 calendar days upon receipt of written notification from the provider. The directory is updated following updates to the file system. This process is the same for all providers, including all M/S and all MH/SUD providers.

- **Day-to-Day Provider Data Extraction Processes**

Additionally, CareFirst performs day-to-day provider data extraction processes to proactively search for directory errors and address them. There are several sources where possible provider directory errors are identified:

Sapphire Digital –

- CareFirst vendor for CareFirst online provider directory
- Daily provider directory files are transmitted to Sapphire Digital
  - Reports for Compilation errors are downloaded at CareFirst by NMDT team
  - Errors are investigated and resolved by Provider Data Accuracy team
- Website allows members to report perceived errors
  - Errors for CareFirst providers are sent to the Provider Data Accuracy team for investigation and resolution

- Errors for non-CareFirst providers (National providers) are forwarded to BCBSA via the Service Now system for investigation by Plan that contracts provider

Provider IT –

- CareFirst provider IT team transmits daily provider file data to BCBSA for ingestion into master provider data repository
- Error reports generated and sent to CareFirst by BCBSA for provider records that fail to load
  - Errors from BCBSA previously delivered via TRMS system
- Daily error reports are created by Provider IT and delivered to Provider Data Accuracy team
- Provider report errors are investigated and resolved by Provider Data Accuracy team using Data Dictionary information contained in file

Service Now –

- Member reported errors from the BCBSA national provider directory for CareFirst contracted providers
- Random calls made to providers by BCBSA to verify data accuracy
- Errors are delivered to CareFirst via Service Now system
- The member reported errors for medical providers are investigated and resolved by Provider Data Accuracy team

BCBSA Provider Data Accuracy Audit -

- BCBSA uploads 20 sample provider records to BCBSA audit site per month
- Provider Data Accuracy team performs audit of posted records
  - 14 data elements are contained
  - 5 elements are scored (address rows; phone number; accepting new patient status; directory print status)
- Errors in audited fields can impact Plan's provider data quality score

In these various data accuracy checks, both M/S and MH/SUD providers are identified. In the supplemental documentation '*PDA TRMS DISCREPANCIES_SAMPLE'*, it demonstrates the identification of both M/S and MH/SUD provider types for errors for investigation. Please see additional supplemental documentation for processes (*NMDT 300.01; NMDT 400.01; PDAT 500.50; PDAT 600.30; PDAT 600.40*).

- **Weekly Reviews**

Weekly reviews for all acute and non-acute institutional facility types in the CareFirst network, is reviewed once weekly by a PI&C Business Analyst. This review looks for any missing or expired documents to ensure that credentials are current and valid based upon the license and certification dates maintained in the database. Requests for any missing or renewed documents are scheduled to be mailed every other week by the PI&C Analyst, in addition to telephone and email outreach. The database is then updated upon receipt of the requested documents. If a provider does not respond after three attempts of the biweekly outreach, the provider is referred to the Provider Contracting team for possible termination. Both M/S and MH/SUD facilities are included in this review and remediation process. Please see additional documentation for an example of these weekly reviews (*Weekly Review Medical Facility 12.31.2024; Weekly Review MH SUD Facility 12.31.2024).*

- **Periodic Reviews**

CareFirst's operating policies and procedures are established to secure compliance with Maryland regulations respectively, including Section 15 – 112 (p) (3) (i-ii) of the Maryland Insurance Article where the carrier is required to contact providers listed in the network directory who have not submitted a claim in the last 6 months to determine if the providers intend to remain in the provider network or periodically review a reasonable sample size of its network directory for accuracy. CareFirst will analyze data to determine if providers have any claims within the past 6 months. If the provider does not have claims within this timeframe, CareFirst will reach out to determine if the provider needs to be terminated from the directory. CareFirst may also elect to perform other periodic reviews to determine directory accuracy. The day-to-day extractions and weekly reviews are example of other types of periodic reviews.

Annual Evaluation - NCQA Accreditation Standards & Network Directory Internal Audit

CareFirst performs annual tests of its directory through a third-party to ensure network directory accuracy monitoring. CareFirst separates the data by M/S and MH/SUD to ensure comparability.

Additionally, CareFirst has NCQA accreditation for network management and received all possible points for the network directory portion. While these results are not specific to M/S and MH/SUD, they demonstrate CareFirst's ongoing efforts to ensure an accurate directory.

Quarterly Reviews

Per CareFirst policy, at the conclusion of each quarter, PI&C requests a report of practitioner and provider records that are directory suppressed (not displayed in the provider directory) from Networks Management Data & Analytics (NMDA). NMDA delivers the report to PI&C and the records are reviewed by specialty and provider type and corrected as necessary. Discrepancies on the report are investigated, documented, and corrected prior to the beginning of the next quarter. Both M/S and MH/SUD practitioner provider records are included in this process.

User-Friendliness

Per policy, CareFirst targets to achieve and maintain a high level of user-friendliness of the provider network directory in relation to identifying and accessing MH/SUD and M/S providers and facilities. This is achieved by monitoring user feedback and requests; annual user review; and the application of recommendations from the Company's marketing and branding strategies. Font size, reading level, intuitive content and organization, pictures/images, ease of navigation, and additional languages if applicable are all reviewed and factored in each year to evaluate overall user-friendliness of the directory.

C. Relationship Between Factors

All factors in the analyses are considered equally and no single factor carries more weight than another Additionally, no factors were considered but rejected. Lastly, all factors apply to both M/S and MH/SUD classified services.

III. Demonstration of Comparability and Stringency as Written

CareFirst applies the Provider Network Directory NQTL the same to M/S and MH/SUD providers by following the same process when checking for and ensuring accuracy of directory records. Updates, corrections, and evaluations of the directory are done simultaneously among M/S and MH/SUD providers and facilities using the same processes. As noted above under Step 1(a), CareFirst has implemented several levels of checkpoints and reviews such as quarterly reviews for maintaining the accuracy of the directory for both M/S and MH/SUD providers and facilities. These checkpoints include triaging and verifying any identified discrepancies and making any needed updates. CareFirst also performs annual internal audits to ensure accuracy of their network directories. This audit is performed by a third-party to ensure objectivity in the reporting.

IV. Demonstration of Comparability and Stringency In Operation

This section demonstrates that in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying network adequacy standards to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying network adequacy standards with respect to M/S benefits.

A. Explanation of how CareFirst Evaluates Comparability

Below is a comprehensive explanation of how CareFirst evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying network adequacy standards to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying network adequacy standards with respect to M/S benefits.

B. Documentation of Outcomes

1. Evaluation of Relevant Data

Data source: Provider system (PDMES)
Data in the following tables, due to data extraction process, claims were not assigned to the provider. We will update the information once the claims are re-run and work to increase the quality of the mapping of claims to providers.
Methodology: Cases are tracked for providers being enrolled to CareFirst with a VA zip code. Provider specialty for MH/SUD vs M/S were mapped/categorized. The number of days from the initial request to the completed request is tracked.

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1.1 Average Days to Add New Providers to the Directory

Classification / Sub-classification	MH/SUD: # Added	MH/SUD: Avg. Days	M/S: # Added	M/S: Avg. Days	Difference / Variance	Methodology, Start/End Dates, Data Source
Outpatient, Office (Professional)	2,043	30	1,798	33	(3)	Data source: Provider system (PDMES) Due to data extraction process, claims were not assigned to the provider. We will update the information once the claims are re-ran. Methodology: Cases are tracked for new providers being enrolled to CareFirst with a VA zip code. Provider specialty for MH/SUD vs M/S were mapped/categorized. The number of days from the initial request to the completed request is tracked.
Outpatient, All Other (Professional)	2,043	30	1,798	33	(3)	
Outpatient, All Other (Facility)	0					No new Facility was added for CareFirst VA area
Subacute Inpatient (Professional)	2,043	30	1,798	33	(3)	
Acute Inpatient (Professional)	2,043	30	1,798	33	(3)	
Subacute Inpatient (Facility)						No new Facility was added for CareFirst VA area
Acute Inpatient (Facility)						No new Facility was added for CareFirst VA area

1.2 Average Days to Remove Terminated Providers from the Directory

Classification / Sub-classification	MH/SUD: # Removed	MH/SUD: Avg. Days	M/S: # Removed	M/S: Avg. Days	Difference / Variance	Methodology, Start/End Dates, Data Source
Outpatient, Office (Professional)	921	7	880	13	(6)	Data source: Provider system (PDMES) Due to data extraction process, claims were not assigned to the provider. We will update the information once the claims are re-ran. Methodology: Cases are tracked for providers being terminated from CareFirst with a VA zip code. Provider specialty for MH/SUD vs M/S were mapped/categorized. The number of days from the initial request to the completed request is tracked.

Outpatient, All Other (Professional)	921	7	880	13	(6)	
Outpatient, All Other (Facility)	0	0	0	0	0	No Facility was termed in the CareFirst VA area
Subacute Inpatient (Professional)	921	7	880	13	(6)	
Acute Inpatient (Professional)	921	7	880	13	(6)	
Subacute Inpatient (Facility)	0	0	0	0	0	No Facility was termed in the CareFirst VA area
Acute Inpatient (Facility)						No Facility was termed in the CareFirst VA area

1.3 Providers Actively Submitting Claims

Classification / Sub-classification	MH/SUD Directory Total	MH/SUD Active #	MH/SUD Active %	M/S Directory Total	M/S Active #	M/S Active %	Difference	Methodology / Active Definition / Claims & Reimbursement Lookback
Outpatient, Office (Professional)	12,582	2,205	18%	14,879	6,635	45%		For any data that did match a claim, we pulled the counts but acknowledge that a majority of the claims did not match the provider directory data. A new extract will be created to supplement this data and categorize it based on POS.
Outpatient, All Other (Professional)	12,582	2,205	18%	14,879	6,635	45%		see above
Outpatient, All Other (Facility)	9	9	100%	20	18	90%		Note that the 9 facilites in MH/SUD also provide M/S

								services. (Hospitals etc.)
Subacute Inpatient (Professional)	12,582	2,205	18%	14,879	6,635	45%		
Acute Inpatient (Professional)	12,582	2,205	18%	14,879	6,635	45%		
Subacute Inpatient (Facility)	19	13	68%	163	75	46%		
Acute Inpatient (Facility)	9	9	100%	20	18	90%		

1.4 Providers Accepting New Patients

Classification / Sub-classification	MH/SUD Directory Total	MH/SUD Accepting #	MH/SUD Accepting %	M/S Directory Total	M/S Accepting #	M/S Accepting %	Difference	Methodology / Verification Date / Data Source
Outpatient, Office (Professional)	12,582	12,241	97%	14,879	#REF!	#REF!		For any data that did match a claim, we pulled the counts but acknowledge that a majority of the claims did not match the provider directory data. A new extract will be created to supplement this data and categorize it based on POS.
Outpatient, All Other (Professional)	12,582	12,241	97%	14,879	#REF!	#REF!		
Outpatient, All Other (Facility)	9	9	100%	20	#REF!	#REF!		
Subacute Inpatient (Professional)	12,582	12,241	97%	14,879	#REF!	#REF!		
Acute Inpatient (Professional)	12,582	12,241	97%	14,879	#REF!	#REF!		
Subacute Inpatient (Facility)	19	19	100%	163	163	100%		
Acute Inpatient (Facility)	9	9	100%	20	#REF!	#REF!		

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1.5 Directory Accuracy, User Experience, Secret Shopper, and Complaint Metrics

Metric	Classification / Sub-classification	MH/SUD Result	M/S Result	Difference / Finding	Definition, Methodology, Data Source, and Analysis
Directory records reviewed	All audited professional provider-location records; the source decks do not break results out by the requested classification/sub-classification.	1,036	1,257	(221)	2026 CareFirst Provider Directory Audit (PRIME/Atlas); random sample from V12 PDMES; delegated and non-delegated professional provider locations; minimum 5 outreach attempts per phone number. Telehealth fields excluded from change/no-change results. Records reviewed: BH/SUD 1,036; M/S 1,257.
Accurate directory records	All audited professional provider-location records; the source decks do not break results out by the requested classification/sub-classification.	206	275	(69)	2026 CareFirst Provider Directory Audit (PRIME/Atlas); random sample from V12 PDMES; delegated and non-delegated professional provider locations; minimum 5 outreach attempts per phone number. Telehealth fields excluded from change/no-change results. "Accurate" is defined as successful without exception/no change: BH/SUD 206; M/S 275.
Directory accuracy rate	All audited professional provider-location records; the source decks do not break results out by the requested classification/sub-classification.	35.6%	31.7%	3.9 pp	2026 CareFirst Provider Directory Audit (PRIME/Atlas); random sample from V12 PDMES; delegated and non-delegated professional provider locations; minimum 5 outreach attempts per phone number. Telehealth fields excluded from change/no-change results. Rate = accurate records ÷ attested records (BH/SUD 206/578; M/S 275/867).
Unable-to-contact rate	All audited professional provider-location records; the source decks do not break results out by the requested classification/sub-classification.	44.2%	31.0%	13.2 pp	2026 CareFirst Provider Directory Audit (PRIME/Atlas); random sample from V12 PDMES; delegated and non-delegated professional provider locations; minimum 5 outreach attempts per phone number. Telehealth fields excluded from change/no-change results. Unable-to-contact = Final Un-status (Unable to Locate, Uncooperative, or Unresponsive) ÷ all reviewed records: BH/SUD 458/1,036; M/S 390/1,257.

Incorrect telephone/address rate	All audited professional provider-location records; the source decks do not break results out by the requested classification/sub-classification.	Address: 37.5%; Phone: 8.1%	Address: 43.6%; Phone: 6.3%	Address: (6.1) pp; Phone: 1.8 pp	2026 CareFirst Provider Directory Audit (PRIME/Atlas); random sample from V12 PDMES; delegated and non-delegated professional provider locations; minimum 5 outreach attempts per phone number. Telehealth fields excluded from change/no-change results. Field-level changes among attested records. Address: BH/SUD 217/578, M/S 378/867. Phone: BH/SUD 47/578, M/S 55/867. Overlap is not reported, so no combined phone/address rate was inferred.
Incorrect network participation rate	All audited professional provider-location records; the source decks do not break results out by the requested classification/sub-classification.	0.2%	0.0%	0.2 pp	2026 CareFirst Provider Directory Audit (PRIME/Atlas); random sample from V12 PDMES; delegated and non-delegated professional provider locations; minimum 5 outreach attempts per phone number. Telehealth fields excluded from change/no-change results. “Not participating with plan” fatal error ÷ attested records: BH/SUD 1/578; M/S 0/867.
Secret shopper calls/contacts completed	All audited professional provider-location records; the source decks do not break results out by the requested classification/sub-classification.	Not reported (>5,000 audit outreach attempts)	Not reported (>5,000 audit outreach attempts)	Not comparable	2026 CareFirst Provider Directory Audit (PRIME/Atlas); random sample from V12 PDMES; delegated and non-delegated professional provider locations; minimum 5 outreach attempts per phone number. Telehealth fields excluded from change/no-change results. These were provider-directory audit outreach attempts, not secret-shopper calls; exact attempt totals were not provided.
Successful appointment scheduling rate	All audited professional provider-location records; the source decks do not break results out by the requested classification/sub-classification.	Not reported	Not reported	Not comparable	Not reported in either attached presentation; successful appointment scheduling was not tested.
Average time to secure appointment	All audited professional provider-location records; the source decks do not break results out by the requested classification/sub-classification.	Not reported	Not reported	Not comparable	Not reported in either attached presentation; time to secure an appointment was not tested.

Directory complaints received	All audited professional provider-location records; the source decks do not break results out by the requested classification/sub-classification.	Not reported	Not reported	Not comparable	Not reported in either attached presentation; no directory complaint volume was supplied.
Directory complaints substantiated	All audited professional provider-location records; the source decks do not break results out by the requested classification/sub-classification.	Not reported	Not reported	Not comparable	Not reported in either attached presentation; no substantiated complaint volume was supplied.
Directory complaints per 1,000 members	All audited professional provider-location records; the source decks do not break results out by the requested classification/sub-classification.	Not reported	Not reported	Not comparable	Not reported in either attached presentation; member counts and complaint volume needed for this rate were not supplied.
Other metric (specify)	Change rate among attested records (telehealth excluded); all audited professional provider-location records	64.4%	68.3%	(3.9 pp)	2026 CareFirst Provider Directory Audit (PRIME/Atlas); random sample from V12 PDMES; delegated and non-delegated professional provider locations; minimum 5 outreach attempts per phone number. Telehealth fields excluded from change/no-change results. Change rate = records attested with changes ÷ attested records, excluding Telehealth field changes: BH/SUD 372/578; M/S 592/867.

The relevant data consist of the Provider Directories section's PDMES enrollment and termination data, directory-status data, documented monitoring controls, and the 2026 CareFirst Provider Directory Audit (PRIME/Atlas). The section does not state start and end dates for the PDMES enrollment, termination, active-claims, or accepting-new-patients extracts; that omission limits period-specific interpretation. The section separately documents weekly-review examples dated 12.31.2024 and a 2026 audit. For professional providers with a Virginia ZIP code, the PDMES tables report 2,043 MH/SUD providers added in an average of 30 days and 1,798 M/S providers added in an average of 33 days, a reported variance of (3) days. They also report 921 MH/SUD providers removed in an average of 7 days and 880 M/S providers removed in an average of 13 days, a reported variance of (6) days. No new facility was added, and no facility was terminated, for the CareFirst Virginia area in the stated facility rows. These results do not identify slower addition or removal for MH/SUD professional providers. The same professional totals are repeated across multiple benefit classifications, so they cannot be treated as independent classification-specific observations. A gap was identified in that claims were not

assigned to providers as successfully as intended through the data-extraction process and that the claims would be re-run; this limitation prevents a complete claims-based validation and the process is being address in a management action plan to rerun the data and the analysis of those results.

The active-claims table reports 12,582 MH/SUD professional directory records, of which 2,205 were active (18%), and 14,879 M/S professional directory records, of which 6,635 were active (45%). The section expressly acknowledges that a majority of claims did not match provider-directory data and that a new extract would be created and categorized based on place of service. The professional active percentages therefore are not a reliable measure of comparative directory administration or provider availability. Facility results were 9 of 9 active for MH/SUD and 18 of 20 active for M/S in outpatient-all-other and acute-inpatient rows, and 13 of 19 active for MH/SUD and 75 of 163 active for M/S in the subacute-inpatient row; the section states that the 9 MH/SUD facilities also provide M/S services, which limits classification-specific inference. The accepting-new-patients table reports 12,241 of 12,582 MH/SUD professional records (97%), but the corresponding M/S professional result is #REF! and therefore provides no quantitative M/S-versus-MH/SUD comparison. Facility accepting-new-patients results are complete only for the subacute-inpatient row, where both MH/SUD and M/S are reported at 100%; other M/S facility cells contain #REF! or are incomplete.

CareFirst also performs an annual third-party directory test, reports that M/S and MH/SUD data are separated for comparison, and received all possible points for the NCQA network-directory portion, although the NCQA result is not classification-specific. These controls provide process evidence of common production, validation, monitoring, outreach, correction, and audit workflows; they do not cure the stated extraction, missing-period, overlap, or classification-granularity limitations. The 2026 CareFirst Provider Directory Audit provides a quantitative comparison for audited professional provider-location records, although the source decks do not break results out by the requested classification or subclassification. The audit reviewed 1,036 BH/SUD records and 1,257 M/S records. It reports 206 accurate BH/SUD records and 275 accurate M/S records, with accuracy calculated among attested records at 35.6% for BH/SUD and 31.7% for M/S, a 3.9 percentage-point difference. The change rate among attested records was 64.4% for BH/SUD and 68.3% for M/S, a reported difference of (3.9) percentage points. The unable-to-contact rate was 44.2% for BH/SUD and 31.0% for M/S, a 13.2 percentage-point difference. Among attested records, address changes were 37.5% for BH/SUD and 43.6% for M/S, while phone changes were 8.1% for BH/SUD and 6.3% for M/S. The incorrect-network-participation rate was 0.2% for BH/SUD and 0.0% for M/S. These results show a less favorable BH/SUD unable-to-contact outcome and a small BH/SUD network-participation error, but they do not show a lower BH/SUD accuracy rate or higher overall change rate. The audit used a random sample from V12 PDMES, included delegated and non-delegated professional provider locations, required a minimum of 5 outreach attempts per phone number, and excluded telehealth fields from change/no-change results. Exact outreach-attempt totals were not reported beyond more than 5,000 audit outreach attempts; successful appointment scheduling, time to secure an appointment, directory complaint volume, substantiated complaints, and complaints per 1,000 members were not reported.

Operational controls were also evaluated. PI&C updates the provider file system within 15 working days or 19 calendar days after written notice; new-directory additions can take up to 120 calendar days because contracting and credentialing must be completed. Provider IT transmits daily files, NMDT reviews extraction-error reports and triages vendor, source-data, or other issues, and the PDA team investigates and corrects discrepancies.

PI&C and NMDA conduct quarterly suppressed-record reviews by specialty and provider type and correct documented discrepancies before the next quarter. A PI&C Business Analyst reviews the institutional credentialing database weekly; missing or renewed documents are requested every other week by mail, telephone, and email, and a provider is referred to Provider Contracting for possible termination after three unsuccessful outreach attempts. Both M/S and MH/SUD facilities are included in that review and remediation process. **Justification and Analysis**

The factors and evidentiary standards identified earlier in the Provider Directories section are provider contracting and information updates, annual evaluation, quarterly review, and user-friendliness. The cited standards and sources include the Directory Listings Policy PIC 202.00, SOP SRV 205.00, Directory Suppress Report Policy PIC 310.00, Provider Directory Policy OP.PR.15, Institutional Credentialing Database Policy PIC 329.00, Provider Directory Data Support Policy CC NMDT 300.00, Provider Data Accuracy Data Support Policy MA NMDT 400.00, the Credentialing and Recredentialing File Audit Process CO QA 320.01, the No Surprises Act, NCQA requirements, provider and contracting data, user feedback, and the identified vendor and internal-system reports. The documented strategy applies updates, corrections, evaluations, directory mapping, quarterly checkpoints, annual testing, daily extraction review, and weekly facility review to both M/S and MH/SUD provider records. The records are handled through the same PI&C, Provider IT, NMDT/NMDA, PDA, Provider Contracting, Sapphire Digital, and BCBSA workflows; provider-type and specialty review is part of the common control structure rather than an additional MH/SUD requirement.

The process evidence does not identify an MH/SUD-specific factor, evidentiary threshold, update deadline, validation step, outreach sequence, audit rule, suppression review, correction pathway, or usability requirement that is more stringent than the corresponding M/S requirement. The completed PDMES addition and removal metrics also do not show slower administration for MH/SUD professional providers. The 2026 audit identifies operational differences that require qualification: BH/SUD had a higher unable-to-contact rate and a 0.2% incorrect-network-participation rate compared with 0.0% for M/S, while BH/SUD had a higher reported accuracy rate and a lower reported change rate. Those mixed outcomes identify areas for continued monitoring and correction, but the evidence does not connect them to a stricter MH/SUD process, standard, or strategy.

Process comparability and quantitative outcome comparability are distinct. Common policies, departments, systems, vendor feeds, outreach, audits, and correction controls support comparability of administration. Quantitative conclusions are narrower because the PDMES tables omit extract start and end dates; claims matching was incomplete; repeated professional totals are not independent classification-level results; some accepting-new-patients cells contain #REF!; the 9 MH/SUD facilities also provide M/S services; the audit is limited to professional provider-location records and lacks the requested classification/subclassification detail; and appointment-access, complaint, and exact outreach-volume measures were not supplied. Accordingly, the available evidence supports no-more-stringent process application to MH/SUD, but it does not support an unqualified conclusion that every operational outcome is equivalent.

V. Findings and Conclusions

As written, the Provider Directories NQTL applies the same identified factors, evidentiary standards, and strategies to M/S and MH/SUD providers and benefits. The documented basis is the common directory-production and update process; the 15-working-day or 19-calendar-day update rule; the contracting-and-credentialing prerequisite for additions; daily Provider IT transmission and NMDT/PDA error triage; quarterly suppression review

and correction; weekly institutional credential monitoring and provider outreach; annual third-party testing; common search mapping and usability review; and the express inclusion of both M/S and MH/SUD records in those controls. No documented policy or workflow imposes an additional or more restrictive directory requirement on MH/SUD providers.

In operation, the completed evidence does not show that directory requirements were applied more stringently to MH/SUD providers. MH/SUD professional-provider addition and removal averages were not slower than the corresponding M/S averages. The 2026 audit reported a higher BH/SUD accuracy rate and lower change rate, but also a higher unable-to-contact rate and a 0.2% incorrect-network-participation rate compared with 0.0% for M/S. Those less favorable BH/SUD results are material monitoring findings; the section does not attribute them to a different MH/SUD standard, system, department, vendor, provider workflow, or correction process. The documented common controls require investigation and correction of discrepancies across provider types.

This conclusion is qualified by the record's limitations. The PDMES extracts do not state start and end dates, claims matching was incomplete, professional totals are repeated across classifications, some M/S accepting-new-patients results are not available, facility categories overlap, and the 2026 audit does not provide the requested classification/subclassification detail or appointment and complaint measures. The evidence therefore supports comparability of the documented design and operational processes and does not demonstrate disparate or more stringent treatment of MH/SUD. It does not establish categorical equivalence for every directory outcome, and the identified BH/SUD contactability and network-participation findings require continued application of the documented validation, outreach, monitoring, and correction controls.

VI. Required Certification

CareFirst certifies that the foregoing comparative analysis of the Provider Directories NQTL was prepared for the Virginia fully insured coverage identified in this report and was reviewed by individuals with appropriate knowledge of the plan terms, policies, procedures, factors, evidentiary standards, operational practices, supporting documentation, and relevant data addressed in the analysis. The analysis applies to the CareFirst entities identified in this report as NAIC 53007 and NAIC 9602 to the extent the NQTL is designed and administered as described in this analysis.

To the best of CareFirst's knowledge and based on the information, documentation, and data reviewed as of the report's version date, this comparative analysis is accurate and complete in all material respects and demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the Provider Directories NQTL to mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, those used to design and apply the NQTL to medical/surgical benefits, as written and in operation. CareFirst will maintain supporting documentation and will update or supplement the analysis if a material change, newly identified data limitation, or corrective action affects this conclusion.

Proprietary and Confidential Information of CareFirst, Inc. and its affiliates and subsidiaries. This information shall only be disclosed as required by law.

NETWORK ADEQUACY

Overview

The following analysis demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the network adequacy requirement to mental health or substance use disorder ("MH/SUD") benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the network adequacy requirement to medical/surgical ("M/S") benefits.

I. Description of the Network Adequacy NQTL

CareFirst assesses network adequacy based on access standards that are consistent with State requirements, industry standards (NCQA), and guidelines produced by the Centers for Medicare and Medicaid Services (CMS). CareFirst maintains an open network and contracts with all providers and facilities that apply, so long as they meet our credentialing standards and accept the terms of participation. CareFirst actively recruits providers based on account requests, member inquiries, and other ongoing efforts to ensure that current and prospective members have access to the providers of their choice.

CareFirst has established a policy to ensure that the network of practitioners is sufficient to provide appropriate access to primary care, behavioral healthcare, and specialty healthcare to meet members' needs and preferences. The components of network adequacy listed below are reviewed, revised and approved, at least annually, by the Quality Improvement Committee.

CareFirst applies the standards for network adequacy as stated in 12VAC5-408-270 of the VA Administrative Code and also examines industry or national accreditation standards as provided by CMS and NCQA. After reviewing the relevant state rules, CMS, and NCQA guidance, CareFirst applies the most stringent measure for network adequacy out of the three sets of guidelines. This ensures that CareFirst satisfies the State requirements while also aiming to meet all industry-accepted access standards. At this time, CareFirst does not use Artificial Intelligence (AI) to make decisions regarding network adequacy.

A. Identification of the NQTL

i. Plan/Coverage Terms Regarding Network Adequacy

The Plan document contains the following sections regarding network adequacy. These sections apply to both M/S benefits and MH/SUD benefits, and do not differentiate between M/S and MH/SUD benefits:

- Definitions
- General Provisions
- Inter-Plan Arrangements Disclosure Amendment

(*Source:* Plan EOC)

ii. Policies/Guidelines/Other Documents Describing Network Adequacy

Network adequacy appears or is described in the following documents:

- Network Adequacy Plan Policy PIC 306.00, pp. 1-2
- Network Sufficiency Standards
- NCQA Network Management Standards Policy PIC 405.00, pp. 2-3
- Improving Access to Behavioral Health Care
- New Behavioral Health Digital Resource Guide

iii. Identification of All MH/SUD Benefits and M/S Benefits which Network Adequacy Standards Apply

All M/S and MH/SUD in-network benefits are subject to network adequacy requirements.

II. Identification and Definition of the Factors and Evidentiary Standards Used in the Design and Application of an Adequate Network

A. Factors and Evidentiary Standards for Designing an Adequate Network

Factor 1	**State Standards**
Definition	CareFirst follows all applicable state standards.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other
Description	Where applicable, CareFirst follows state laws regarding network adequacy requirements.
Source(s) of Factor	• 12VAC5-408-270 of the VA Administrative Code and
Evidentiary Standards and Applicable Thresholds	It is CareFirst policy to file a provider Network Access Plan each year with the VBOI and monitor the adequacy of the provider network to meet the healthcare needs of its members.
Source(s) of Evidentiary Standards	• 12VAC5-408-270 of the VA Administrative Code

Factor 2	**Industry Standards**
Definition	The generally accepted or required network adequacy standards.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other

Description	CareFirst relies upon industry standards when reviewing network data for network adequacy.
Source(s) of Factor	• NCQA standards and guidelines • CMS network adequacy guidance
Evidentiary Standards and Applicable Thresholds	NCQA standards
Source(s) of Evidentiary Standards	• NCQA network standards • NCQA Network Standard - 1 Availability of Practitioners • NCQA Network Standard - 2 Accessibility of Services • NCQA Network Standard - 3 Assessment of Network Adequacy • NCQA Network Standard - 4 Marketplace Network Transparency and Experience • NCQA Network Standard - 5 Continued Access to Care • NCQA Network Standard - 6 Physician and Hospital Directories • NCQA Network Standard - 7 Delegation of NET • CMS network adequacy guidance: Updated 2024 Medicare-Medicaid Plan Network Adequacy Criteria and Guidance

a. Factors and Evidentiary Standards for Maintaining an Adequate Network

All factors, evidentiary standards, and sources listed above that apply to developing an adequate network apply to ongoing network adequacy testing and confirmation of compliance. Additionally, the below factors, evidentiary standards, and sources apply to the design and application of strategies to address provider shortages within the network.

Factor 1	**Network Need**
Definition	CareFirst prioritizes addressing geographic and specialty shortages identified in network reporting or customer complaints.
Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst relies upon the geographic accessibility standards to confirm network adequacy or work to adjust the volume of providers by adding more providers by geographic area.

Source(s) of Factor	• Out-of-network utilization trends • Customer access complaints • Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results • Network disruption studies • Claim data and trends • Non-participating provider trends
Evidentiary Standards and Applicable Thresholds	Out-of-network utilization trends/Claims data and trends: • CareFirst aims to maintain a 98% in-network claim percentage. If that number drops below 98%, CareFirst increases recruiting and contracting efforts. Customer access complaints: • Through customer complaints, CareFirst identifies network inadequacies and works to add more providers to the network to ensure access to care for members. CareFirst aims to review all access and adequacy complaints. CAHPS results: • Upon receiving CAHPS survey results, network adequacy feedback is forwarded to the CareFirst Provider Contracting team to research and recruit providers if needed. Network disruption studies: • On a quarterly basis, a network disruption report is generated to highlight any potential gaps in network adequacy such as provider shortages or a narrow network that does not have sufficient capacity to serve members If gaps in providers are identified, it is sent to the CareFirst Provider Contracting team to outreach and recruit the needed providers to join the CareFirst network. Non-participating provider trends • After 10 claims and or 2 or more Single Case Agreements (SCA) received in less than 3 months, CareFirst will outreach to provider to begin discussions to participate in the network. CareFirst will outreach via phone, mail, and email. CareFirst will make 10 attempts to reach the provider. In addition, if an SCA is received after outreach has been attempted, we will use this communication to bring that provider into the network.
Source(s) of Evidentiary Standards	• Out-of-network utilization trends • Customer access complaints

	• Network disruption studies • Claim data and trends • Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey results

Factor 2	**Technology and Virtual Connect Strategies**
Definition	CareFirst maintains a virtual connect strategy to enhance access to care. These strategies include contracting with services like CloseKnit (M/S and MH/SUD), Headway (MH/SUD), and Navigator (SUD) to enhance both virtual and in-person care. Additional details regarding these programs are included in the Processes and Strategy sections below.
Application Benefit Classification(s)	• In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst contracts with various third-party vendors to increase access to care through virtual options and patient guidance.
Source(s) of Factor	• Virtual connect strategies • Technology strategies
Evidentiary Standards and Applicable Thresholds	CareFirst utilizes technology and virtual connect options to increase network accessibility. Specifically, CareFirst provides CloseKnit at no cost-sharing for M/S and MH/SUD telehealth visits. CareFirst also decreases barriers to contracting through use of Headway to minimize administrative barriers for behavioral health providers.
Source(s) of Evidentiary Standards	• Virtual connect strategies • Technology strategies

Factor 3	**Open Network**
Definition	CareFirst continuously maintains an open network and contracts with all applying providers who meet our credentialing standards and accept terms of participation. Maintaining an open network allows for CareFirst to contract with new providers at any time and reduces the contracting timeframe as there are no contracting windows.

Application Benefit Classification(s)	• In-Network Inpatient • In-Network Outpatient Office • In-Network Outpatient Other
Description	CareFirst maintains an open network to allow for year-round contracting efforts to improve network adequacy and regularly address any network deficiencies or provider shortages.
Source(s) of Factor	• Network sufficiency and access plan
Evidentiary Standards and Applicable Thresholds	CareFirst maintains an open network to ensure continued growth of the member network and to decrease barriers to contracting.
Source(s) of Evidentiary Standards	• Network sufficiency and access plan

A. Processes

CareFirst maintains an open network and contracts with all applying providers who meet our credentialing standards and accept terms of participation. We also actively recruit providers based on account requests, or member inquiries, to ensure our current and prospective members have access to the providers of their choice.

On an annual basis, CareFirst reviews its non-PAR participating provider claims within its service area (e.g., MD, DC and N. VA) to:

1. identify if our Members are seeking services outside the network,
2. why they are going out of network,
3. by whom are they being treated,
4. with what frequency or volume and
5. if the provider has been recruited recently by CareFirst to participate.

The above review allows our Provider Contracting team to continuously monitor out of network provider usage and identify old and new providers for recruitment. This process enables CareFirst to keep up with member preferences and changes to member geographic distribution. Our goal each year is to maintain a level of in-network claims at 98%.

CareFirst conducts a Network Adequacy Analysis at least yearly, which measures geographic distribution of practitioners to member residences for urban, suburban, and rural areas. This allows us to assess where members are located in relation to providers and determine if there are any changes or potential deficiencies. To ensure our provider network size aligns with our enrollment, we assess our Practitioner to member ratios for the following provider types:

- adult and pediatric primary care practitioners,
- obstetricians/gynecologists (OB/GYNs),
- high-volume medical specialists (Cardiology, Dermatology, Orthopedics, Oncology, Nephrology, and Psychiatry) and
- behavioral health practitioners.

CareFirst assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary. To evaluate the availability of practitioners who provide primary care services, specialty care services and behavioral health care services, CareFirst has established standards for the number and geographic distribution by type of practitioner providing primary care, specialty care and behavioral health care. CareFirst annually analyzes performance against the standards for the number and geographic distribution by type of practitioner providing primary care, specialty care and behavioral health care. To assess member experience in accessing the network, CareFirst annually:

- Analyzes data from member experience, complaints and appeals about network adequacy for nonbehavioral and behavioral healthcare services.
- Compiles and analyzes requests for and utilization of out-of-network services.
- Uses analyses to determine if there are gaps in the network specific to particular geographic areas or types of practitioners or providers.
- Prioritizes opportunities for improvement identified from analyses of availability accessibility and CAHPS survey results and member complaints and appeals Implements interventions on at least one opportunity, if applicable.
- Reviews QHP Enrollee Experience Survey results.
- Measures the effectiveness of interventions, if applicable.

B. Strategy

CareFirst assesses the cultural, ethnic, racial and linguistic needs of its members and adjusts the availability of practitioners within its network, if necessary. To evaluate the availability of practitioners who provide primary care services, specialty care services and behavioral health care services, CareFirst has established standards for the number and geographic distribution by type of practitioner providing primary care, specialty care and behavioral health care. CareFirst annually analyzes performance against the standards for the number and geographic distribution by type of practitioner providing primary care, specialty care and behavioral health care.

CareFirst has established mechanisms to provide access to appointments for primary care services, behavioral healthcare services and specialty care services. Using a defined methodology, CareFirst collects and performs an annual analysis of data to measure its performance against its standards for access to:

- Regular and routine care appointments.

- Urgent care appointments.
- After-hours care.
- Behavioral healthcare
- High volume and high impact specialty care

To assess member experience with its services, CareFirst evaluates member complaints, appeals and requests for out-of-network services by:

- Collecting valid measurement data for the five required categories of complaints/appeals.
- Compiling requests for and utilization of out-of-network services.

To comply with NCQA standards, CareFirst considers both high volume and high impact specialists. High volume specialists are identified by the number of claims bailed. The top four specialties billing the highest volume of claims are categorized as high volume. High impact specialists are identified by total cost of claims billed. The top three specialties billing the most in claim amount are categorized as high impact. Based on these definitions and NCQA standards, CareFirst applies the following goals for practitioner to member ratio based on practitioner specialty and whether they are high volume or high impact specialists:

- 1:400 for adult and pediatric PCPs;
- 1:1,000 for OB/GYNs (high-volume);
- 1:3,000 for orthopedists (high-volume);
- 1:5,000 for cardiologists, dermatologists (high-volume)
- 1:5,000 for nephrologists, and oncologists (high impact); and
- 1:2,000 for all behavioral health practitioners.

NCQA standards also include geographic standards that CareFirst follows to ensure that there are sufficient practitioners in all areas of the network The geographic standards are below, and CareFirst strives to meet 95% or higher in each category:

- Primary Care: 2 family/general practitioners, 2 internists/geriatricians and 2 pediatric PCPs within 5 miles of member’s residence for urban, 10 miles for suburban and 20 miles for rural areas.
- High-Volume Specialists (OB/GYN, Cardiology,
- Dermatology): 2 OB/GYN and 1 high- volume specialist for each type within 5 miles of member’s residence for urban, 10 miles for suburban and 30 miles for rural areas.

- High-Impact Specialists (Nephrology, Oncology, Psychiatry): 1 each for Oncology and Nephrology within 5 miles of the member's residence for urban, 10 miles for suburban and 30 miles for rural; 1 Psychiatrist within 8 miles of member's residence for urban, 18 miles for suburban and 45 miles for rural areas; and
- High-Volume Behavioral Health Specialists (Psychiatry, Psychology, Licensed Professional Counselor, Masters' Level Social Worker): 1 each within 8 miles of the member's residence for urban, 18 miles for suburban and 45 miles for rural areas.

Any identified gaps or shortages are managed through a gap remediation process and recruitment efforts are initiated. Both external and internal sources are used to identify providers for recruitment. These include:

- competitor directories
- hospital directories of providers with admitting privileges
- online yellow pages
- Google/Bing maps
- medical societies directories
- member requests
- provider referrals

The gap remediation progress is monitored through the Quality Improvement Committee (QIC) which meets at least 7 times yearly, but more often if necessary and works to address provider shortages. The QIC is responsible for the following:

- Review and approve the Population Health Strategy Description
  - assess the population health needs of CareFirst communities and the members it serves.
  - determine how CareFirst addresses those needs; identify opportunities for improvement.
- Review and approve Quality Improvement Program, Evaluation and Workplan
  - approve the plan to maintain and improve operational quality throughout the organization.
  - oversee quality improvement functions within the organization.
  - analyze and evaluate results of those improvement functions.
- Assess organization wide performance against the health plan's quality and efficiency targets.
  - review and approve goals and objectives.

  - review performance against targets
- Establish practitioner and network adequacy availability and access standards.
  - measure and evaluate health plan's ability to meet standards.
  - identify and address opportunities for improvement.
  - select quality initiatives to improve access to care and services.
- Establish quality performance goals, objectives, and thresholds.
  - measure and evaluate outcomes.
  - identify and address barriers to improved performance.
- Review and approve policies, procedures, and standards to support quality improvement programs.
  - meet appropriate National Committee on Quality Assurance (NCQA) standards
  - meet all applicable accreditation and regulatory standards and guidelines.
- Analyze member and provider satisfaction and experience results.
  - identify and address opportunities for improvement.
- Review, analyze and approve subcommittee reports, programs, evaluations and/or minutes (Quality Improvement Advisory, Credentialing, Pharmacy, Care Management, Delegation Oversight, and Service Committees)
  - Provides feedback and guidance to subcommittees.

The QIC is chaired by a medical director; additional committee membership includes medical and behavioral health directors; Director of Quality, Manager of Quality, Quality Analysts, and functional area representatives from throughout CareFirst. The committee will invite other appropriate associates to the committee as required, based on specific reporting needs.

CareFirst utilizes internal time/access/distance standards testing to ensure proper network adequacy. To confirm compliance with these standards, CareFirst uses an application provided by a third party vendor called Quest. CareFirst uploads the membership and provider data files to this program and run queries using provider type, provider location, & member location. This allows CareFirst to assess the distance between a member in a given zip code and the closest provider location in miles of a given provider type. From this, the time/access/distance standards testing results are created.

In addition to following NCQA access standards, CareFirst has taken steps to improve access by adopting virtual strategies. The following virtual strategies apply to MH/SUD or M/S care as outlined below:

- CloseKnit which offers an integrated experience between primary and behavioral health care. CloseKnit providers can assess needs to help members connect with doctors and is accessible 24/7/365. (M/S and MH/SUD services).
- Headway expands access to in-network mental health care by removing the barriers faced by providers, health plans, and the patients they serve. Headway's secure online platform is available to CareFirst's network of mental health providers at no cost and enables efficient scheduling, billing and more. Members can browse and book appointments with clinicians based on specialty, demographic information, and real-time availability – and obtain immediate price transparency. Practitioner-patient matching is important in mental health, maybe even more so than in other types of care. Through this initiative, we further invest in mental health providers. (MH services)
- Through the partnership with Navigator, CareFirst Members seeking evaluation and treatment for SUD have access to 24/7/365 support by calling the mental health and substance use phone number on the back of their insurance card. The number connects each individual with a licensed behavioral health clinician with expertise in SUD who helps them understand treatment options and schedules an evaluation on demand in a same-day or next-day timeframe. Once placed in a treatment program, Navigator follows and supports the Member for up to 6 months through any transitions of care and help them troubleshoot rough patches on the way to recovery. (SUD services)
- CareFirst offers a cost share waiver for intensive outpatient SUD services. When participating in this program, costs for eligible services may be waived depending on your benefits. Our support team through Navigator can connect Members with trusted providers within recovery centers. There are currently 15 facilities with 45 physical locations accessible to members. Some also offer virtual care. Program information is publicly available here: https://member.carefirst.com/members/health-wellness/staying-healthy/addiction-program.page (SUD services)

C. Relationship Between Factors

All factors in the analyses are considered equally and no single factor carries more weight than another Additionally, no factors were considered but rejected. Lastly, all factors apply to both M/S and MH/SUD classified services.

III. Demonstration of Comparability and Stringency as Written

Federal and State regulations establish minimum standard requirements for carriers for network adequacy. Federal agencies such as CMS and National Accreditation standards such as NCQA also provide industry standards for network adequacy. CareFirst policies and strategies meet the respective State required standards, and as indicated above, standards utilized may be a combination of State, CMS, and NCQA standards/guidelines to enable CareFirst to strive to meet slightly more demanding standards if applicable for improved adequacy.

Using data to determine if the standards for time, distance, and provider-to-enrollee ratios are being met is a major part of the process for assessing network adequacy and determining if there are any gaps in access or provider shortages that need to be addressed. Other sources that CareFirst uses to access network adequacy and determine if there are any gaps in access or provider shortages include: the quarterly network disruption studies/reports; member complaints; CAHPS surveys; OON utilization claims, non-participating provider trends, member requests; new member address reviews, and marketability analysis. These can all be used to review and evaluate the Company's network adequacy and members' access to providers.

CareFirst offers additional virtual benefits for MH/SUD services to provide members with a variety of ways to access MH/SUD care. These services are broader for MH/SUD services as CareFirst only applies one virtual strategy for M/S services, which is CloseKnit, but provides four virtual strategies for MH/SUD. These strategies significantly increase access to MH/SUD care. Specifically, Headway allows access to 1,221 providers serving 9,511 members Additionally, Navigator has offered 100% of members with same-day or next-day in-network appointments. Please see below for further infographics regarding these programs.

All factors and evidentiary standards are applied to network adequacy standards for both M/S and MH/SUD providers. Additionally, CareFirst has taken steps to ensure access to MH and SUD providers through virtual strategies to reduce barriers to care. Based on this assessment, CareFirst confirms that the network adequacy NQTL is applied no more stringently to MH/SUD providers than to M/S providers in writing.

IV. Demonstration of Comparability and Stringency In Operation

This section demonstrates that in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying network adequacy standards to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying network adequacy standards with respect to M/S benefits.

A. Explanation of how CareFirst Evaluates Comparability

Below is a comprehensive explanation of how CareFirst evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying network adequacy standards to MH/SUD benefits in a classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying network adequacy standards with respect to M/S benefits.

B. Documentation of Outcomes

1. Evaluation of Relevant Data

a. Time/Access/Distance Standards and Provider to Member Ratios

Primary Care	URBAN	SUBURBAN	RURAL	RATIO
2 Family or General Practitioners	Within 5 miles	Within 10 miles	Within 20 miles	1:400
2 Internists Geriatricians	Within 5 miles	Within 10 miles	Within 20 miles	1:400
2 pediatric PCPs	Within 5 miles	Within 10 miles	Within 20 miles	1:400
High-Volume Specialists				
2 OB/GYN	Within 5 miles	Within 10 miles	Within 30 miles	1:1000
1 Cardiology	Within 5 miles	Within 10 miles	Within 30 miles	1:5000

1 Orthopedics	Within 5 miles	Within 10 miles	Within 30 miles	1:3000
1 Dermatology	Within 5 miles	Within 10 miles	Within 30 miles	1:5000
High-Impact Specialists				
1 Nephrology	Within 5 miles	Within 10 miles	Within 30 miles	1:5000
1 Oncology	Within 5 miles	Within 10 miles	Within 30 miles	1:5000
1 Psychiatry	Within 8 miles	Within 18 miles	Within 45 miles	1:2000
High-Volume Behavioral Health Specialists				
Psychiatry	Within 8 miles	Within 18 miles	Within 45 miles	1:2000
Psychology	Within 8 miles	Within 18 miles	Within 45 miles	1:2000
Licensed Professional Counselor	Within 8 miles	Within 18 miles	Within 45 miles	1:2000
Masters' Level Social Worker	Within 8 miles	Within 18 miles	Within 45 miles	1:2000

b. CareFirst GHMSI PPO Time/Access/Distance Standards Results

Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Urban	84,747	Addiction Medicine - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	Allergy and Immunology - PPO	Inv 1 in 15 miles	84,747	100
Urban	84,747	Applied Behavioral Analyst - PPO	Inv 1 in 15 miles	84,747	100
Urban	84,747	Cardiovascular Disease - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	Chiropractic - PPO	Inv 1 in 15 miles	84,747	100

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Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Urban	84,747	Dermatology - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	Endocrinology - PPO	Inv 1 in 15 miles	84,747	100
Urban	84,747	ENT/Otolaryngology - PPO	Inv 1 in 15 miles	84,747	100
Urban	84,747	Gastroenterology - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	General Surgery - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	Gynecology, OB/GYN Nurse-Midwifery - PPO	Inv 1 in 5 miles	84,740	99.9
Urban	84,747	Licensed Clinical Social Worker - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	Licensed Professional Counselor - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	Nephrology - PPO	Inv 1 in 15 miles	84,747	100
Urban	84,747	Neurology - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	Oncology-Medical and Surgical - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	Oncology-Radiation/Radiation Oncology - PPO	Inv 1 in 15 miles	84,747	100

Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Urban	84,747	Ophthalmology - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	Pediatrics-Routine/Primary Care - PPO	Inv 1 in 5 miles	84,747	100
Urban	84,747	Physiatry, Rehabilitative Medicine - PPO	Inv 1 in 15 miles	84,747	100
Urban	84,747	Plastic Surgery - PPO	Inv 1 in 15 miles	84,747	100
Urban	84,747	Podiatry - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	Primary Care (non-pediatric) - PPO	Inv 1 in 5 miles	84,747	100
Urban	84,747	Psychiatry-Adolescent and Child, Outpatient - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	Psychiatry-Geriatric, Outpatient - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	Psychiatry-Outpatient - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	Psychology - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	Pulmonology - PPO	Inv 1 in 10 miles	84,746	99.9

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Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Urban	84,747	Rheumatology - PPO	Inv 1 in 15 miles	84,747	100
Urban	84,747	Urology - PPO	Inv 1 in 10 miles	84,747	100
Urban	84,747	All Other licensed or certified providers - PPO	Inv 1 in 15 miles	84,747	100
Suburban	75,746	Addiction Medicine - PPO	Inv 1 in 25 miles	75,746	100
Suburban	75,746	Allergy and Immunology - PPO	Inv 1 in 30 miles	75,746	100
Suburban	75,746	Applied Behavioral Analyst - PPO	Inv 1 in 30 miles	75,746	100
Suburban	75,746	Cardiovascular Disease - PPO	Inv 1 in 20 miles	75,746	100
Suburban	75,746	Chiropractic - PPO	Inv 1 in 30 miles	75,746	100
Suburban	75,746	Dermatology - PPO	Inv 1 in 30 miles	75,746	100
Suburban	75,746	Endocrinology - PPO	Inv 1 in 40 miles	75,746	100
Suburban	75,746	ENT/Otolaryngology - PPO	Inv 1 in 30 miles	75,746	100
Suburban	75,746	Gastroenterology - PPO	Inv 1 in 30 miles	75,746	100

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Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Suburban	75,746	General Surgery - PPO	Inv 1 in 20 miles	75,746	100
Suburban	75,746	Gynecology, OB/GYN Nurse-Midwifery - PPO	Inv 1 in 10 miles	75,705	99.9
Suburban	75,746	Licensed Clinical Social Worker - PPO	Inv 1 in 25 miles	75,746	100
Suburban	75,746	Licensed Professional Counselor - PPO	Inv 1 in 25 miles	75,746	100
Suburban	75,746	Nephrology - PPO	Inv 1 in 25 miles	75,746	100
Suburban	75,746	Neurology - PPO	Inv 1 in 30 miles	75,746	100
Suburban	75,746	Oncology-Medical and Surgical - PPO	Inv 1 in 20 miles	75,746	100
Suburban	75,746	Oncology-Radiation/Radiation Oncology - PPO	Inv 1 in 40 miles	75,746	100
Suburban	75,746	Ophthalmology - PPO	Inv 1 in 20 miles	75,746	100
Suburban	75,746	Pediatrics-Routine/Primary Care - PPO	Inv 1 in 10 miles	75,742	99.9
Suburban	75,746	Physiatry, Rehabilitative Medicine - PPO	Inv 1 in 30 miles	75,746	100

Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Suburban	75,746	Plastic Surgery - PPO	Inv 1 in 40 miles	75,746	100
Suburban	75,746	Podiatry - PPO	Inv 1 in 30 miles	75,746	100
Suburban	75,746	Primary Care (non-pediatric) - PPO	Inv 1 in 10 miles	75,746	100
Suburban	75,746	Psychiatry-Adolescent and Child, Outpatient - PPO	Inv 1 in 25 miles	75,746	100
Suburban	75,746	Psychiatry-Geriatric, Outpatient - PPO	Inv 1 in 25 miles	75,746	100
Suburban	75,746	Psychiatry-Outpatient - PPO	Inv 1 in 25 miles	75,746	100
Suburban	75,746	Psychology - PPO	Inv 1 in 25 miles	75,746	100
Suburban	75,746	Pulmonology - PPO	Inv 1 in 30 miles	75,746	100
Suburban	75,746	Rheumatology - PPO	Inv 1 in 40 miles	75,746	100
Suburban	75,746	Urology - PPO	Inv 1 in 30 miles	75,746	100
Suburban	75,746	All Other licensed or certified providers - PPO	Inv 1 in 40 miles	75,746	100

Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Rural	26,286	Addiction Medicine - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Allergy and Immunology - PPO	Inv 1 in 75 miles	26,286	100
Rural	26,286	Applied Behavioral Analyst - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Cardiovascular Disease - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Chiropractic - PPO	Inv 1 in 75 miles	26,286	100
Rural	26,286	Dermatology - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Endocrinology - PPO	Inv 1 in 90 miles	26,286	100
Rural	26,286	ENT/Otolaryngology - PPO	Inv 1 in 75 miles	26,286	100
Rural	26,286	Gastroenterology - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	General Surgery - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Gynecology, OB/GYN Nurse-Midwifery - PPO	Inv 1 in 30 miles	26,286	100
Rural	26,286	Licensed Clinical Social Worker - PPO	Inv 1 in 60 miles	26,286	100

Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Rural	26,286	Licensed Professional Counselor - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Nephrology - PPO	Inv 1 in 75 miles	26,286	100
Rural	26,286	Neurology - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Oncology-Medical and Surgical - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Oncology-Radiation/Radiation Oncology - PPO	Inv 1 in 90 miles	26,286	100
Rural	26,286	Ophthalmology - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Pediatrics-Routine/Primary Care - PPO	Inv 1 in 30 miles	26,286	100
Rural	26,286	Physiatry, Rehabilitative Medicine - PPO	Inv 1 in 75 miles	26,286	100
Rural	26,286	Plastic Surgery - PPO	Inv 1 in 90 miles	26,286	100
Rural	26,286	Podiatry - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Primary Care (non-pediatric) - PPO	Inv 1 in 30 miles	26,286	100

Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Rural	26,286	Psychiatry-Adolescent and Child, Outpatient - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Psychiatry-Geriatric, Outpatient - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Psychiatry-Outpatient - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Psychology - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Pulmonology - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	Rheumatology - PPO	Inv 1 in 90 miles	26,286	100
Rural	26,286	Urology - PPO	Inv 1 in 60 miles	26,286	100
Rural	26,286	All Other licensed or certified providers - PPO	Inv 1 in 90 miles	26,286	100

c. CareFirst BlueChoice HMO Time/Access/Distance Standards Results

Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Rural	141,878	Addiction Medicine - HMO	Inv 1 in 60 miles	141,878	100

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Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Rural	141,878	Allergy and Immunology - HMO	Inv 1 in 75 miles	141,878	100
Rural	141,878	Applied Behavioral Analyst - HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	Cardiovascular Disease – HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	Chiropractic - HMO	Inv 1 in 75 miles	141,878	100
Rural	141,878	Dermatology – HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	Endocrinology – HMO	Inv 1 in 90 miles	141,878	100
Rural	141,878	ENT/Otolaryngology – HMO	Inv 1 in 75 miles	141,878	100
Rural	141,878	Gastroenterology – HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	General Surgery – HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	Gynecology, OB/GYN Nurse-Midwifery – HMO	Inv 1 in 30 miles	141,878	100
Rural	141,878	Licensed Clinical Social Worker – HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	Licensed Professional Counselor - HMO	Inv 1 in 60 miles	141,878	100

Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Rural	141,878	Nephrology – HMO	Inv 1 in 75 miles	141,878	100
Rural	141,878	Neurology- HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	Oncology-Medical and Surgical – HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	Oncology-Radiation/Radiation Oncology - HMO	Inv 1 in 90 miles	141,878	100
Rural	141,878	Ophthalmology - HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	Pediatrics-Routine/Primary Care - HMO	Inv 1 in 30 miles	141,878	100
Rural	141,878	Physiatry, Rehabilitative Medicine – HMO	Inv 1 in 75 miles	141,878	100
Rural	141,878	Plastic Surgery – HMO	Inv 1 in 90 miles	141,878	100
Rural	141,878	Podiatry – HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	Primary Care (non-pediatric) – HMO	Inv 1 in 30 miles	141,878	100
Rural	141,878	Psychiatry-Adolescent and Child, Outpatient – HMO	Inv 1 in 60 miles	141,878	100

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Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Rural	141,878	Psychiatry-Geriatric, Outpatient – HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	Psychiatry-Outpatient – HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	Psychology – HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	Pulmonology – HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	Rheumatology – HMO	Inv 1 in 90 miles	141,878	100
Rural	141,878	Urology – HMO	Inv 1 in 60 miles	141,878	100
Rural	141,878	All Other licensed or certified providers – HMO	Inv 1 in 90 miles	141,878	100
Suburban	140,570	Addiction Medicine – HMO	Inv 1 in 25 miles	140,570	100
Suburban	140,570	Allergy and Immunology – HMO	Inv 1 in 30 miles	140,026	99.6
Suburban	140,570	Applied Behavioral Analyst – HMO	Inv 1 in 30 miles	140,570	100
Suburban	140,570	Cardiovascular Disease – HMO	Inv 1 in 20 miles	140,570	100
Suburban	140,570	Chiropractic – HMO	Inv 1 in 30 miles	140,570	100

Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Suburban	140,570	Dermatology – HMO	Inv 1 in 30 miles	140,570	100
Suburban	140,570	Endocrinology – HMO	Inv 1 in 40 miles	140,570	100
Suburban	140,570	ENT/Otolaryngology – HMO	Inv 1 in 30 miles	140,565	99.9
Suburban	140,570	Gastroenterology – HMO	Inv 1 in 30 miles	140,570	100
Suburban	140,570	General Surgery – HMO	Inv 1 in 20 miles	140,570	100
Suburban	140,570	Gynecology, OB/GYN Nurse-Midwifery – HMO	Inv 1 in 10 miles	139,865	99.5
Suburban	140,570	Licensed Clinical Social Worker – HMO	Inv 1 in 25 miles	140,570	100
Suburban	140,570	Licensed Professional Counselor – HMO	Inv 1 in 25 miles	140,570	100
Suburban	140,570	Nephrology – HMO	Inv 1 in 25 miles	140,570	100
Suburban	140,570	Neurology – HMO	Inv 1 in 30 miles	140,570	100
Suburban	140,570	Oncology-Medical and Surgical – HMO	Inv 1 in 20 miles	140,570	100

Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Suburban	140,570	Oncology-Radiation/Radiation Oncology – HMO	Inv 1 in 40 miles	140,570	100
Suburban	140,570	Ophthalmology – HMO	Inv 1 in 20 miles	140,570	100
Suburban	140,570	Pediatrics-Routine/Primary Care – HMO	Inv 1 in 10 miles	140,513	99.9
Suburban	140,570	Physiatry, Rehabilitative Medicine – HMO	Inv 1 in 30 miles	140,570	100
Suburban	140,570	Plastic Surgery – HMO	Inv 1 in 40 miles	140,570	100
Suburban	140,570	Podiatry – HMO	Inv 1 in 30 miles	140,570	100
Suburban	140,570	Primary Care (non-pediatric) – HMO	Inv 1 in 10 miles	140,570	100
Suburban	140,570	Psychiatry-Adolescent and Child, Outpatient – HMO	Inv 1 in 25 miles	140,570	100
Suburban	140,570	Psychiatry-Geriatric, Outpatient – HMO	Inv 1 in 25 miles	140,570	100
Suburban	140,570	Psychiatry-Outpatient – HMO	Inv 1 in 25 miles	140,570	100
Suburban	140,570	Psychology – HMO	Inv 1 in 25 miles	140,570	100

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Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Suburban	140,570	Pulmonology – HMO	Inv 1 in 30 miles	140,570	100
Suburban	140,570	Rheumatology – HMO	Inv 1 in 40 miles	140,570	100
Suburban	140,570	Urology – HMO	Inv 1 in 30 miles	140,570	100
Suburban	140,570	All Other licensed or certified providers – HMO	Inv 1 in 40 miles	140,570	100
Urban	119,819	Addiction Medicine – HMO	Inv 1 in 10 miles	119,819	100
Urban	119,819	Allergy and Immunology – HMO	Inv 1 in 15 miles	119,819	100
Urban	119,819	Applied Behavioral Analyst – HMO	Inv 1 in 15 miles	119,819	100
Urban	119,819	Cardiovascular Disease – HMO	Inv 1 in 10 miles	119,819	100
Urban	119,819	Chiropractic – HMO	Inv 1 in 15 miles	119,819	100
Urban	119,819	Dermatology – HMO	Inv 1 in 10 miles	119,819	100
Urban	119,819	Endocrinology – HMO	Inv 1 in 15 miles	119,819	100
Urban	119,819	ENT/Otolaryngology – HMO	Inv 1 in 15 miles	119,819	100

Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Urban	119,819	Gastroenterology – HMO	Inv 1 in 10 miles	119,819	100
Urban	119,819	General Surgery – HMO	Inv 1 in 10 miles	119,819	100
Urban	119,819	Gynecology, OB/GYN Nurse-Midwifery - HMO	Inv 1 in 5 miles	119,744	99.9
Urban	119,819	Licensed Clinical Social Worker – HMO	Inv 1 in 10 miles	119,819	100
Urban	119,819	Licensed Professional Counselor - HMO	Inv 1 in 10 miles	119,819	100
Urban	119,819	Nephrology – HMO	Inv 1 in 15 miles	119,819	100
Urban	119,819	Neurology – HMO	Inv 1 in 10 miles	119,804	99.9
Urban	119,819	Oncology-Medical and Surgical – HMO	Inv 1 in 10 miles	119,819	100
Urban	119,819	Oncology-Radiation/Radiation Oncology – HMO	Inv 1 in 15 miles	119,819	100
Urban	119,819	Ophthalmology – HMO	Inv 1 in 10 miles	119,819	100
Urban	119,819	Pediatrics-Routine/Primary Care - HMO	Inv 1 in 5 miles	119,819	100

Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Urban	119,819	Physiatry, Rehabilitative Medicine – HMO	Inv 1 in 15 miles	119,819	100
Urban	119,819	Plastic Surgery – HMO	Inv 1 in 15 miles	119,819	100
Urban	119,819	Podiatry – HMO	Inv 1 in 10 miles	119,819	100
Urban	119,819	Primary Care (non-pediatric) – HMO	Inv 1 in 5 miles	119,819	100
Urban	119,819	Psychiatry-Adolescent and Child, Outpatient – HMO	Inv 1 in 10 miles	119,819	100
Urban	119,819	Psychiatry-Geriatric, Outpatient – HMO	Inv 1 in 10 miles	119,819	100
Urban	119,819	Psychiatry-Outpatient – HMO	Inv 1 in 10 miles	119,819	100
Urban	119,819	Psychology – HMO	Inv 1 in 10 miles	119,819	100
Urban	119,819	Pulmonology – HMO	Inv 1 in 10 miles	119,743	99.9
Urban	119,819	Rheumatology – HMO	Inv 1 in 15 miles	119,819	100
Urban	119,819	Urology – HMO	Inv 1 in 10 miles	119,819	100

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Locality Classification	Total Members	Provider Type	Standard	Members with Access	Percentage with Access
Urban	119,819	All Other licensed or certified providers – HMO	Inv 1 in 15 miles	119,819	100

d. Inpatient In-Network Claim Rates

M/S Inpatient	M/S Sub-Acute Inpatient Professional	M/S Acute Inpatient Professional	M/S Sub-Acute Inpatient Facility	M/S Acute Inpatient Facility	Total M/S Inpatient
Total # of Claims	1,142	45,848	270	4,757	52,017
# of Claims INN	921	43,495	248	4,658	49,322
# of Claims OON	221	2,354	22	99	2,696
% of Claims INN	81%	95%	92%	98%	95%

MH/SUD Inpatient	MH/SUD Sub-Acute Inpatient Professional	MH/SUD Acute Inpatient Professional	MH/SUD Sub-Acute Inpatient Facility	MH/SUD Acute Inpatient Facility	Total MH/SUD Inpatient
Total # of Claims	70	2,692	1,490	936	5,188
# of Claims INN	29	2,543	964	604	4,140
# of Claims OON	42	149	526	332	1,049
% of Claims INN	41%	94%	65%	65%	80%

e. Outpatient In-Network Claim Rates

M/S Outpatient	M/S Outpatient Office Professional	M/S Outpatient Other Professional	M/S Outpatient Other Facility	Total M/S Outpatient
Total # of Claims	749,102	450,888	93,304	1,293,294
# of Claims INN	721,387	421,950	90,993	1,234,330
# of Claims OON	27,717	28,952	2,313	58,982
% of Claims INN	96%	94%	98%	95%

MH/SUD Outpatient	MH/SUD Outpatient Office Professional	MH/SUD Outpatient Other Professional	MH/SUD Outpatient Other Facility	Total MH/SUD Outpatient
Total # of Claims	99,616	154,590	8,499	262,705
# of Claims INN	90,465	143,391	6,818	240,674
# of Claims OON	9,151	11,199	1,681	22,031
% of Claims INN	91%	93%	80%	92%

Proprietary and Confidential Information of CareFirst, Inc. and its affiliates and subsidiaries. This information shall only be disclosed as required by law.

In-Network MH/SUD Providers and Facilities Data Collection

Classification / Sub-classification	Entity Type	Total MH/SUD Providers or Facilities Identified	Number In-Network	Percentage In-Network	Data Period	Data Source / System	Methodology, Definitions, and Notes
Outpatient, Office (Professional)	Professional providers	18,050	12,582	69.7%	CY2025 Jan-Dec	PDMES	Definition of provider; distinct provider counting method; practitioner identifier used; duplicate and multi-location handling; applicable network/product; exclusions.
Outpatient, All Other (Professional)	Professional providers	18,050	12,582	69.7%	CY2025 Jan-Dec	PDMES	Included specialties and services; distinct provider counting method; practitioner identifier used; duplicate and multi-location handling; applicable network/product; exclusions.
Outpatient, All Other (Facility)	Facilities	9	9	100.0%	CY2025 Jan-Dec	PDMES	Included facility types; facility identifier used; individual location versus organizational entity counting method; applicable network/product; exclusions.
Subacute Inpatient (Professional)	Professional providers	18,050	12,582	69.7%	CY2025 Jan-Dec	PDMES	Included practitioner types; definition of subacute services; distinct provider counting method; practitioner identifier used; applicable network/product; exclusions.
Acute Inpatient (Professional)	Professional providers	18,050	12,582	69.7%	CY2025 Jan-Dec	PDMES	Included practitioner types; definition of acute inpatient services; distinct provider counting method; practitioner identifier used; applicable network/product; exclusions.
Subacute Inpatient (Facility)	Facilities	70	19	27.1%	CY2025 Jan-Dec	PDMES	Included facility types; definition of subacute inpatient facility; facility identifier and location counting method; applicable network/product; exclusions.
Acute Inpatient (Facility)	Facilities	9	9	100.0%	CY2025 Jan-Dec	PDMES	Included facility types; definition of acute inpatient facility; facility identifier and location counting method; applicable network/product; exclusions.
Total, if an unduplicated aggregate is requested	Providers and facilities	18,129	12,610	69.6%		PDMES	Do not sum classification rows unless duplicates across classifications have been removed. Document the unduplicated aggregate methodology.

2. Justification and Analysis

CareFirst develops and follows network access standards that comply with NCQA, CMS, and state regulatory guidance. To determine which network access standard to apply, CareFirst compares state, NCQA, and CMS access standards and selects the most stringent requirement. For example, if the CMS standards is 1 provider within 15 miles and the NCQA standard is 1 provider within 20 miles, CareFirst applies the 1 provider in 15 miles standard. Additionally, CareFirst has decided to evaluate behavioral health access to include 1 provider within 8 miles for urban, 18 miles for suburban, and 45 miles for rural areas to increase access to high-volume behavioral health specialists. This change is not reflected in the above reporting but will be accessed as the standard moving forward. This change will leave only primary care and gynecology with more stringent access standards at 1 in 5 miles for urban, 1 in 10 miles for suburban, and 1 in 30 miles for rural areas.

The goal for achieving network adequacy is for at least 95% of members across the urban, suburban, and rural areas to have access to the specialties as outlined in the network standards tables provided above. Provider specialties for MH/SUD care include Addiction Medicine, Applied Behavioral Analytics, Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), Psychiatrists, and Psychologists. CareFirst also has virtual options for behavioral health care to increase access which are discussed elsewhere in this document.

Based on the results provided above, CareFirst meets or exceeds time/access/distance standards for all specialties within the PPO and HMO networks with at least 95% of members having access in each subset. Additionally, all MH/SUD specialties had an access rate of 100%. Time/access/distance standards for M/S specialties like Gynecology, Pediatric Primary Care, and Pulmonology were met, however, the access percentage drops to 99.9% of members with access to these specialties in the PPO network. In the HMO network, M/S time/access/distance standards are met for Allergy and Immunology, Gynecology, Neurology, Pediatric Primary Care, and Pulmonology, however those specialties also fall below 100% to 99.6-99.9% of members with access.

Review of claims data to compare INN and OON utilization rates shows comparable rates of INN utilization as 15% higher for inpatient M/S services than for MH/SUD inpatient services when reviewed the combined totals. Specifically, inpatient sub-acute professional, inpatient sub-acute facility, and inpatient acute facility INN utilization was significantly lower than anticipated for MH/SUD care despite meeting T/A/D standards. CareFirst will review this finding and determine if any action is necessary to increase INN utilization in those categories. Outpatient claims for M/S and MH/SUD had an overall similar INN utilization rate of 95% for M/S and 92% for MH/SUD, demonstrating a robust network of outpatient providers and facilities.

V. Findings and Conclusions

The above analysis demonstrates that: (1) the processes, strategies, evidentiary standards, and other factors used to design and apply the network adequacy requirement to MH/SUD benefits, as written and in operation, are comparable to and are applied no more stringently than the processes, strategies, evidentiary standards, and other factors used to design and apply the network adequacy requirement to M/S benefits; and (2) CareFirst complies with the relevant data requirements under the MHPAEA Final Rules.

Federal and State regulations establish minimum standard requirements for carriers for network adequacy. Federal agencies such as CMS and National Accreditation standards such as NCQA also provide industry standards for network adequacy. CareFirst policies and strategies meet the respective State required standards, and as indicated above, standards utilized may be a combination of State, CMS, and NCQA standards/guidelines to enable CareFirst to strive to meet slightly more demanding standards if applicable for improved adequacy.

Using data to determine if the standards for time, distance, and provider-to-enrollee ratios are being met is a major part of the process for assessing network adequacy and determining if there are any gaps in access or provider shortages that need to be addressed. Other sources that CareFirst uses to access network adequacy and determine if there are any gaps in access or provider shortages include: the quarterly network disruption studies/reports; member complaints; CAHPS surveys; OON utilization claims, non-participating provider trends, member requests; new member address reviews, and marketability analysis. These can all be used to review and evaluate the Company's network adequacy and members' access to providers.

CareFirst offers additional virtual benefits for MH/SUD services to provide members with a variety of ways to access MH/SUD care. These services are broader for MH/SUD services as CareFirst only applies one virtual strategy for M/S services, which is CloseKnit, but provides five virtual strategies for MH/SUD. These strategies significantly increase access to MH/SUD care. Specifically, Headway allows access to 1,221 providers serving 9,511 members Additionally, Navigator has offered 100% of members with same-day or next-day in-network appointments. Please see below for further infographics regarding these programs.
All factors and evidentiary standards are applied to network adequacy standards for both M/S and MH/SUD providers. Additionally, CareFirst has taken steps to ensure access to MH and SUD providers through virtual strategies to reduce barriers to care. Based on this assessment, CareFirst confirms that the network adequacy NQTL is applied no more stringently to MH/SUD providers than to M/S providers in writing.

Operationally, the goal for achieving network adequacy is for at least 95% of members across the urban, suburban, and rural areas to have access to the specialties as outlined in the network standards tables provided above. Provider specialties for MH/SUD care include Addiction Medicine, Applied Behavioral Analytics, Licensed Clinical Social Workers (LCSWs), Licensed Professional Counselors (LPCs), Psychiatrists, and Psychologists. CareFirst also has virtual options for behavioral health care to increase access which are discussed elsewhere in this document.

CareFirst meets or exceeds time/access/distance standards for all specialties within the PPO and HMO networks with at least 95% of members having access in each subset. Additionally, all MH/SUD specialties had an access rate of 100%. Time/access/distance standards for M/S specialties like Gynecology, Pediatric Primary Care, and Pulmonology were met, however, the access percentage drops to 99.9% of members with access to these specialties in the PPO network. In the HMO network, M/S time/access/distance standards are met for all specialties with Allergy and Immunology, Gynecology, Neurology, Pediatric Primary Care, and Pulmonology, falling below 100% to 99.6-99.9% of members with access.

The in-operation findings are further supported by the in-network claim rate analysis discussed in the justification and analysis section. The claim rate data shows that members predominantly accessed services through in-network providers for both M/S and MH/SUD benefits. For inpatient services, 94.8% of M/S claims were in-network, based on 49,322 in-network claims out of 52,017 total claims, compared to 79.8% of MH/SUD inpatient claims, based on 4,140 in-network claims out of 5,188 total claims. For outpatient services, 95.4% of M/S outpatient claims were in-

network, based on 1,234,330 in-network claims out of 1,293,294 total claims, compared to 91.6% of MH/SUD outpatient claims, based on 240,674 in-network claims out of 262,705 total claims.

The above analysis of network access across urban, suburban, and rural areas shows that CareFirst maintains an adequate network for members. While the network is accessible and adequate, CareFirst takes additional steps to increase access to behavioral health and substance use disorder services by continuing to set stricter standards for access than the prevailing regulatory bodies require for MH/SUD specialties and through alternative options like virtual care and same-day treatment options.

VI. Required Certification

CareFirst certifies that the foregoing comparative analysis of the Network Adequacy NQTL was prepared for the Virginia fully insured coverage identified in this report and was reviewed by individuals with appropriate knowledge of the plan terms, policies, procedures, factors, evidentiary standards, operational practices, supporting documentation, and relevant data addressed in the analysis. The analysis applies to the CareFirst entities identified in this report as NAIC 53007 and NAIC 9602 to the extent the NQTL is designed and administered as described in this analysis.

To the best of CareFirst's knowledge and based on the information, documentation, and data reviewed as of the report's version date, this comparative analysis is accurate and complete in all material respects and demonstrates that the processes, strategies, evidentiary standards, and other factors used to design and apply the Network Adequacy NQTL to mental health and substance use disorder benefits are comparable to, and are applied no more stringently than, those used to design and apply the NQTL to medical/surgical benefits, as written and in operation. CareFirst will maintain supporting documentation and will update or supplement the analysis if a material change, newly identified data limitation, or corrective action affects this conclusion.