MHPAEA Summary Form

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

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

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

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

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

Overview:

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

1. Definition of Medical Necessity

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

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

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

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

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

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

CareFirst requires that all services be medically necessary in order to be covered services. This is an industry standard for health insurance coverage.

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

Some of the sources used to evaluate the factors are: Evidence of Coverage, Medical Necessity Criteria, MCG, ASAM, CareFirst Medical Policy, Medical Director reviews and IRO.

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

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

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

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

As-written analysis indicates that CareFirst uses the Modified Appropriateness Evaluation Protocol (AEP) Criteria, the Apollo Managed Care Physical Therapy, Occupational Therapy, Speech Therapy and Rehabilitation Criteria, MCG Guidelines 25th edition, for Behavioral Health, Ambulatory Care, Inpatient & Surgical Care, and Home Care, The American Society of Addiction Medicine (ASAM) criteria, and CareFirst Medical Policy Reference Manual to conduct medical necessity review. These criteria apply uniformly to both M/S & MH/SUD services.

As part of in-operation analysis, CareFirst conducts care management audits to help ensure that medical necessity criteria are applied in a consistent and impartial manner. A Nurse and Behavioral Health and Substance Abuse Interrater review is conducted to help ensure that nursing and behavioral health staff are compliant with regulatory MHPAEA and related interdepartmental

standards. Corrective action is initiated if an interrater score falls below 90%. Monthly Quality Audits are conducted of Utilization Specialists for Medical, Surgical and Behavioral Health to help ensure compliance with MHPAEA, documentation standards, and timeliness. An overall audit score of 85% or above per month is the minimum to meet the Utilization management Standards. Additionally, an Interrater Reliability Monitoring program is in place to evaluate the consistency with which Medical Director, Physician Reviewers apply Medical, Behavioral Health and Substance Use, Pharmacy, and Dental medical necessity criteria in decision making. A score of 90 – 100% is considered acceptable. If the results are below 90% the Senior Medical Director will evaluate the scores and decide whether to convene a review process with the Medical Directors/Physician Reviewers. The reviews provide on-going confirmation that CareFirst's requirements for authorization for the inpatient classification are the same for M/S and MH/SUD services.

CareFirst also conducts a comparative analysis of utilization management data to determine in-operation compliance of the NQTL. Data is grouped into benefit classification & subclassification to calculate denial rates and evaluate parity for M/S and MH/SUD services. Please refer to *Attachment 1* for CY2021 detailed comparative analysis.

2. Prior Authorization Review Process

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

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

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

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

Review Process for HMO plans:

- Utilization Management Coordinator (UMC) receives request for service/treatment by right fax/mail/Medical Management authorization system from provider.
- Utilization Management department receives benefit determination request from member or provider. No actual request for services will be received by CareFirst.
- Utilization Management Specialist (UMS) receives case(s) from UMC OR Utilization Management (UM) Call Center Team and ensure whether services/treatments requested or provided need to be preauthorized prior to approval for

payment. Inpatient requests come to the Utilization Management Review department for review and approval for all LOBs when the request is for Out of network or Procedures that are or could be considered cosmetic, experimental/investigational, or otherwise not medically necessary.

- Outpatient requests come to the Utilization Management Review department for review and decision determination when the request is for Procedures are or could be considered cosmetic, experimental/investigational, or not otherwise medically necessary, request is for HMO (some POS) members and if the service is out of network.
- If a member is not eligible (e.g., does NOT have an active policy), notify the requesting provider.

Review Process for POS plans:

- Utilization Management Coordinator (UMC) receives request for service/treatment by right fax/mail/Medical Management authorization system from provider.
- Utilization Management department receives benefit determination request from member or provider. No actual request for services will be received by CareFirst.
- Utilization Management Specialist (UMS) receives case(s) from UMC OR Utilization Management (UM) Call Center Team and ensure whether services/treatments requested or provided need to be preauthorized prior to approval for payment. Inpatient requests come to the Utilization Management Review department for review and approval for all LOBs when the request is for Out of network or Procedures that are or could be considered cosmetic, experimental/investigational, or otherwise not medically necessary.
- Outpatient requests come to the Utilization Management Review department for review and decision determination when the request is for Procedures are or could be considered cosmetic, experimental/investigational, or not otherwise medically necessary, request is for HMO (some POS) members and if the service is out of network.
- If a member is not eligible (e.g., does NOT have an active policy), notify the requesting provider.

Review Process for PPO plans:

- Utilization Management Coordinator (UMC) receives request for service/treatment by right fax/mail/Medical Management authorization system from provider.
- Utilization Management department receives benefit determination request from member or provider. No actual request for services will be received by CareFirst.

- Utilization Management Specialist (UMS) receives case(s) from UMC OR Utilization Management (UM) Call Center Team and ensure whether services/treatments requested or provided need to be preauthorized prior to approval for payment. Inpatient requests come to the Utilization Management Review department for review and approval for all LOBs when the request is for Out of network or Procedures that are or could be considered cosmetic, experimental/investigational, or otherwise not medically necessary.
- If a member is not eligible (e.g., does NOT have an active policy), notify the requesting provider.

Prior Authorization criteria is applicable to both Med/Surg and MH/SUD benefits, classifications, and sub-classifications.

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

The following factors are used in the development of Prior Authorization limitations applicable to both M/S and MH/SUD benefits:

1. High levels of variation in length of stay: Extended length of stay 30 days or more for admission with same or similar diagnosis in same/similar care settings
2. Lack of adherence to quality standards: Review of cases when established quality standards are not met
3. Variability in cost and quality of treatment: Identification and Review of how cost and quality of treatment can vary
4. Clinical efficacy of proposed treatment or service: Effectiveness of proposed treatment plan for the disease
5. Current and projected demand for services: Actual and forecasted utilization levels of services
6. Licensing and accreditation of providers: Qualifications of providers including CMS certification and State licensure

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

CareFirst uses the following sources and/or evidentiary standards to evaluate the factors identified above:

Factor	Sources (i.e., processes, strategies, or evidentiary standards)
1. High levels of variation in length of stay	Clinical expert review, Internal claims analysis
2. Lack of adherence to quality standards	National accreditation standards of the National Committee for Quality Assurance (NCQA)
3. Variability in cost and quality of treatment	National accreditation standards of the National Committee for Quality Assurance (NCQA), Internal claims analysis

4. Clinical efficacy of proposed treatment or service	Clinical expert review, CareFirst Medical Directors, CareFirst Medical Policies and External IRO
5. Current and projected demand for services	Internal claims analysis and utilization review reporting
6. Licensing and accreditation of providers	State and Federal requirements, National accreditation standards of the National Committee for Quality Assurance (NCQA)

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

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

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

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

As-written analysis indicates that CareFirst uses the Modified Appropriateness Evaluation Protocol (AEP) Criteria, the Apollo Managed Care Physical Therapy, Occupational Therapy, Speech Therapy and Rehabilitation Criteria, MCG Guidelines 25th edition, for Behavioral Health, Ambulatory Care, Inpatient & Surgical Care, and Home Care, The American Society of Addiction

Medicine (ASAM) criteria, and CareFirst Medical Policy Reference Manual to conduct prior authorization review. These criteria apply uniformly to both M/S & MH/SUD services.

As part of in-operation analysis, CareFirst conducts care management audits to help ensure that prior authorization criteria are applied in a consistent and impartial manner. A Nurse and Behavioral Health and Substance Abuse Interrater review is conducted to help ensure that nursing and behavioral health staff are compliant with regulatory MHPAEA and related interdepartmental standards. Corrective action is initiated if an interrater score falls below 90%. Monthly Quality Audits are conducted of Utilization Specialists for Medical, Surgical and Behavioral Health to help ensure compliance with MHPAEA, documentation standards, and timeliness. An overall audit score of 85% or above per month is the minimum to meet the Utilization management Standards. Additionally, an Interrater Reliability Monitoring program is in place to evaluate the consistency with which Medical Director, Physician Reviewers apply Medical, Behavioral Health and Substance Use, Pharmacy, and Dental prior authorization criteria in decision making. A score of 90 – 100% is considered acceptable. If the results are below 90% the Senior Medical Director will evaluate the scores and decide whether to convene a review process with the Medical Directors/Physician Reviewers. The reviews provide on-going confirmation that CareFirst's requirements for authorization for the inpatient classification are the same for M/S and MH/SUD services.

CareFirst also conducts a comparative analysis of utilization management data to determine in-operation compliance of the NQTL. Data is grouped into benefit classification & subclassification to calculate denial rates and evaluate parity of M/S and MH/SUD services. Please refer to *Attachment 1* for CY2021 detailed comparative analysis.

3. Concurrent Review Process

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

Concurrent Review means any process used by the carrier or its private review agent to conduct utilization review for ongoing health care or for an extension of treatment beyond previously approved health care. ***(Source- COMAR 31.10.51)***

Concurrent care decisions: If an ongoing course of treatment has been approved to be provided over a period or number of treatments:

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

Utilization Management Specialists perform medical and behavioral health utilization management activities, including but not limited to medical necessity of care determinations and eligibility for coverage. ***(Spreadsheet- MHP NQTL Self-Funded Account Standard Response)***

Principles of Process: The Utilization Management Specialists use the Organization's approved criteria assigned for the place of service to determine appropriateness of level of care, continued stay, and post-acute admission appropriateness.

Procedure:

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

- Utilization Management Specialists review DRG admissions once the outlier status is reached, and every 3 days following based on medical necessity and follow the departmental process for review with a Medical Director.
- Non-clinical staff monitors Members that are Medicare Primary for continued stay or discharge date via communication with facility contact and/or Admission, Discharge, and Transfer Report and follow the outlined process for Medicare Primary Members refer to Medicare SOP.
- Utilization Management Specialists review cases initially leveled a 2 for potential change to level 1 based on available clinical information.
- Upon notification of discharge Utilization Management Specialists/Nonclinical staff update the Member's authorization to ensure all inpatient days are included in the authorization and close the auth.

UM does not apply any penalties for late or no Utilization request. These penalties would be applied by services/claims.

Concurrent review criteria are applicable to both Med/Surg and MH/SUD benefits, classifications, and sub-classifications.

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

The following factors are used in the development of Concurrent Review limitations applicable to both M/S and MH/SUD benefits:

1. High levels of variation in length of stay: Extended length of stay 30 days or more for admission with same or similar diagnosis in same/similar care settings
2. Lack of adherence to quality standards: Review of cases when established quality standards are not met
3. Variability in cost and quality of treatment: Identification and Review of how cost and quality of treatment can vary
4. Clinical efficacy of proposed treatment or service: Effectiveness of proposed treatment plan for the disease
5. Current and projected demand for services: Actual and forecasted utilization levels of services
6. Licensing and accreditation of providers: Qualifications of providers including CMS certification and State licensure

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

CareFirst uses the following sources and/or evidentiary standards to evaluate the factors identified above:

Factor	Sources (i.e., processes, strategies, or evidentiary standards)

1. High levels of variation in length of stay	Clinical expert review, Internal claims analysis
2. Lack of adherence to quality standards	National accreditation standards of the National Committee for Quality Assurance (NCQA)
3. Variability in cost and quality of treatment	National accreditation standards of the National Committee for Quality Assurance (NCQA), Internal claims analysis
4. Clinical efficacy of proposed treatment or service	Clinical expert review, CareFirst Medical Directors, CareFirst Medical Policies and External IRO
5. Current and projected demand for services	Internal claims analysis and utilization review reporting
6. Licensing and accreditation of providers	State and Federal requirements, National accreditation standards of the National Committee for Quality Assurance (NCQA)

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

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

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

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

As-written analysis indicates that CareFirst uses the Modified Appropriateness Evaluation Protocol (AEP) Criteria, the Apollo Managed Care Physical Therapy, Occupational Therapy, Speech Therapy and Rehabilitation Criteria, MCG Guidelines 25th edition, for Behavioral Health, Ambulatory Care, Inpatient & Surgical Care, and Home Care, The American Society of Addiction Medicine (ASAM) criteria, and CareFirst Medical Policy Reference Manual to conduct concurrent review. These criteria apply uniformly to both M/S & MH/SUD services.

As part of in-operation analysis, CareFirst conducts care management audits to help ensure that concurrent review criteria are applied in a consistent and impartial manner. A Nurse and Behavioral Health and Substance Abuse Interrater review is conducted to help ensure that nursing and behavioral health staff are compliant with regulatory MHPAEA and related interdepartmental standards. Corrective action is initiated if an interrater score falls below 90%. Monthly Quality Audits are conducted of Utilization Specialists for Medical, Surgical and Behavioral Health to help ensure compliance with MHPAEA, documentation standards, and timeliness. An overall audit score of 85% or above per month is the minimum to meet the Utilization management Standards. Additionally, an Interrater Reliability Monitoring program is in place to evaluate the consistency with which Medical Director, Physician Reviewers apply Medical, Behavioral Health and Substance Use, Pharmacy, and Dental concurrent review criteria in decision making. A score of 90 – 100% is considered acceptable. If the results are below 90% the Senior Medical Director will evaluate the scores and decide whether to convene a review process with the Medical Directors/Physician Reviewers. The reviews provide on-going confirmation that CareFirst's requirements for authorization for the inpatient classification are the same for M/S and MH/SUD services.

CareFirst also conducts a comparative analysis of utilization management data to determine in-operation compliance of the NQTL. Data is grouped into benefit classification & subclassification to calculate denial rates and evaluate parity of M/S and MH/SUD services. Please refer to *Attachment 1* for CY2021 detailed comparative analysis.

4. Retrospective Review Process

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

Retrospective Review means utilization review of health care that has been provided to an enrollee.

Utilization review criteria are determined by the type of service, drug or device a provider seeks to be reimbursed as no member receiving services for any condition at any setting will or can be treated identically. Utilization Management does not apply any penalties for late or no Utilization request. These penalties would be applied by services/claims.

Retrospective Review criteria is applicable to both Med/Surg and MH/SUD benefits, classifications, and sub-classifications.

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

The following factors are used in the development of Retrospective Review limitations applicable to both M/S and MH/SUD benefits:

1. High levels of variation in length of stay: Extended length of stay 30 days or more for admission with same or similar diagnosis in same/similar care settings
2. Lack of adherence to quality standards: Review of cases when established quality standards are not met
3. Variability in cost and quality of treatment: Identification and Review of how cost and quality of treatment can vary
4. Clinical efficacy of proposed treatment or service: Effectiveness of proposed treatment plan for the disease
5. Current and projected demand for services: Actual and forecasted utilization levels of services
6. Licensing and accreditation of providers: Qualifications of providers including CMS certification and State licensure

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

CareFirst uses the following sources and/or evidentiary standards to evaluate the factors identified above:

Factor	Sources (i.e., processes, strategies, or evidentiary standards)
1. High levels of variation in length of stay	Clinical expert review, Internal claims analysis

2. Lack of adherence to quality standards	National accreditation standards of the National Committee for Quality Assurance (NCQA)
3. Variability in cost and quality of treatment	National accreditation standards of the National Committee for Quality Assurance (NCQA), Internal claims analysis
4. Clinical efficacy of proposed treatment or service	Clinical expert review, CareFirst Medical Directors, CareFirst Medical Policies and External IRO
5. Current and projected demand for services	Internal claims analysis and utilization review reporting
6. Licensing and accreditation of providers	State and Federal requirements, National accreditation standards of the National Committee for Quality Assurance (NCQA)

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

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

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

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

As-written analysis indicates that CareFirst uses the Modified Appropriateness Evaluation Protocol (AEP) Criteria, the Apollo Managed Care Physical Therapy, Occupational Therapy, Speech Therapy and Rehabilitation Criteria, MCG Guidelines 25th edition, for Behavioral Health, Ambulatory Care, Inpatient & Surgical Care, and Home Care, The American Society of Addiction Medicine (ASAM) criteria, and CareFirst Medical Policy Reference Manual to conduct retrospective review. These criteria apply uniformly to both M/S & MH/SUD services.

As part of in-operation analysis, CareFirst conducts care management audits to help ensure that retrospective review criteria are applied in a consistent and impartial manner. A Nurse and Behavioral Health and Substance Abuse Interrater review is conducted to help ensure that nursing and behavioral health staff are compliant with regulatory MHPAEA and related interdepartmental standards. Corrective action is initiated if an interrater score falls below 90%. Monthly Quality Audits are conducted of Utilization Specialists for Medical, Surgical and Behavioral Health to help ensure compliance with MHPAEA, documentation standards, and timeliness. An overall audit score of 85% or above per month is the minimum to meet the Utilization management Standards. Additionally, an Interrater Reliability Monitoring program is in place to evaluate the consistency with which Medical Director, Physician Reviewers apply Medical, Behavioral Health and Substance Use, Pharmacy, and Dental retrospective review criteria in decision making. A score of 90 – 100% is considered acceptable. If the results are below 90% the Senior Medical Director will evaluate the scores and decide whether to convene a review process with the Medical Directors/Physician Reviewers. The reviews provide on-going confirmation that CareFirst's requirements for authorization for the inpatient classification are the same for M/S and MH/SUD services.

CareFirst also conducts a comparative analysis of utilization management data to determine in-operation compliance of the NQTL. Data is grouped into benefit classification & subclassification to calculate denial rates and evaluate parity of M/S and MH/SUD services. Please refer to *Attachment 1* for CY2021 detailed comparative analysis.

5. Emergency Services

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

There is no information related to emergency services that is not already reported under other NQTLs. Therefore, this NQTL is considered as Not Applicable for the purpose of this plan analysis.

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

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

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

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

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

6. Pharmacy Services

Pharmacy services means any of the following activities:

a. Providing pharmaceutical care.
b. Compounding, dispensing, or distributing prescription drugs or devices.
c. Compounding or dispensing nonprescription drugs or devices.
d. Monitoring prescriptions for prescription and nonprescription drugs or devices.
e. Providing information, explanation, or recommendations to patients and health care practitioners about the safe and effective use of prescription or nonprescription drugs or devices.
f. Identifying and appraising problems concerning the use or monitoring of therapy with drugs or devices.
g. Acting within the parameters of a therapy management contract, as provided under Subtitle 6A of the Health-Occupations Article.
h. Administering vaccinations in accordance with § 12–508 of the Health-Occupations Article or self–administered drugs in accordance with § 12–509 of the Health-Occupations Article.
i. Delegating a pharmacy act to a registered pharmacy technician, pharmacy student, or an individual engaged in a Board approved pharmacy technician training program.
j. Supervising a delegated pharmacy act performed by a registered pharmacy technician, pharmacy student, or an individual engaged in a Board approved pharmacy technician training program.
k. Providing drug therapy management in accordance with § 19–713.6 of the Health – General Article; or
l. Prescribing and dispensing contraceptive medications and self–administered contraceptive devices approved by the U.S. Food and Drug Administration.

(Source- COMAR 31.10.51)

Please refer to Prescription Drug Formulary Design NQTL #7 for more information.

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

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

NA

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

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

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

7. Prescription Drug Formulary Design

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

"Prescription Drug Formulary Design" means a continually updated list of prescription drugs approved for reimbursement, including both generic and specialty drugs, and plan features that base reimbursement, cost-sharing, or authorization requirements on the formulary category into which a drug is placed. ***(Source- COMAR 31.10.51)***

CVS Caremark, as part of a prescription drug benefit plan offering, utilizes formulary tools including copay tiering and specialty drug classification, as well as pharmacy utilization management (UM) tools with accompanying UM criteria. These tools and coverage limitations are essential to optimizing patient outcomes, reducing waste and unnecessary drug use, while providing cost-effective prescription drug benefit coverage. CVS Caremark considers the following formulary and UM tools as the prescription drug benefit NQTL's most used in client plan offerings for both M/S and MH/SUD services:

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

	Medical/Surgical	**Mental Health / Substance Use Disorder**
Formulary Copay Tiering		
Description	A formulary is a list of drugs covered by a drug plan offering prescription drug benefit. A formulary is sometimes referred to as a covered drug list. The copay tiers on a formulary determine the amount that the member pays for coverage of a prescription. The copay tiers are based on whether the drug is formulary-eligible, included as covered on the formulary, available as a generic or a brand product, and whether the brand or generic drug product is considered preferred or non-preferred.	
Specialty Drug Designation		

	Medical/Surgical	Mental Health / Substance Use Disorder
Description	Specialty drug designation is applied to drugs or drug classes that are typically higher-cost drugs that require special handling, special storage, or close clinical monitoring of the member. Due to the special handling of the drug or the drug's limited distribution, the prescription may need to be dispensed from a Specialty Pharmacy. The applicable copay for a specialty drug would apply.	
Pharmacy Prior Authorization (PA)		
Description	Prior Authorization is required before members fill prescriptions for certain drugs. The doctor may need to provide medical history or laboratory tests to determine if these medications are appropriate. Without prior authorization from CareFirst, the drugs may not be covered. Pharmacy prior authorization is typically utilized in drug classes where the potential for use for unapproved indications exists, the potential for inappropriate over- or under-utilization exists, or when safety concerns exist with a drug or drug class. Cost may also be a consideration in determining if prior authorization is appropriate.	
Pharmacy Step Therapy (ST)		
Description	Step therapy is a pharmacy UM strategy typically employed in therapeutic classes with broad generic availability. ST is generally used to promote the use of the most cost-effective products in the therapeutic class, provided efficacy and safety are equivalent, with the potential for reduced cost from greater utilization of generics and/or lower cost brands.	
Pharmacy Quantity Limits (QL)		
Description	Quantity Limits establish a maximum quantity of certain medications that will be covered over a specified period. The limit is expressed in terms of dose or quantity dispensed per prescription, dose or quantity dispensed per time period, the amount covered for the drug, or the number of prescriptions claims for the drug over a period. Pharmacy QLs are applied to each drug class regardless of whether the intended use is for a MH/SUD condition or a MED/SURG condition. Pharmacy QLs generally apply to both generic and brand drugs.	

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

Clinical guidelines and FDA labeling are given more weight to ensure that NQTL's are clinically sound.

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

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

Factors	The same factors are considered when establishing pharmacy QL for drugs used in MH/SUD conditions as for drugs used in M/S conditions:
	• Enhance patient safety
	  ○ Potential for a drug to be prescribed in greater quantities and/or at a higher dose than deemed safe and effective by the FDA
	  ○ To promote appropriate drug dosing, including strength and frequency	

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

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

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

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

	Medical/Surgical	Mental Health / Substance Use Disorder
	• May have an FDA-mandated risk evaluation and mitigation strategies (REMS) drug safety programs or Black Box Warning • Monthly prescription costs • Review by the Pharmacy Pharmaceutical Technology Evaluation Committee (PTEC)	
Pharmacy Prior Authorization (PA)		
Factors with specific definition/evidentiary standards	The same factors and evidentiary standards are considered when establishing pharmacy PA for drugs used in MH/SUD conditions as for drugs used in M/S conditions: • Patient safety concerns exist with a drug or drug class, unknown long-term safety or durability. This is evaluated by reviewing approved drug compendia and published peer-review clinical literature • Applicable lab values or other test results required for appropriate treatment by following accepted clinical practice guidelines, consensus statements, or comparable publications • Appropriate medication uses for indications or conditions based on national guidelines • Use in appropriate patient populations as defined in accepted clinical practice guidelines, consensus statements, or comparable publications • Use limited to a specific population based on FDA-approved indications, standard clinical practice, and guidelines • Potential for inappropriate or off-label use is addressed by reviewing FDA product labeling and validating against approved drug compendia • Opportunity for optimizing patient outcomes, to ensure treatment goals of the drug are being met. This is done by conducting annual review of UM criteria and clinical programs by internal pharmacists in the Clinical Development department and medical directors in the Medical Affairs department. Review and update of UM criteria is also conducted by external clinical experts, who are physicians practicing in the relevant clinical area. • Requirement for additional treatment supportive therapies, including but not limited to behavioral counseling, diet therapy, case management, and other standard non-drug supportive therapies • Reduce waste, unnecessary drug use, fraud, or abuse by tasking CVS Caremark National P&T Committee with reviewing and approving any new prior auth coverage criteria for clinical appropriateness	

	Medical/Surgical	Mental Health / Substance Use Disorder
Pharmacy Step Therapy (ST)		
Factors with specific definition/evidentiary standards	The same factors and evidentiary standards are considered when establishing ST for drugs used in MH/SUD conditions as for drugs used in M/S conditions: • Promote the use of the most cost-effective products in the therapeutic class; promote generics and/or lower cost brands, by reviewing approved drug compendia, conducting comparison of similar drugs in terms of safety and efficacy and referencing accepted clinical practice guidelines, consensus statements, or comparable publications • Clinical safety. efficacy and adverse events based on FDA approved labeling, national clinical guideline recommendations, and comparative review of similar drugs • Multiple dosage forms available for the same or similar chemical entities, or availability of unique dosage forms. • Conduct an annual review of UM criteria and clinical programs by internal pharmacists in the Clinical Development department and medical directors in the Medical Affairs department. Review and update of UM criteria is also conducted by external clinical experts, who are physicians practicing in the relevant clinical area. • Availability of therapeutic alternatives, including generics, used to treat the same condition depending on accepted clinical practice guidelines, clinical peer-review and defined standards of care • Review and approval of coverage criteria for clinical appropriateness by the CVS Caremark National P&T Committee	
Pharmacy Quantity Limits (QL)		

Factors with specific definition/evidentiary standards	The same factors are considered when establishing pharmacy QL for drugs used in MH/SUD conditions as for drugs used in M/S conditions:
	• Enhance patient safety by following FDA product labeling, reviewing approved drug compendia and published peer-review clinical literature, and following accepted clinical practice guidelines and standards of care
	  o Potential for a drug to be prescribed in greater quantities and/or at a higher dose than deemed safe and effective by the FDA
	  o To promote appropriate drug dosing, including strength and frequency
	  o To prevent overutilization	

	Medical/Surgical	Mental Health / Substance Use Disorder
	○ When abuse or misuse by the patient is possible ○ For opioids and narcotics, when appropriate dosing and appropriate duration of use is based on treatment for acute or chronic pain • Cost and cost effectiveness by reviewing approved drug compendia, conducting comparison of similar drugs in terms of safety and efficacy and referencing accepted clinical practice guidelines, consensus statements, or comparable publications ○ Prevention of overutilization ○ Discouragement of misuse and waste through dose efficiency QLs, which ensure that the appropriate tablet strength is utilized ○ Lack of documented efficacy/unknown efficacy at higher doses • Discourage misuse, waste, and abuse by tasking CVS Caremark National P&T Committee with regularly reviewing and approving any new prior auth coverage criteria for clinical appropriateness ○ Maximum daily dosing or maximum duration of use limits	

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

The CVS Caremark National Pharmacy and Therapeutics Committee (P&T Committee) is an external advisory body of experts from across the United States, composed of 22 independent health care professionals including 18 physicians and four pharmacists, all of whom have broad clinical backgrounds and/or academic expertise regarding prescription drugs. Most of the P&T Committee members are actively practicing pharmacists and physicians. Two physicians and two pharmacists are experts in the care of the elderly or disabled. One of the physicians is a medical ethicist. The role of the medical ethicist is to assist in the decision-making process by facilitating the discussion, as needed, and to provide unbiased feedback with respect to the logic and appropriateness of the conclusions drawn and the decisions reached.

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

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

Pharmacology, Psychiatry (adult/pediatric/adolescent), Rheumatology.

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

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

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

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

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

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

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

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

- When the factors for formulary copay tier designation are considered consistently across all drugs and drug classes, the outcome shows that the MH and SUD categories have either a higher or a similar percentage of drugs covered at preferred copay tiers compared to the MED/SURG category. There are fewer drugs designated as a Specialty drug in the MH and SUD categories compared to the MED/SURG category.
- When the factors for pharmacy prior authorization are considered consistently across all drugs and drug classes, the outcome shows that the NQTL of prior authorization is applied to a varying percentage of drugs across all three categories. Outcome of Step Therapy analysis shows that when the factors for step therapy are considered consistently across all drugs and drug classes, the outcome shows that the NQTL is applied to a varying percentage of drugs across all three categories.
- Similarly, outcome of Quantity Limits shows that when the factors for quantity limits are considered consistently across all drugs and drug classes, the outcome shows that the NQTL is applied to a varying percentage of drugs across all three categories.

Please refer to *Attachment 2* for the Advance Control Formulary Plan used for Large Group health plans and *Attachment 3* for the Marketplace Exchange Formulary Plan used for Individual, Small Group, and Student health plans.

This analysis demonstrates that this NQTL does not discriminate against individuals based on M/S diagnosis, MH/SUD diagnosis, or other health conditions.

8. Case Management

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

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

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

(Source- COMAR 31.10.51)

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits
Care Support Programs – CareFirst offers health care programs designed to promote the collaborative process of assessment, planning, and facilitation, and advocacy for options and services to meet a Qualified Individual's health needs through communication and available resources to promote quality cost- effective outcomes. These programs are available to Qualified Individuals to manage the care of certain complex chronic or high-risk acute diseases. These programs include but are not limited to: • Care coordination • Case management • Condition specific support • Informed decision-making support • Disease management • Lifestyle coaching, and health promotion programs. (***Source- Plan doc, Section F, Care Support Programs)*** Patient-Centered Medical Home Program (PCMH)- CareFirst utilizes the Care Management Core Target methodology for initiation of care management services all PCMH patients. As part of this program, medical and associated services directed by the PCMH team of medical professionals, assist with fostering the health care provider's partnership with a Qualifying	

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

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

(Source- Plan doc, Section J, Patient-Centered Medical Home)

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

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

(Source- Plan doc, Section C, Inpatient and Outpatient Mental Health and Substance Use Disorder Services)

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

Members are identified for potential Care Management services through various points of entry and resources. CareFirst utilizes a risk and stratification process to identify members who are at risk for a breakdown in health status, emergency room visits, hospital admissions and/or readmissions. Members may also be identified for services from CareFirst clinical programs, accounts, member self-referrals, caregivers, facility discharge planners and providers. Care Management takes an interdisciplinary team approach to identify both clinical and non-clinical interventions to help members regain optimum health or improved functional capability, in the right setting and in a cost-effective manner. It involves a comprehensive assessment of

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

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

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

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

Case Management process for MS and MH/SUD is as follows:

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

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

Assignment, Assessment and Engagement:

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

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

Case Closure: Case management case is closed when the member achieves the established goals for the Plan of Care goals, and it is determined that CM interventions and/or services are no longer required. Members are referred to other support programs upon case closure for continued support as deemed appropriate.
(Source- CO PCMH 202.02 Member Selection Criteria SOP (MCM and BHCM))

Information provided can be referenced from the following sources:
(Source- Policy Manual: Health Services, Policy Section: Case/Care Management: CO PCMH 103.00 Member Consent Policy (MCM and BHCM); ***CO PCMH 104.00 Care Plan Implementation Policy (MCM and BHCM)***; ***CO PCMH 105.00 Care Plan Documentation Policy (MCM and BHCM)***; ***CO PCMH 202.02 Member Selection Criteria SOP (MCM and BHCM)***; ***CO PCMH 203.01 Member Consent SOP (MCM and BHCM)***; ***CO PCMH 204.01 Care Plan Activation SOP (MCM and BHCM); CO BHS 205.01 Care Plan Documentation SOP (BHCM)***; ***CO PCMH 205.02 Member Engagement SOP (MCM and BHCM); CO CM 100.02 Criteria for Eligibility and Acceptance into the Care Management Program (CM); CO CM 100.04 Member Outreach Process (CM); CO CM 100.05 Complex Case Documentation Guidelines)***

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

CareFirst considers several factors when determining applicability of case management services for both MH/SUD and M/S benefits, including:

1. High risk for breakdown in health status: A member having high risk for breakdown of health status due to an adverse event or negative health consequence related to member's existing disease/condition.

2. Hospital admissions and/or readmissions: Total count of member hospital admissions and/or readmissions within 30 days of being discharged from a previous hospital stay. (Standard benchmark used by CMS is the 30-day readmission rate)
3. Emergency room visits: Total count of member emergency room visits
4. Diagnosis indicating the need for coordination of care to assist members gain optimal recovery and/or manage their health care needs independently: Medical Diagnosis from Physician indicating the need for case management services
5. Presence of psychosocial issues that prevent or impede appropriate access to care: Psychosocial issues preventing appropriate access to care like financial difficulties, loss of job, divorce, grief/loss issues etc.
6. Members requiring health education or monitoring to help them transition to self-care or independence: Members in need of health education or monitoring
7. Members requiring assistance with arranging appointments, transportation, or referrals to available community resources: Deliberate organization of patient care activities such as arranging appointments, transportation, referrals to community resources to facilitate the appropriate delivery of healthcare services.
8. Members indicating presence of social determinants to health: Social determinants of health cause many challenges for members and may vary widely based on the area in which they live. This contributes to variations in health by region and in each of the areas we serve, with different geographic areas presenting different challenges. Chronic issues such as lack of access to healthy food, poverty, poor housing, and lack of access to medical care all contribute to reduced health outcomes. ***(Source- CareFirst Medical Provider Manual)***
9. Medications and appointments non-compliance: The patient actively decides not to use the medications and keep up appointments or follow treatment recommendations due to adverse side effects, complex medication schedules, lack of symptoms, forgetfulness, fear/worry, misunderstanding or presence of mental health issues.

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

Factor	Sources (i.e., processes, strategies, or evidentiary standards)
1. High risk for breakdown in health status	Member's medical history, CareFirst risk and stratification process
2. Hospital admissions and/or readmissions	Member's medical history, CareFirst risk and stratification process
3. Emergency room visits	Member's medical history, CareFirst risk and stratification process

4. Diagnosis indicating the need for coordination of care to assist members gain optimal recovery and/or manage their health care needs independently	Physician's referral/diagnosis
5. Presence of psychosocial issues that prevent or impede appropriate access to care	Member's request
6. Members requiring health education or monitoring to help them transition to self-care or independence	Member's medical history
7. Members requiring assistance with arranging appointments, transportation, or referrals to available community resources	Member's request
8. Members indicating presence of social determinants to health	Member's medical history
9. Medications and appointments non-compliance	Member's medical history

Additionally, CareFirst relies on the following evidentiary standards to determine if a factor is met, requiring the application of an NQTL:

- CareFirst maintains a resource library housing multiple community and benefit resources, educational materials, and clinical pathways.
- CareFirst utilizes industry-based standards for staffing and productivity, accumulated from external partners.
- CareFirst utilizes a risk and stratification process to identify members who are at risk for a breakdown in health status, emergency room visits, hospital admissions and/or readmissions.
- CareFirst Care Managers are Registered Nurses with a minimum of 5 years clinically related experience working in Care Management, Discharge Coordination, Home Health, Utilization Review, Disease Management, or other direct patient care experience. CareFirst Behavioral Health Care Managers are Master Level, Licensed Clinicians with a minimum of 5 years clinically related experience working in Care Management, Discharge Coordination, Utilization Review, or other direct patient care experience.

The Care Management program adheres to the Case Management Society of America's (CMSA) definition of case management which states, "Case Management is a collaborative process of assessment, planning, facilitation, care coordination, evaluation and

advocacy for options and services to meet an individual's and family's comprehensive health needs through communication and available resources to promote patient safety, quality of care and cost- effective outcomes." (www.cmsa.org)

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

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

- CareFirst utilizes a risk and stratification process to identify members who are at risk for a breakdown in health status, emergency room visits, hospital admissions and/or readmissions. Members may also be identified for services from CareFirst clinical programs, accounts, member self-referrals, caregivers, facility discharge planners and providers.
- *CareFirst ID/Strat Predictive Composite Score:* Since 2022, CareFirst uses predictive modeling to identify potential candidates for its care coordination programs, including case management. CareFirst has developed a predictive identification and stratification algorithm that incorporates industry standard medical and pharmacy Prospective Risk scores, Episode Grouper, and social determinants of health (SDOH). The care management programs that are currently supported by the ID/Strat composite score include: Behavioral Health Complex Care Management, Complex Care Management, Oncology, HIV/AIDS, and Pediatrics.
- *Care Management Core Target methodology* is used by CareFirst for initiation of care management services all PCMH patients. To identify members in need of medical care plans, CareFirst uses the Core Target criteria; Core Target 1, Core Target 2, and Core Target 3.
  - Core Target 1 (CT1) identifies through specific criteria and is characterized as having high costs, high hospital utilization, and health instability. (See Medical Core Target (CT1) Criteria)
  - Core Target 2 (CT2) identifies as members who do not yet meet the criteria for inclusion in Core Target 1 but have been identified by the PCP, in collaboration with the LCC, as needing Care Coordination.
  - Core Target 3 (CT3) identifies as members who have been an IBS>=6, identified through other means, having a potential to be included in CT1. IBS (Illness Burden Score) in the above-mentioned chart is the score for each member and is based on the Member's unique claims history using the trailing 12 months of claims experience. This score shows the relative current illness level of the Member and helps identify Members that are most likely to have high future costs.

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

The data below for the year **2021** shows the total number of CareFirst case management cases for M/S and MH/SUD. Based on the analysis:

- CareFirst has comparable average case duration for M/S and MH/SUD services requests with an average case duration of 93.2 days and 99.4 days respectively.
- There is a relatively higher engagement rate for MH/SUD (i.e., 50% as compared to 48% for M/S cases).
- The engagement rate is calculated based on cases that had a successful encounter and cases that were turned into a care plan. (Cases with care plans/ Number of members successfully outreached to)

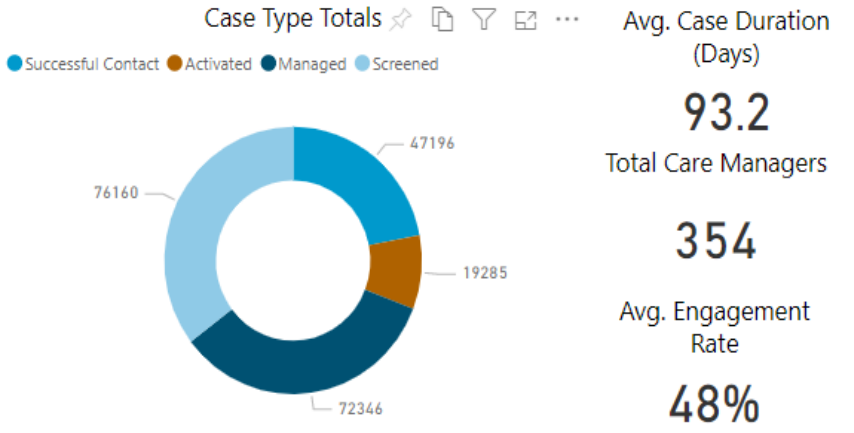


Figure 1: Medical/Surgical Total Cases

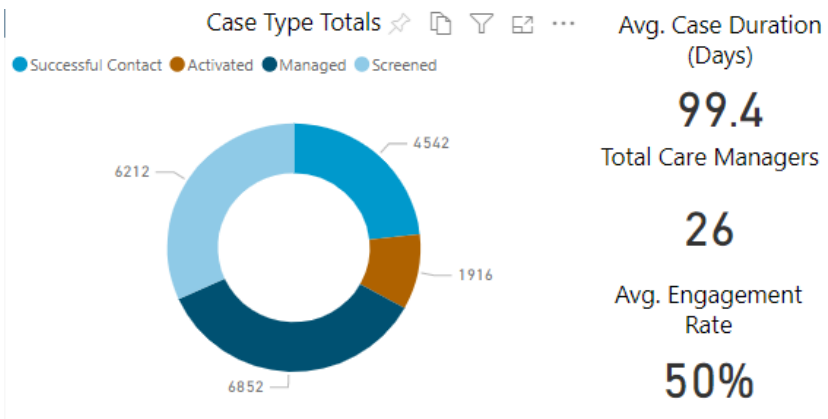


Figure 1: Behavioral Health Total Cases

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

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

Additionally, to ensure comparable design, development and application, M/S and MH/SUD care managers conduct Care Management QI reviews. CM care plans are reviewed for adherence to departmental guidelines and benefit administration. CareFirst's quality team conducts quarterly file review audits of care management cases, including MH/SUD and M/S. A sample of cases is selected at random and reviewed for compliance with specific criteria. For each case, there is a review of specific criteria for the Initial Assessment and the Ongoing Management. ***(Source- CO CM 400.05 Commercial Case Management Care Plan Quality Review Audit Process)***

Initial Assessment review includes the following criteria:

- Initial assessment of member health status, including condition-specific issues
- Documentation of clinical history, including medications
- Initial assessment of the activities of daily living (ADL)
- Initial assessment of behavioral health status, including cognitive functions
- Initial assessment of social determinants of health
- Evaluation of cultural and linguistic needs, preferences, or limitations
- Evaluation of visual and hearing needs, preferences, or limitations
- Evaluation of caregiver resources and involvement
- Evaluation of available benefits
- Evaluation of available community resources
- Assessment of life-planning activities
- Beginning the assessment for at least one factor within 30 calendar days of identifying a member for complex case management.

Ongoing Management Assessment review includes the following criteria:

- Development of case management plans that include prioritized goals, that consider member and caregiver goals, preferences, and desired level of involvement in the complex case management program

- Identification of barriers to meeting goals and complying with the case management plan
- Development of schedules for follow-up and communication with members
- Development and communication of member self-management plans
- Assessment of progress against case management plans and goals, and modification as needed.

For both Initial Assessment and Ongoing Management, the goal is to meet at least 90% of criteria. If less than 90% of criteria are met, more frequent file review audits are conducted. The ongoing audits ensure CareFirst remains in compliance with the National Committee for Quality Assurance's (NCQA's) standards for Population Health Management.

Case Management is a voluntary program and members/dependents who reach out or referred to CareFirst by a provider are accepted upon confirmation of coverage under the policy. Eligibility criteria followed by CareFirst is the same for M/S and MH/SUD population. Determination is made through professional consideration and objective data using the following guidelines:

- Member must agree to participate and comply with all elements in any given Care Support Program. ***(Source- Plan doc, Section F, Care Support Programs)***
- Member has an active CareFirst policy with the Case Management benefit ***(Source – CareFirst case management team)***
- Member has a diagnosis which indicates that he/she may benefit from coordination of care to assist them to gain optimal recovery and/or manage their health care independently.
- Psychosocial issues present that prevent or impede appropriate access to care which could potentially be alleviated by intervention from a Care Manager
- Member requires health education or monitoring to transition to self-care or independence

9. Process for Assessment of New Technologies

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

"Process for Assessment of New Technology" means a systematic, scientific process to follow for evaluating medical and surgical treatments and mental health and substance use treatment in order to ensure that members under the carrier's health benefit plan have access to appropriate treatments not previously covered by the carrier. ***(Source- COMAR 31.10.51)***

As stated in Medical Policy Reference Manual (MPRM) Policy Number 0.00.001, the term "experimental/investigational" is described as services or supplies that are in the developmental stage and are in the process of human or animal testing.

According to the plan document, Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

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

*Technology includes drugs, devices, processes, systems, or techniques. ***(Source-Plan doc, Section 1 Definitions)***.

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

Process for Assessment of New Technologies criteria is applicable to both Med/Surg and MH/SUD benefits, classifications, and sub-classifications.

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

The Blue Cross and Blue Shield Association's Technology criteria are developed using a tournament style of progression; all five criteria must be met, and the evidence must be sufficient for a service to be considered medically necessary. The criteria are based on the evaluation of the following factors:

- Approval from the appropriate U.S. government regulatory bodies
- The scientific evidence permitting conclusions concerning the effect on health outcomes
- Effect on net health outcomes
- Effectiveness as compared to any established alternatives
- Attainability outside the investigational settings

The criteria are reviewed and approved annually by the BlueCross BlueShield Medical Policy Panel and there have been no recent revisions. The current Panel is comprised of thirty-four external consultants and internal staff that have medical, clinical, and research expertise including data analysis and interpretation. The Panel considers physician specialty society recommendations, the view of prudent medical practitioners practicing in relevant clinical areas, government agencies (such as the FDA), and any other relevant factors in the assessment of new and emerging technology and the development of medical policies. There are no differences in the criteria when applied to medical/surgical, mental health and substance use disorder services.

Also, on behalf of CareFirst, AIM manages the utilization management process for genetic tests used to assess medical, mental health, and substance use disorder. The AIM/IDNA guidelines for genetic testing are based on medical evidence associated with the genetic tests. The overall evidence review process is based on the CDC ACCE Framework for Clinical Utility and includes reviewing evidence related to four critical criteria for M/S as well as MH/SUD:

- Analytic validity.
- Clinical validity.
- Clinical utility; and
- Ethical, legal and social implications.

Targeted areas of interest including specific characters of the genetic disorder, quality of clinical validation, potential intervention and outcomes, and ethical and socioeconomic considerations.

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

The evidentiary sources used to define the New Technology assessment requirements are the Technology assessment criteria used to ensure that the Blue Cross and Blue Shield Association Technology Evaluation Center (TEC) criteria are met. A Technology Assessment is a review process that determines if a medical technology (drug, device, process, system, or technique) is safe, effective, and accepted in the medical community. New and emerging health care technologies are presented before a committee comprised of the Plan's Medical Directors, and associates of the Healthcare Policy Department. The assessment includes presenting the following questions to a physician specialist, vendor, or organization who presents new or emerging technology to CareFirst for consideration for coverage:

1. In your professional opinion, do you believe the Blue Cross and Blue Shield Association Technology Evaluation Center (TEC) criteria described below? If so, please indicate which criteria are met and briefly explain.
    - The technology must have final approval from the appropriate U.S. government regulatory bodies.
        - Applies to 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.
    - The scientific evidence must permit conclusions concerning the effect on health outcomes.
        - The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals.
    - Technology must improve the net health outcome.
        - Do the beneficial effects on health outcomes outweigh any harmful effects?
    - The technology must be as effective as any established alternatives.
        - Are treatment and health outcomes the same or improved as a result using technology?
    - The improvement must be attainable outside the investigational settings.
2. Provide evidence on the established treatment alternatives, including similar alternatives if any, and how they compare to the [insert technology name] in terms of long-term safety and efficacy implications and impact on quality of life.
3. Provide evidence of the alternatives in the inpatient/outpatient settings that are medically appropriate and how they compare to the industry.
4. Please provide additional information or opinions that you think could be beneficial.

The Technology Assessment Committee, including Plan Medical Directors and Registered Nurses, uses the five Blue Cross and Blue Shield Association Technology Evaluation Center (TEC) criteria listed below to assess new and evolving technology. Within a structured framework the Technology Assessment Committee conducts an independent and unbiased assessment of the new or

emerging technology. 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.

1. The technology must have final approval from the appropriate U.S. government regulatory bodies:
   This criterion applies to 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. Any approval that is granted as an interim step in the Food and Drug Administration (FDA) regulatory process is not sufficient. The indication for which the technology is approved need not be the same as those which Blue Cross and Blue Shield Association's Technology Evaluation Center is evaluating.

2. The scientific evidence must permit conclusions concerning the effect of technology on health outcomes:
   The PICO (population, intervention, comparison, and outcome) framework is used in evidence-based medicine to frame and answer a health care related question and to assess the effect of the technology on health outcomes. The evidence should consist of well-designed and well-conducted investigations published in peer-reviewed journals. The quality of the body of studies and the consistency of the results are considered in evaluating the evidence. The evidence should demonstrate that 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. Opinions and evaluations by national medical associations, consensus panels, or other technology evaluation bodies are evaluated according to the scientific quality of the supporting evidence and rationale.

3. Technology must improve the net health outcome:
   The technology's beneficial effects on health outcomes should outweigh any harmful effects on health outcomes. An assessment of the technology and its risks or benefits guides the determination of whether the technology will improve the health outcome of the patient. For example, the impact on net health outcome was an important part of the decision to not provide coverage for Transcranial Magnetic Stimulation (TMS) for treating obsessive compulsive disorder (OCD). The providers who described this technology to the Technology Assessment Committee (TAC) reported that TMS administered prior to traditional treatments for OCD enhances the efficacy of the traditional treatments. No data was available to support that claim. When questioned regarding the durability of the enhanced response to therapy produced by TMS, the providers stated the effect is not durable and repeated TMS is required each time an enhancement to therapy is desired. The committee

determined insufficient evidence exists to document the beneficial effects of TMS prior to treatment for OCD. Consequently, the current medical policy stance for TMS was not changed and this treatment remains experimental/investigational.

4. Technology must be as beneficial as any established alternatives:
   Technology should improve the net health outcome as much as, or more than, established alternatives. Using a meta-analysis approach the body of evidence is assessed to determine if the technology is equal to, less than or superior to the standard of care or other alternative options. As an example, when assessing new technologies consideration is given to how the new technology compares with currently accepted tests or treatments for a particular purpose. In 2021, the Technology Assessment Committee (TAC) reviewed the Genomind Professional Px Express test, which is a pharmacogenomic test that is intended to inform medication selection for patients who have been diagnosed with major depressive disorder. A similar pharmacogenomic test that serves the same purpose as the Genomind Professional Px Express test, the GeneSight Psychotropic test, has been a covered benefit, and considered medically necessary by CareFirst since 2018. The similarities between the two psychotropic tests, Genomind Professional Px Express, and GeneSight Psychotropic test were discussed by the committee. The committee decided the Genomind Professional Px Express test was medically necessary and should be covered for the same indications as the GeneSight Psychotropic test.

5. The improvement must be attainable outside the investigation settings:
   When used under the usual conditions of medical practice, the technology should be reasonably expected to satisfy TEC Criteria #3 and #4.

For AIM Genetic testing, the evidentiary review process of primary literature is based on the Evaluation of Genomic Applications in Practice and Prevention (EGAPP) working group and the Agency for Healthcare Research and Quality (AHRQ) evidence evaluation recommendations. This includes an assessment of clinical utility, clinical validity (incorporating prevalence, penetrance, and expressivity), potential harms and recommended algorithms for genetic testing. When warranted more detailed assessment addressing analytic validity, incorporating laboratory quality control (QC) factors (e.g., platform/assay used, test sensitivity and specificity, variant classification methods, laboratory-specific quality control processes, and report quality) is included.

During the review, the PICO model is used to develop key questions for evaluating the following:

- Study design
- Selection of patients
- Sample size and power

- Outcomes/efficacy under ideal circumstances and in real world settings
- Data extraction
- Study funding/conflicts of interest
- Prevalence of genetic condition

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

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

On behalf of CareFirst, AIM manages the utilization management process for genetic tests used to assess medical, mental health, and substance use disorder. The fundamental framework for reviewing genetic tests does not vary by the disease category, although the guidelines themselves may be organized by certain categories. To ensure comparability, the team maintains a comprehensive database of content related to genetic disease and genetic testing technology. All guidelines are formally updated semi-annually, with off-cycle revisions to coverage criteria triggered by publication of new literature, professional society guidelines and supporting evidence. Subject matter experts perform quarterly research scoping to identify new evidence for review and incorporation into the published guidelines. Because the division is also reviewing preauthorization requests in real time, AIM is tuned to clinician ordering patterns and has visibility into potential areas of abuse. Additionally, transparent, and accessible mechanisms are in place for subject matter experts to receive and evaluate feedback from clinical providers and laboratories. Finally, editorial safeguards are in place to reduce the need for updates at market adjustments by avoiding specific proprietary test names when able and instead focusing on the validated testing methods.

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

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

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

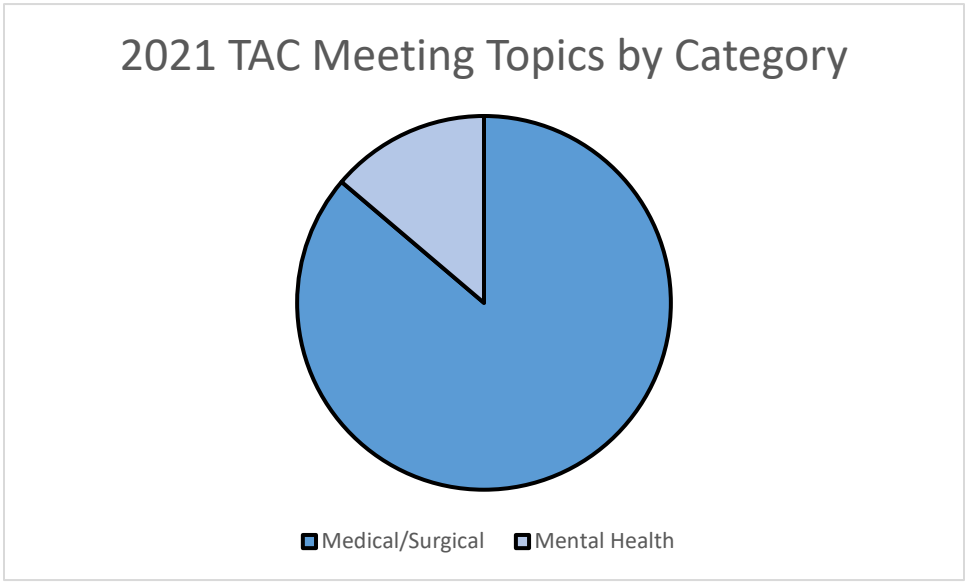
The BlueCross BlueShield Association Technology Evaluation Center (TEC) criteria is applied to an assessment of new and emerging criteria for medical/surgical, mental health and substance use disorders treatment in each classification listed above. The criteria were developed using a tournament style of progression; all five criteria must be met, and the evidence must be sufficient for a service to be considered medically necessary. The Plan does not differentiate its process when creating or revising a medical policy, regardless of if it is specific to medical/surgical, mental health, or substance use disorder.

Services or supplies that do not meet all five of the criteria listed below are deemed to be Experimental/Investigational:

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

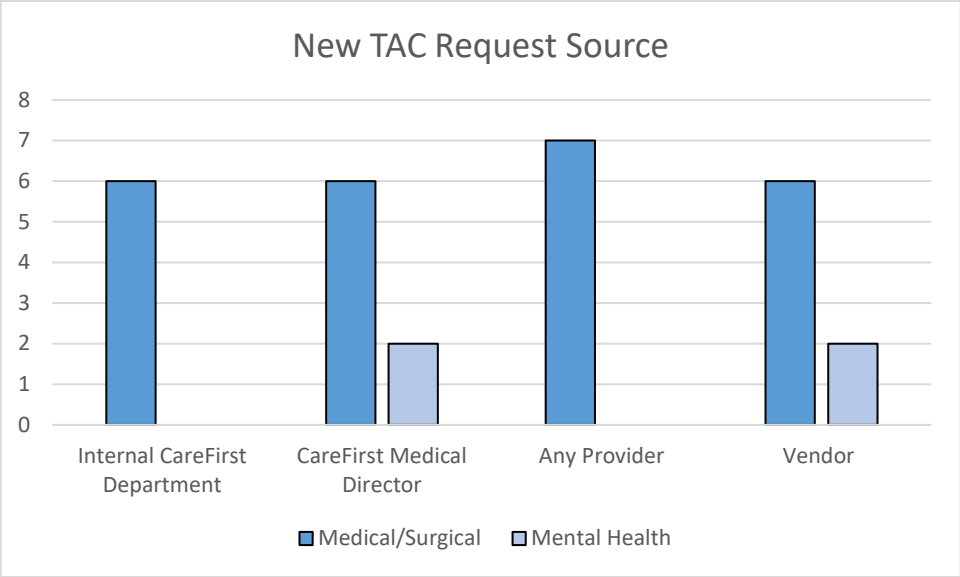
The Technology Assessment Committee (TAC) provides a forum in which evidence is evaluated to determine whether a procedure, technique, drug, or device will be covered by CareFirst. The committee is comprised of the Plan's Medical Directors, associates of the Healthcare Policy Department, and other members of the Health Services division. The committee includes a CareFirst Medical Director who is a psychiatrist with over thirty years' experience providing care to patients with mental health and substance use disorders. This physician is also board certified by the American Board of Psychiatry & Neurology. In addition,

the Director of Behavioral Health is a Licensed Clinical Professional Counselor, with a Master of Arts in Counseling Psychology and seventeen years' experience treating patients in various inpatient and outpatient settings.



The pie chart above illustrates the 2021 TAC meeting volume, broken out by medical/surgical and mental health. 13.79% of all 2021 meeting topics were related to mental health.

Technology assessment is a method by which new, emerging, or current technologies are thoroughly researched and evaluated. The Technology Assessment Committee (TAC) provides a forum in which evidence is evaluated to determine whether a procedure, technique, drug, or device will be covered. CareFirst does not limit or restrict who can submit a request to the Technology Assessment Committee for review of new or emerging technology. 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.



The above bar graph outlines the TAC topic requestor type and a separation for requests concerning medical and mental health.

Please refer to *Attachment 1* for CY2021 detailed comparative analysis. Based on the data analysis, CareFirst assesses the new technology requests for both medical/surgical and as mental health and substance use disorder consistently using the BlueCross BlueShield Association Technology Evaluation Center criteria and develops a new policy or makes necessary changes to existing policies based on the assessment.

CareFirst's concludes the Assessment of New Technology NQTL, factors, sources and evidentiary standards used to define these procedures for both M/S and MH/SUD are developed and applied comparably and no more stringently.

10. Standards for Provider Credentialing and Contracting

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

"Provider Credentialing and Contracting" means a carrier's processes and procedures and standards for determining which health care providers to contract with, either directly or through a subcontracting entity, to provide health care services to the carrier's enrollees under the carrier's health benefit plan. ***(Source- COMAR 31.10.51)***

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

"Facility" means a person, other than an individual, that provides health care services. "Facility" includes entities that bill for a bundled set of services that include services provided by staff employed by the facility. Examples of facilities include hospitals, outpatient radiology centers, and residential treatment centers. ***(Source- COMAR 31.10.51)***

For Professional Providers:
CareFirst BlueCross BlueShield and CareFirst BlueChoice, Inc. (CareFirst) contract with independently practicing licensed healthcare practitioners who provide services covered under the member's plan's medical benefits. The practitioner must be licensed in the state where the member receives the service and must be within the CareFirst service area, which includes Maryland, Washington, D.C., and Northern Virginia.

- Providers requesting to participate in CareFirst's provider networks are required to submit a completed credentialing application and copies of credentials. ***(Source- CareFirst Medical Provider Manual)***
- CareFirst encourages professional providers to use of the Council for Affordable Quality Healthcare (CAQH) ProView® application. This application is compliant with the Maryland and the District of Columbia Uniform Credentialing Form regulations.
- The practitioner can complete the credentialing application process through CAQH ProView secure website.
- Once the application is submitted, CareFirst begins the credentialing process to validate if the credentialing criteria is met. These criteria are as specified in the Credentialing standard section addressed above.

- If the credentialing criteria is met, then the CareFirst Medical Director refers the practitioner to the Credentialing Advisory Committee (CAC) for a recommendation to approve the application.
- If the credentialing criteria is not met, the Medical Director may request additional information, or deny the application or defer for recommendation.
- The decision is communicated to the Practitioner or the group practice, if the practitioner is part of a group practice. The Practitioner has an opportunity for appeal within 30 days.

For Institutional Providers:

- Providers need to submit a completed Request for Information (RFI) Application and a Facility Data Sheet for each location along with all required credentialing documents.
- Institutional and ancillary providers are required to have a physical location in the CareFirst service area, meet all credentialing requirements ***(Source- CareFirst Medical Provider Manual)***
- Institutions requesting to participate in CareFirst's provider network need to have both State Licensure and CMS certification ***(Source-Institutional and Ancillary Credentialing Requirements)***

Credentialing criteria apply to all providers and facilities who contract with CareFirst for any level of service regardless of classifications or sub-classifications. CareFirst does not credential out of network (non-participating) providers.

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

Provider Credentialing factors are as follows:

1. Current unrestricted licensure of providers: Education and training in relevant field, CMS/ Board certification, and state licensure
2. Valid DEA/CDS: Valid Drug Enforcement Agency and Controlled Dangerous Substance registration if applicable as per State requirements.
3. Provider Work history: Acceptable history of professional liability claims, previous or current state/Medicare/Medicaid sanctions, restrictions on licensure, hospital privileges and/or limitations on scope of practice
4. Participating privileges of providers: Active, unrestricted, admitting privileges at a participating network hospital, except as otherwise agreed to by CareFirst in its sole discretion
5. Provider practice hours: Minimum 20 office hours/ week to see patients
6. Malpractice insurance coverage: Current malpractice insurance coverage with minimum limits

(Source-CareFirst Medical Provider Manual)

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

Credentialing and Contracting standards apply to providers and not to benefits. CareFirst Credentialing Standards were developed in accordance with the National Committee on Quality Assurance (NCQA) Health Plan Standards for Credentialing and Recredentialing and applicable jurisdictional regulations (e.g., Maryland Health General Article 15-112.1 regarding uniform credentialing).

The evidentiary standard(s) for each of the factors identified:

Factor	Sources (i.e., processes, strategies, or evidentiary standards)
1. Current unrestricted licensure of providers	National standards, applicable jurisdictional regulations
2. Valid DEA/CDS	National Committee for Quality Assurance (NCQA) and applicable jurisdictional regulations
3. Provider Work history	National standards, applicable jurisdictional regulations, internal experts
4. Participating privileges of providers	Internal experts, applicable jurisdictional regulations
5. Provider practice hours	Applicable jurisdictional regulations, market research
6. Malpractice insurance coverage	Market research

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

All practitioners who apply to be credentialed follow the same review process. The applications are reviewed by the same CareFirst teams, including the CAC and the Medical Director and have the same review timelines.

The Credentialing Advisory Committee (CAC) 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 CAC 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.

- Reviews summary information (the complete credentialing file is available for review if requested by CAC) 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, and refers recommendations to CareFirst's Quality Improvement Committee (QIC) for final approval.
- Reviews providers are no longer considered to be in good standing.
- Reviews and approves entities recommended for delegated credentialing arrangements.
- Reviews delegated credentialing reports and develops recommendations for improvements; and
- Meets routinely throughout the year to ensure timely credentialing decisions, maintains contemporaneous minutes, documenting discussions about credentialing and reporting credentialing activities and recommendations to the QIC.

The CAC includes representation from a range of participating practitioners including contracted, board-certified practitioners representing primary care, psychiatry and specialty practices; Sr. Medical Director; Plan Medical Directors; ad hoc members appointed by the Medical Director for purpose of offering specialized expertise in the medical or behavioral health field which is the subject of the case or issue presented to the Committee; Representative from the Office of Corporate Counsel; Director, Provider Information and Credentialing; Manager, Provider Information and Credentialing, and support staff. The practitioners on the Committee elect the chairperson.

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

The credentialing criteria and process is comparable for all practitioners and organizational providers regardless of type of specialty and applies to all providers and facilities who contract with CareFirst for any level of service the applications are

reviewed by the same CareFirst teams, including the CAC and the Medical Director and have the same review timelines. All practitioners who apply to be credentialed follow the same review process.

All physician providers (M/S or MH/SUD) must meet the same standards of being licensed, carry unrestricted DEA and CDS licenses, and carry $1/$3M malpractice coverage. All non-physician providers (M/S or MH/SUD) must meet the same standards of being licensed and provide verification of education and training. Non-physician M/S providers must carry $1/$3M malpractice coverage, while non-physician MH/SUD providers must carry $.5/$1.5M malpractice coverage which is a lower standard to meet for MH/SUD providers.

11. Exclusions for Failure to Complete a Course of Treatment

"Failure to Complete a Course of Treatment" means a patient's failure to follow a documented treatment plan prescribed or recommended by a healthcare professional, including, but not limited to, on the Uniform Treatment Plan form when the treatment is for mental health or a substance use disorder. ***(Source- COMAR 31.10.51)***

There is no information related to emergency services that is not already reported under other NQTLs. Therefore, this NQTL is considered as Not Applicable for the purpose of this plan analysis.

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

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

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

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

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

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

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

"Restrictions that Limit Duration or Scope of Benefits for Services" means non-numerical limits or restrictions based on geographic location, facility type, provider specialty, and other criteria, including exclusions of a specific or type of MH/SUD treatment, that limit the scope or duration of benefits for services provided under the plan or coverage. ***(Source- COMAR 31.10.51)***

Service Area Restrictions for HMO plans:

CareFirst BlueChoice's Service Area is a clearly defined geographic area in which CareFirst BlueChoice has arranged for the provision of health care services to be generally available and readily accessible to Members. The Service Area is as follows: the District of Columbia; the State of Maryland; in the State of Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the areas of Fairfax and Prince Williams Counties in Virginia lying east of Route 123. ***(Source- Plan doc, Section 7, Service Area).***

Except for those services described in the Inter-Plan Arrangement Disclosure or where otherwise authorized by CareFirst BlueChoice, there are no benefits for services rendered outside the CareFirst BlueChoice Service Area. ***(Source- Plan doc, Attachment C).***

As used in the Inter-Plan Arrangements Disclosure Amendment "Out-of-Area Covered Healthcare Services" means:

1. Emergency Services.
2. Urgent Care.
3. Follow-up care after emergency surgery for services provided by the physician, surgeon, oral surgeon, periodontist, or podiatrist who performed the surgical procedure, for follow-up care that is Medically Necessary, directly related to the condition for which the surgical procedure was performed and provided in consultation with the Member's Primary Care Physician.
4. Obtained outside the geographic area CareFirst BlueChoice serves.

Any other services will not be covered when processed through any Inter-Plan Programs arrangements. **(*Source- Plan doc, Inter-Plan Arrangements Disclosure Amendment)***

Members who temporarily reside out of the Service Area (i.e., school, travel, work), for at least ninety (90) consecutive days will be able to take advantage of the Away from Home Care Program. This program allows Members, who meet the criteria, the opportunity to obtain benefits of an affiliated host Blue Cross and Blue Shield HMO. This program is not coordination of benefits. There is no new or additional premium billed under this Program ***(Source-Plan doc, Section 7, Service Area).***

Service Area Restrictions for POS plans:

CareFirst BlueChoice's Service Area is a clearly defined geographic area in which CareFirst BlueChoice has arranged for the provision of health care services to be generally available and readily accessible to Members. The Service Area is as follows: the District of Columbia; the State of Maryland; in the State of Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the areas of Fairfax and Prince Williams Counties in Virginia lying east of Route 123. ***(Source- Plan doc, Section 7, Service Area).***

Except for those services described in the Inter-Plan Arrangement Disclosure or where otherwise authorized by CareFirst BlueChoice, there are no benefits for services rendered outside the CareFirst BlueChoice Service Area. ***(Source- Plan doc, Attachment C).***

As used in the Inter-Plan Arrangements Disclosure Amendment "Out-of-Area Covered Healthcare Services" means:

1. Emergency Services.
2. Urgent Care.
3. Follow-up care after emergency surgery for services provided by the physician, surgeon, oral surgeon, periodontist, or podiatrist who performed the surgical procedure, for follow-up care that is Medically Necessary, directly related to the condition for which the surgical procedure was performed and provided in consultation with the Member's Primary Care Physician.
4. Obtained outside the geographic area CareFirst BlueChoice serves.

Any other services will not be covered when processed through any Inter-Plan Programs arrangements. **(*Source- Plan doc, Inter-Plan Arrangements Disclosure Amendment)***

Members who temporarily reside out of the Service Area (i.e., school, travel, work), for at least ninety (90) consecutive days will be able to take advantage of the Away from Home Care Program. This program allows Members, who meet the criteria, the

opportunity to obtain benefits of an affiliated host Blue Cross and Blue Shield HMO. This program is not coordination of benefits. There is no new or additional premium billed under this Program ***(Source- Plan doc, Section 7, Service Area).***

Service Area Restrictions for PPO plans:

CareFirst BlueChoice's Service Area is a clearly defined geographic area in which CareFirst BlueChoice has arranged for the provision of health care services to be generally available and readily accessible to Members. The Service Area is as follows: The District of Columbia; the State of Maryland; in the State of Virginia, the cities of Alexandria and Fairfax, Arlington County, the town of Vienna and the areas of Fairfax and Prince Williams Counties in Virginia lying east of Route 123 ***(Source- Plan doc, Section 7, Service Area).***

Facility-level Restriction: No facility level restrictions that could be identified for this plan.

MH/SUD Exclusions:
Benefits will not be provided for the following inpatient and outpatient MH/SUD services:

- Services provided by pastoral or marital counselors
- Therapy for sexual problems
- Treatment for learning disabilities and intellectual disabilities
- Travel time to the Member's home to conduct therapy
- Services rendered or billed by schools, or halfway houses or members of his/her staff*
- Marriage counseling

(Source- Plan doc, Section 16, Exclusions & Limitations)

*Note that schools and halfway houses are not facilities such that they can bill for covered services rendered. Licensed health care practitioners who provide services at a school or a halfway house may bill for covered services from those places of service. This is consistent with Medicare.

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

The factors considered when determining service area limitations are:

1. Terms of the Licensee agreement with the BlueCross BlueShield Association; and
2. State and federal law.

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

There are no evidentiary standards for the factors identified.

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

The service area restrictions are set by the terms of CareFirst's contract with the BlueCross BlueShield Association and state and federal law

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

The plan report has a detailed summary explanation of the service area restriction, factors and sources used to define this limitation for both M/S and MH/SUD which appears to be developed and applied comparably and no more stringently.

- The limitations on service area apply to all M/S and MH/SUD covered benefits. A member may equally access emergency services outside of the service area for a MH/SUD emergency as they do for a M/S emergency. The factors considered when establishing the service area restrictions do not consider whether services being accessed are to treat a MH/SUD or M/S condition.
- CareFirst does not have any data to review to determine whether the service area restriction is working comparably in operation. The service area restrictions are set by the terms of CareFirst's contract with the BlueCross BlueShield Association and state and federal law. CareFirst did not create the restriction, nor does it have the ability to change the restriction on service area for any network products.

13. Restrictions for Provider Specialty

"Restrictions for Provider Specialty" means, for services that are within the scope of practice for a health care provider, restrictions based on the licensure or certification of a health care provider that limit the scope or duration of benefits for services provided under the plan or coverage. ***(Source- COMAR 31.10.51)***

Provider's scope of practice is dictated by their state license. As reviewed and approved by CareFirst's Legal team, this section is considered 'Not Applicable'.

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

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

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

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

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

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

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

"Reimbursement" means compensation, or the amount allowed to a health care provider, member, or other person entitled to reimbursement by a carrier, or the combined amount of the carrier's payment and member's cost-sharing responsibility, for providing health care services, medications, or supplies to enrollees of the health benefit plan. Reimbursement includes, but is not limited to, fee for service payments, capitation payments, bundled or global payments, and bonuses or other incentive payments. ***(Source- COMAR 31.10.51)***

Standard (or base fee schedule) Reimbursement standards apply to providers or facilities and not to benefits. They apply to all providers and facilities who contract with CareFirst for any level of service.

Participating providers agree to accept a plan allowance (also called allowed benefit or allowed amount) as payment in full for their services. Participating providers may not bill the member for amounts that exceed the allowed amount for covered services. Members may be liable for non-covered services, deductibles, copayments, and coinsurance. ***(Source- CareFirst Medical Provider Manual)***

Methods of Reimbursement for Facilities - CareFirst provides several methods of hospital reimbursement:

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

(Source- CareFirst Medical Provider Manual)

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

Providers: the same standard fee schedule is used for in-network (INN) and out-of-network (OON), the only exception are 4 E/M CPTs (99213-99214, 99232) that we allow a higher non-Facility rate on for INN Psychiatrist only.

Facilities: the same standard fee schedule if used for INN and OON, the only exception is Dialysis facilities which have a lesser fee schedule for OON.

Standard **Provider Fee** Schedule (used for both INN and OON):

1. Medicare reimbursement rates: Medicare fee schedule and any annual changes.
2. Competitive Intelligence: Information about industry reimbursement rates or evidence of cost of care provided by the facility.
3. Geographic region: Created by considering Medicare regions
4. Network type (HMO or PPO): Type of network that the provider is participating in (Health Maintenance Organization, Preferred Provider Organization).
5. Place of Service: Where the provider is providing services to members. ***(Source-CareFirst Medical Provider Manual)***
6. Training, expertise, and licensure of provider: What training, license, or expertise does the provider have?
7. Market demands: What the market requires for reimbursement rates.

Standard **Facility Fee** Schedules (used for both INN and OON):

- Maryland Hospital reimbursement is required to follow HSCRC regulations, therefore not comparable to other Facility reimbursement.
- All other MH/SUD facilities are contracted through negotiated terms, based on the specialized services.
- Non-Hospital Standard Facility Fee Schedule, including MHSA, Birthing Center, SNF, ASC, Hospice, Home Health, Dialysis:
    1. Medicare reimbursement rates: Medicare fee schedule and any annual changes.
    2. Competitive Intelligence: Information about industry reimbursement rates
    3. Geographic region: Created by considering Medicare regions
    4. Network type (HMO or PPO): Type of network that the provider is participating in (Health Maintenance Organization, Preferred Provider Organization).
    5. Specialized Services: What training, services and, or expertise do the facility and staff have for select services, what the market requires for reimbursement rates.

If a Provider or Facility submits a request to negotiate their rates the contracting team considers the following factors regardless of MH/SUD or M/S:

1. Impact of Group's request
2. Access
3. Services rendered
4. 1099
5. Network participation
6. Practice size
7. Provider scores
8. Concurrent rates
9. Medicare & Medicaid benchmarks
10. Market validation
11. Comparison of practices
12. SIU concerns
13. Market trends
14. Value-based arrangements
15. Member complaints.

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

When developing its Standard **Provider Fee** Schedule, CareFirst takes into consideration the following:

1. Medicare reimbursement rates: Rates paid by Medicare under the MPFS or MAC for local jurisdictions
2. Competitive Intelligence: Provider complaints and correspondence, industry benchmarking data, competitive research
3. Geographic region: DC, Baltimore Metro and Rural MD, these are defined by county that match CMS for the same locality.
4. Network type (HMO or PPO): Provider contract
5. Place of Service: Provider application, industry standards, state law
6. Training, expertise, and licensure of provider: Provider application, Medicare reductions for limited licensed provider, competitive intelligence
7. Market demands: Provider feedback, competitive intelligence; provider correspondence that may include blinded competitor information, this information is generally submitted by providers when providing market validation or evidence

that other payors are allowing higher rates; Industry benchmarking data such as purchased market benchmarking data, i.e., IDB Watson and Truven.

When developing its Standard **Facility Fee** Schedules, CareFirst takes into consideration the following:

- Maryland Hospital reimbursement is required to follow HSCRC regulations, therefore not comparable to other Facility reimbursement.
- All other MH/SUD facilities are contracted through negotiated terms, based on the specialized services. There is a base fee schedule used as a starting point for these negotiations.
- Non-Hospital Standard Facility Fee Schedule, including MHSA, Birthing Center, SNF, ASC, Hospice, Home Health, Dialysis:
  1. Medicare reimbursement rates (when available, public fee schedule not available for all facility types): Rates paid by Medicare under the Facility fee schedules local jurisdictions when applicable.
  2. Competitive Intelligence: Provider complaints and correspondence through fee negotiations, industry benchmarking data, competitive research
  3. Geographic region: Medicare uses Wage Index values by CBSA to add a weighting to their base fee schedule. CareFirst only has 2 geo regions for facility fee schedule of DC (include P and Mont Co.) and Maryland (excluding those DC counties).
  4. Network type (HMO or PPO): Provider contract
  5. Specialized services and Market Demands: Provider application, provider feedback, provider correspondence that may include blinded competitor information, this information is generally submitted by providers when providing market validation or evidence that other payors are allowing higher rates; Industry benchmarking data such as purchased market benchmarking data, i.e., IDB Watson and Truven.

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

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

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

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

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

Development of the fee schedule is subjective, however, we are cognizant of MHPAEA, so every modification is reviewed to ensure we are not more stringent in our provider allowances for services related to mental health and substance use disorders. Such changes to the fee schedule go through a series of quality review checks and approvals throughout our company. Upon review of the standard fee schedules the assigned Reimbursement Analyst, employed by CareFirst, develops proposed rates based on the factors identified in Step 2. To ensure that we are not being more stringent on MH/SUD services the rates (listed in Step 5) are compared against Medicare to validate that the rates are not a lesser % of Medicare than M/S rates. This analysis is sent to the Manager of Provider Reimbursement for review of all rates, % of Medicare and final approval of any changes. The Manager of Provider Reimbursement will also validate that the percentage of Medicare for MH/SUD rates is no less than that of the E/M rates used by M/S. The teams design includes certified professional coders, and individuals who have been involved in decision making over rates since at least 2009.

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

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

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

Negotiation requests are managed by the Institutional, Ancillary and Professional Contracting Department. The teams are responsible for evaluating the Provider or Facility request and developing a recommendation. Any changes are reviewed and approved by the Executive Management Team. An analysis of Group's business with CareFirst is conducted which contains the utilization and rates for all CPT codes billed by the Group in the past year. It compares the Group's current rates, standard rates, requested rates and Medicare rates for all services, were applicable. We also provide the group with our market validation tool to help them conduct a blinded weighted analysis to determine the gap in reimbursement between CareFirst and their other payers. This process is followed for all providers regardless of their specialty or facility type.

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