Maryland NQTL Analysis Report

2024

Wellfleet Insurance Company

The below summary form is prepared to satisfy the requirements of §15-144 (m)(2), Insurance Article, Annotated Code of Maryland. The summary form must be made available to plan members and to the public on the carrier's website. Confidential and proprietary information must be removed from the summary form. Confidential and proprietary information that is removed from the summary form must satisfy § 15-144(h)(1), Insurance Article, Annotated Code of Maryland. The MHPAEA Summary Form includes the MHPAEA Data Report.

MHPAEA Summary Form

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), Wellfleet must make sure that there is "parity" between mental health and substance use disorder benefits, and medical and surgical benefits. This generally means that financial requirements and treatment limitations applied to mental health or substance use disorder benefits cannot be more restrictive than the financial requirements and treatment limitations applied to medical and surgical benefits. The types of limits covered by parity protections include: • Financial requirements—such as deductibles, copayments, coinsurance, and out-of-pocket limits; and • Treatment limitations—such as limits on the number of days or visits covered, or other limits on the scope or duration of treatment (for example, being required to get prior authorization). Wellfleet 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 our Compliance Department at corporatecompliance.wellfleetinsurance.com. If you have questions on your specific health plan, please call (877)657-5030.

Benefit Classifications:

Covered Service	M/S or MH/SUD	Benefit Classification
Hospital Care Includes Hospital room & board expenses/misc. services and supplies.	M/S & MH/SUD	Inpatient In-Network & Inpatient Out-of-Network
Preadmission Testing	M/S & MH/SUD	Inpatient In-Network & Inpatient Out-of-Network
Physician's Visits while Confined	M/S & MH/SUD	Inpatient In-Network & Inpatient Out-of-Network
Skilled Nursing Facility Benefit	M/S	Inpatient In-Network & Inpatient Out-of-Network
Inpatient Rehabilitation Facility Expense Benefit	M/S	Inpatient In-Network & Inpatient Out-of-Network
Registered Nurse Services for private duty nursing while confined * included in MHSUD with respect to gender	M/S & MH/SUD	Inpatient In-Network & Inpatient Out-of-Network

affirming surgeries and services rendered inpatient		
Physical Therapy while Confined (inpatient) * included in MHSUD with respect to gender affirming surgeries and services rendered inpatient	M/S & MH/SUD	Inpatient In-Network & Inpatient Out-of-Network
Surgeon Services (Inpatient) * included in MHSUD with respect to gender affirming surgeries and services rendered inpatient	M/S & MH/SUD	Inpatient In-Network & Inpatient Out-of-Network
Anesthetist (Inpatient) * included in MHSUD with respect to gender affirming surgeries and services rendered inpatient	M/S & MH/SUD	Inpatient In-Network & Inpatient Out-of-Network
Assistant Surgeon (Inpatient) * included in MHSUD with respect to gender affirming surgeries and services rendered inpatient	M/S & MH/SUD	Inpatient In-Network & Inpatient Out-of-Network
Residential Treatment	MH/SUD	Inpatient In-Network & Inpatient Out-of-Network
Physician's Office Visits	M/S & MH/SUD	Outpatient Office In-Network & Outpatient Office Out-of-Network
Specialist/Consultant Physician Services	M/S & MH/SUD	Outpatient Office In-Network & Outpatient Office Out-of-Network
Allergy Injections/Treatment	M/S	Outpatient Office In-Network & Outpatient Office Out-of-Network
Chiropractic Care Benefit	M/S	Outpatient Office In-Network & Outpatient Office Out-of-Network
Shots and Injections unless Considered Preventive Services	M/S	Outpatient Office In-Network & Outpatient Office Out-of-Network
Tuberculosis screening, Titers, QuantiFERON B tests including shots (not under preventive services)	M/S	Outpatient Office In-Network & Outpatient Office Out-of-Network
Preventive	M/S	Outpatient Office In-Network & Outpatient Office Out-of-Network
Surgeon Services (Outpatient) * included in MHSUD with respect to gender affirming surgeries and services rendered outpatient	M/S & MH/SUD	Outpatient Other In-Network & Outpatient Other Out-of-Network
Anesthetist (Outpatient)) * included in MHSUD with	M/S &	Outpatient Other In-Network & Outpatient Other Out-

respect to gender affirming surgeries and services rendered outpatient	MH/SUD	of-Network
Assistant Surgeon (Outpatient)) * included in MHSUD with respect to gender affirming surgeries and services rendered outpatient	M/S & MH/SUD	Outpatient Other In-Network & Outpatient Other Out-of-Network
Outpatient Surgical Facility and Miscellaneous Expenses for Services & Supplies) * included in MHSUD with respect to gender affirming surgeries and services rendered outpatient	M/S & MH/SUD	Outpatient Other In-Network & Outpatient Other Out-of-Network
Abortion Expense	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Bariatric Surgery	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Organ Transplant Surgery	M/S	Inpatient In-Network & Inpatient Out-of-Network
Reconstructive Surgery) * included in MHSUD with respect to gender affirming surgeries and services rendered outpatient	M/S & MH/SUD	Outpatient Other In-Network & Outpatient Other Out-of-Network
Home Health Care Expenses	M/S & MH/SUD	Outpatient Other In-Network & Outpatient Other Out-of-Network
Hospice Care Coverage	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Urgent Care Centers for Non-Life-Threatening Conditions	M/S & MH/SUD	Outpatient Other In-Network & Outpatient Other Out-of-Network
Non-Emergency Ambulance Service Ground and/or Air, Water Transportation	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Diagnostic Imaging Services	M/S & MH/SUD	Outpatient Other In-Network & Outpatient Other Out-of-Network
CT scan, MRI and/or PET Scans	M/S & MH/SUD	Outpatient Other In-Network & Outpatient Other Out-of-Network
Laboratory Procedures (Outpatient)	M/S & MH/SUD	Outpatient Other In-Network & Outpatient Other Out-of-Network

Chemotherapy and Radiation Therapy	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Infusion Therapy	M/S & MH/SUD	Outpatient Other In-Network & Outpatient Other Out-of-Network
Cardiac Rehabilitation	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Pulmonary Rehabilitation	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Rehabilitation Therapy including, Physical Therapy, and Occupational Therapy and Speech Therapy	M/S & MH/SUD	Outpatient Other In-Network & Outpatient Other Out-of-Network
Habilitation Services (PT/OT/SP to keep, learn skills or improve skills for functioning of daily living)	M/S & MH/SUD	Outpatient Other In-Network & Outpatient Other Out-of-Network
Diabetic Services and Supplies (including Equipment and Training)	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Dialysis Treatment	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Durable Medical Equipment	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Enteral Formulas and Nutritional Supplements	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Hearing Aids	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Infertility Treatment	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Prosthetic [and Orthotic] Devices	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Outpatient Private Duty Nursing	M/S & MH/SUD	Outpatient Other In-Network & Outpatient Other Out-of-Network
Treatment for Temporomandibular Joint (TMJ) Disorders	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network

Pediatric Dental Care Benefit	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Pediatric Preventive Dental Care	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Pediatric Emergency Dental	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Pediatric Routine Dental Care	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Endodontic Services	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Pediatric Prosthodontic Services	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Pediatric Medically Necessary Orthodontic Care	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Pediatric Vision Care Benefit	M/S	Outpatient Other In-Network & Outpatient Other Out-of-Network
Gender Affirming Services and Procedures	MH/SUD	Inpatient In-Network & Inpatient Out-of-Network; Outpatient Other In-Network & Outpatient Other Out-of-Network
Emergency Services in an Emergency Department	M/S & MH/SUD	Emergency
Emergency Ambulance Service Ground and/or Air, Water Transportation	M/S & MH/SUD	Emergency
Prescription Drugs	M/S & MH/SUD	Prescription
Behavioral Health Crisis Services & Observation Services	MH/SUD	Emergency

(a) Explain the methodology used to assign M/S and MH/SUD benefits to each classification and/or sub-classification.

Medical/Surgical Benefits Definition: Benefits with respect to items or service for Medical/Surgical Conditions, which unless otherwise specified

in applicable state law, includes conditions listed in ICD-10 Chapter 5, Sub-chapter 1; sub-chapter 8.

Mental Health/Substance Use Disorder Benefits Definition: Benefits with respect to items or services for Mental Health/Substance Use Disorder Conditions, which unless otherwise specified in applicable state law, includes conditions listed in ICD-10 CM code manual Chapter 5, sub-chapters 1–7 and 9–11 and diagnostic criteria established by the American Psychiatric Association published as the latest edition of DSM (Diagnostic and Statistical Manual of Mental Disorders).

Inpatient Definition: All days in a health care facility that meet the medical necessity for an inpatient level of care; includes any and all services and supplies utilized during the inpatient days and billed by the facility.

Inpatient IN-Network: Healthcare items or services that meet the definition of Inpatient above, and:

(1) are delivered by a network of providers established through direct contract, leased network, or delegation; and

(2) are recognized under a plan as providing an in-network benefit.

Inpatient Out-of-Network: Healthcare items or services that meet the definition of Inpatient above and are delivered outside of any network of providers established or recognized under a plan to provide an out-of-network benefit.

Outpatient Definition: All covered items or services, including physician-administered medications, which are none of the below:

(1) An inpatient, emergency, or retail pharmacy item or service

(2) An episode of care which took place in a prison or other correctional facility

(3) An episode of care which took place in a military treatment facility

(4) An episode of care which took place in a custodial care facility

This includes all services and supplies occurring during the visit and billed for by the facility.

Outpatient IN-Network: Healthcare items or services that meet the definition of outpatient above and are delivered by a network of providers established through direct contract, leased network or delegation.

Outpatient IN-Network OFFICE: Any healthcare item, service, or episode, which has ALL the following criteria:

(1) It meets the definition for Outpatient

(2) The episode is either:

a. A general office visit by primary care physician or specialist

b. Psychotherapy

c. Family counselling/group therapy

d. Telemedicine

e. Medication Management

(3) It is delivered by a network of providers established through direct contract, leased network, or delegation and are recognized under a plan as providing an in- network benefit.

Outpatient IN-Network ALL OTHER: Any healthcare item, service, or episode, which has ALL the following criteria:

(1) It meets the definition for General Outpatient Classification, and

(2) The episode is not any of the following:

a. A general office visit by primary care physician or specialist

b. Psychotherapy

c. Family counselling/group therapy

d. Telemedicine

e. Medication Management

(3) It is delivered by a network of providers established through direct contract, leased network, or delegation and are recognized under a plan as providing an in- network benefit.

Outpatient Out-of-Network: Healthcare items or services that meet the definition of outpatient above and are delivered outside of any network of providers established through direct contract, leased network, or delegation.

Outpatient Out-of-Network OFFICE: Any healthcare item, service, or episode, which has ALL the following criteria:

(1) It meets the definition for General Outpatient Classification

(2) The episode is either:

a. A general office visit by primary care physician or specialist

b. Psychotherapy

c. Family counselling/group therapy

d. Telemedicine

e. Medication Management

(3) It is delivered outside of any network of providers established through direct contract, leased network, or delegation.

Outpatient Out-of-Network ALL OTHER: Any healthcare item, service, or episode, which has ALL the following criteria:

(1) It meets the definition for General Outpatient Classification, and

(2) The episode is not any of the following:

a. A general office visit by primary care physician or specialist

b. Psychotherapy

c. Family counselling/group therapy

d. Telemedicine

e. Medication Management

(3) It is delivered outside of any network of providers established through direct contract, leased network, or delegation.

Emergency Services Definition: Any healthcare item, service, or episode on a claim, which occurs in an Emergency Department or ambulance setting. This includes all services and/or supplies provided during the visit and billed by the facility or provider.

Pharmacy/Prescription Drug Services Definition: Covered medications, drugs, and associated supplies that legally require and are obtained through a medical prescription.

Overview:

Wellfleet has 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. The NQTL's listed below demonstrate how the health plans achieve parity.

Prior Authorization; Formulary Design; Provider Directories; Provider Reimbursement; Provider Shortages

For each NQTL provided below, provide the detailed comparative analysis as described in the template below.

Prior Authorization Review Process

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits
Prior Authorization (Preauthorization or "PA") for Medical is a decision prior to a member's receipt of a Covered Service, procedure, or device that the Covered Service, procedure or device is Medically Necessary. Prior Authorization (Preauthorization or "PA") for Pharmacy (Prescription Drugs) is a decision made prior to a member's receipt and coverage of a Prescription Drug to determine that the Drug is Medically Necessary and being utilized appropriately. Wellfleet delegates its non-Pharmacy Utilization Management to Cigna Healthcare Management (Cigna). Cigna is responsible for determining which non-Pharmacy benefits are eligible for PA. As such, Cigna's utilization management policies are used to determine prior authorization factors, sources, and evidentiary standards. Once the benefits subject to prior authorization are determined, Cigna performs utilization management on Wellfleet's behalf. Their policies are used to determine operational aspects of Prior Authorization. Wellfleet contracts with Cigna - Payer Solutions Precertification List. The Prior Authorization NQTL with respect to Cigna applies to Inpatient In Network and Out of Network, Outpatient – All Other In Network and Out of Network benefits. Wellfleet delegates the act of utilization review for Pharmacy to Express Scripts (ESI), however the application of the Prior Authorization NQTL and the guidelines that drive the decisions by ESI are approved by Wellfleet's Pharmacy and Therapeutics Committee (P&T) and Value Assessment	Prior Authorization (Preauthorization or "PA") for Medical is a decision prior to a member's receipt of a Covered Service, procedure, or device that the Covered Service, procedure or device is Medically Necessary. Prior Authorization (Preauthorization or "PA") for Pharmacy (Prescription Drugs) is a decision made prior to a member's receipt and coverage of a Prescription Drug to determine that the Drug is Medically Necessary and being utilized appropriately. Wellfleet delegates its non-Pharmacy Utilization Management to Cigna Healthcare Management (Cigna). Cigna is responsible for determining which non-Pharmacy benefits are eligible for PA. As such, Cigna's utilization management policies are used to determine prior authorization factors, sources, and evidentiary standards. Once the benefits subject to prior authorization are determined, Cigna performs utilization management on Wellfleet's behalf. Their policies are used to determine operational aspects of Prior Authorization. Wellfleet contracts with Cigna - Payer Solutions Precertification List. The Prior Authorization NQTL with respect to Cigna applies to Inpatient In Network and Out of Network, Outpatient – All Other In Network and Out of Network benefits. Wellfleet delegates the act of utilization review for Pharmacy to Express Scripts (ESI), however the application of the Prior Authorization NQTL and the guidelines that drive the decisions by ESI are approved by Wellfleet's Pharmacy and Therapeutics Committee (P&T) and Value Assessment

Committee (VAC). The Prior Authorization NQTL as it applies to ESI, is for the pharmacy benefits. The prior authorization list for our utilization review agent Cigna (Medical) is located on Wellfleet's website https://wellfleetstudent.com/providers/ . Search Other Provider Resources - Prior Authorization Requirements – Cigna Precertification Code Listing. There is no separate Prior Authorization code list for behavioral health services. All services subjected to Prior Authorization are reviewed at the CPT/HCPCS level for in network and out of network outpatient- all other benefit classification. The Inpatient out of network and in network benefit classification is reviewed for the number of days stays, and codes applicable to the stay. Prescription Drug Prior Authorization information is described in several locations and does not discriminate or delineate between MS and MH/SUD medications. The same listing/set of guidelines is utilized for both the MS and MH/SUD classification, in order to provide a holistic view of all requirements under the plan. Our full listing of prescription drug products requiring prior authorization can be found in both our prescription drug formulary and prior authorization guidelines, found here: Formularies - Wellfleet Rx The Precertification Process is included in the member's certificate at the following pages which can be found by https://wellfleetstudent.com/ by searching for the plan under "Search For Your School".	Committee (VAC). The Prior Authorization NQTL as it applies to ESI, is for the pharmacy benefits. The prior authorization list for our utilization review agent Cigna (Medical) is located on Wellfleet's website https://wellfleetstudent.com/providers/ . Search Other Provider Resources - Prior Authorization Requirements – Cigna Precertification Code Listing. There is no separate Prior Authorization code list for behavioral health services. All services subjected to Prior Authorization are reviewed at the CPT/HCPCS level for in network and out of network outpatient- all other benefit classification. The Inpatient out of network and in network benefit classification is reviewed for the number of days stays, and codes applicable to the stay. Prescription Drug Prior Authorization information is described in several locations and does not discriminate or delineate between MS and MH/SUD medications. The same listing/set of guidelines is utilized for both the MS and MH/SUD classification, in order to provide a holistic view of all requirements under the plan. Our full listing of prescription drug products requiring prior authorization can be found in both our prescription drug formulary and prior authorization guidelines, found here: Formularies - Wellfleet Rx The Precertification Process is included in the member's certificate at the following pages which can be found by https://wellfleetstudent.com/ by searching for the plan under "Search For Your School".
McDaniel College https://www.studentinsurance.com/Docs/Resources/8495_Final%202425%20McDaniel%20College%20MD%20SHIP%20Cert%20Combined%209.17.24%20MS.pdf = Pages 6-17, 37 - 39	McDaniel College https://www.studentinsurance.com/Docs/Resources/8495_Final%202425%20McDaniel%20College%20MD%20SHIP%20Cert%20Combined%209.17.24%20MS.pdf = Pages 6-17, 37 - 39
Washington College https://www.studentinsurance.com/Docs/Resources/8060_FINAL%2023-	Washington College https://www.studentinsurance.com/Docs/Resources/8060_FINAL%2023-

24%20Washington%20College%20SHIP%20Cert%20Combined%20w%20Notices%2010.9.23%20JR.pdf = Pages 5-11, 39-41	24%20Washington%20College%20SHIP%20Cert%20Combined%20w%20Notices%2010.9.23%20JR.pdf = Pages 5-11, 39-41
St John's College https://www.studentinsurance.com/Docs/Resources/8264_FINAL%2023-24%20St%20John's%20College%20Cert%20combined%20w%20notices%2012.21.23.pdf = Pages 6-12, 44-46	St John's College https://www.studentinsurance.com/Docs/Resources/8264_FINAL%2023-24%20St%20John's%20College%20Cert%20combined%20w%20notices%2012.21.23.pdf = Pages 6-12, 44-46
Notre Dame of Maryland Univ https://www.studentinsurance.com/Docs/Resources/7799_Final%20MD%202223%20Notre%20Dame%20SHIP%20Cert%20Combined%20REV.pdf = Pages 6-10, 40-42	Notre Dame of Maryland Univ https://www.studentinsurance.com/Docs/Resources/7799_Final%20MD%202223%20Notre%20Dame%20SHIP%20Cert%20Combined%20REV.pdf = Pages 6-10, 40-42
The plan language is included below: To begin the Pre-Certification process, call Us at the phone number found on Your ID card. Pre-Certification is recommended for the following Inpatient services or supplies: 1. All Inpatient admissions for M/S/MH/SUD, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of a Substance Misuse Disorder, or a residential Treatment facility; 2. All Inpatient maternity care after the initial 48/96 hours; 3. Surgery; 4. Transplant Services; Pre-Certification is not required for an Emergency Medical Condition, or Urgent Care, or Hospital Confinement for the initial 48/96 hours of maternity care. Pre-Certification is not a guarantee that benefits will be paid. If an Inpatient service or supply has received Pre-Certification, We will not deny reimbursement for the service or supply delivered unless: 1. The information submitted regarding the service or supply was fraudulent or intentionally misrepresentative; 2. Critical information required by Us was omitted such that Our determination would have been different had We known the critical information; 3. A planned course of Treatment for the Insured Person was not	The plan language is included below: To begin the Pre-Certification process, call Us at the phone number found on Your ID card. Pre-Certification is recommended for the following Inpatient services or supplies: 1. All Inpatient admissions for M/S/MH/SUD, including length of stay, to a Hospital, Skilled Nursing Facility, a facility established primarily for the Treatment of a Substance Misuse Disorder, or a residential Treatment facility; 2. All Inpatient maternity care after the initial 48/96 hours; 3. Surgery; 4. Transplant Services; Pre-Certification is not required for an Emergency Medical Condition, or Urgent Care, or Hospital Confinement for the initial 48/96 hours of maternity care. Pre-Certification is not a guarantee that benefits will be paid. If an Inpatient service or supply has received Pre-Certification, We will not deny reimbursement for the service or supply delivered unless: 1. The information submitted regarding the service or supply was fraudulent or intentionally misrepresentative; 2. Critical information required by Us was omitted such that Our determination would have been different had We known the critical information;

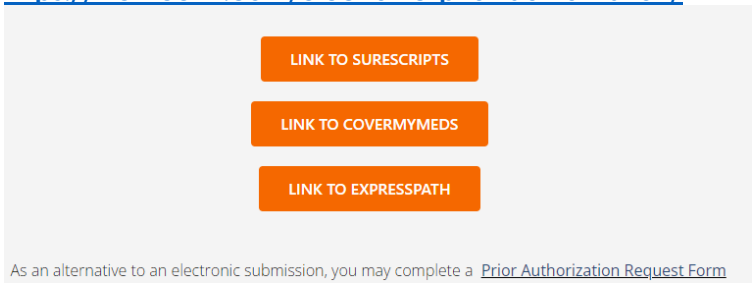
4. On the date the pre-certified service or supply was delivered the Insured Person was not covered by the Policy. The Private Review Agent will make all initial determinations on whether to authorize or certify: 1. A non-emergency course of Treatment for an Insured Person within 2 working days after receipt of the information necessary to make the determination; 2. An extended stay in a health care facility or additional health care services within 1 working day after receipt of the information necessary to make the determination. If within 3 calendar days after receipt of the initial request for health care services, the Private Review Agent does not have sufficient information to make a determination, the Private Review Agent shall inform the health care provider that additional information must be provided. For emergency inpatient admission, the Private Review Agent shall make all determinations on whether to authorize or certify the inpatient admission, within 2 hours after receipt of the information necessary to make the determination. If an initial determination is made by the Private Review Agent not to authorize or certify a health care service and the health care provider believes the determination warrants an immediate reconsideration, the Private Review Agent may provide the health care provider the opportunity to speak with the Physician that rendered the determination, by telephone on an expedited basis, within a period to time not to exceed 24 hours of the health care provider seeking the reconsideration. For emergency inpatient admissions, the Private Review Agent will not render an Adverse Benefit Determination solely because the Hospital did not notify Us of the emergency admission within 2 working days after that admission: 1. If the Insured Person's medical condition prevented the Hospital from determining the Insured Person's status; or	3. A planned course of Treatment for the Insured Person was not substantially followed by the Provider; or 4. On the date the pre-certified service or supply was delivered the Insured Person was not covered by the Policy. The Private Review Agent will make all initial determinations on whether to authorize or certify: 1. A non-emergency course of Treatment for an Insured Person within 2 working days after receipt of the information necessary to make the determination; 2. An extended stay in a health care facility or additional health care services within 1 working day after receipt of the information necessary to make the determination. If within 3 calendar days after receipt of the initial request for health care services, the Private Review Agent does not have sufficient information to make a determination, the Private Review Agent shall inform the health care provider that additional information must be provided. For an admission for residential crisis services for Treatment of a mental, emotional, or substance misuse disorder, the Private Review Agent shall make all determinations on the admission for residential crisis services within 2 hours after receipt of the information necessary to make the determination. If an initial determination is made by the Private Review Agent not to authorize or certify a health care service and the health care provider believes the determination warrants an immediate reconsideration, the Private Review Agent may provide the health care provider the opportunity to speak with the Physician that rendered the determination, by telephone on an expedited basis, within a period to time not to exceed 24 hours of the health care provider seeking the reconsideration. For emergency inpatient admissions, the Private Review Agent will not render an Adverse Benefit Determination solely because the Hospital did not notify Us of the emergency admission within 2 working days after that admission:

2. If the Hospital was not aware of the emergency admission notification requirement. With respect to the Insured Person who is in danger due to an involuntary or voluntary psychiatric admission, the following applies: • The Private Review Agent will not issue an Adverse Benefit Determination as to voluntary inpatient admission for the Treatment of a mental, emotional or substance misuse disorder during the first 24 hours after voluntary admission. • The Private Review Agent will not render an Adverse Benefit Determination as to involuntary inpatient admission, as determined to be Medically Necessary by the Insured Person's treating Physician and based on a determination that the Insured Person is in imminent danger to self and to others. The Private Review Agent will not render a determination as to the admission for up to 72 hours after involuntary Inpatient admission. If a course of Treatment has been preauthorized or approved for an Insured Person, the Private Review Agent may not retrospectively render an Adverse Benefit Determination regarding the preauthorization, or approved services delivered to the Insured Person. When prior authorization is not received under the medical benefit, Wellfleet will close the claim as a denial for lack of precertification. The specific remark indicates that services require a precertification and please contact the telephone number on the back of ID card to initiate process. Wellfleet has a timely filing limitation of 15 months from the date of service. When prior authorization is not received or is denied under the pharmacy benefit, the claim will continue to reject for 'Prior Authorization Required' at point of sale. A paid claim will not be transmitted to the filling pharmacy unless a prior authorization is received and approved.	1. If the Insured Person's medical condition prevented the Hospital from determining the Insured Person's status; or 2. If the Hospital was not aware of the emergency admission notification requirement. With respect to the Insured Person who is in danger due to an involuntary or voluntary psychiatric admission, the following applies: • The Private Review Agent will not issue an Adverse Benefit Determination as to voluntary inpatient admission for the Treatment of a mental, emotional or substance misuse disorder during the first 24 hours after voluntary admission. • The Private Review Agent will not render an Adverse Benefit Determination as to involuntary inpatient admission, as determined to be Medically Necessary by the Insured Person's treating Physician and based on a determination that the Insured Person is in imminent danger to self and to others. The Private Review Agent will not render a determination as to the admission for up to 72 hours after involuntary Inpatient admission. If a course of Treatment has been preauthorized or approved for an Insured Person, the Private Review Agent may not retrospectively render an Adverse Benefit Determination regarding the preauthorization, or approved services delivered to the Insured Person. When prior authorization is not received under the medical benefit, Wellfleet will close the claim as a denial for lack of precertification. The specific remark indicates that services require a precertification and please contact the telephone number on the back of ID card to initiate process. Wellfleet has a timely filing limitation of 15 months from the date of service. When prior authorization is not received or is denied under the pharmacy benefit, the claim will continue to reject for 'Prior Authorization Required' at point of sale. A paid claim will not be transmitted to the filling pharmacy unless a prior authorization is received and approved.

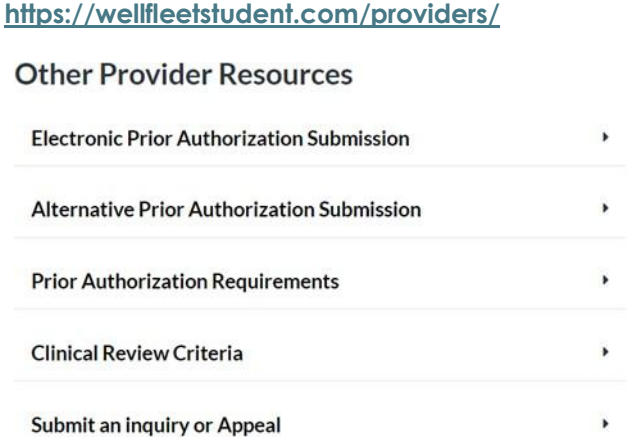
TO INITIATE PRIOR AUTHORIZATION PROCESS FOR MEDICAL:	

https://wellfleetstudent.com/providers/

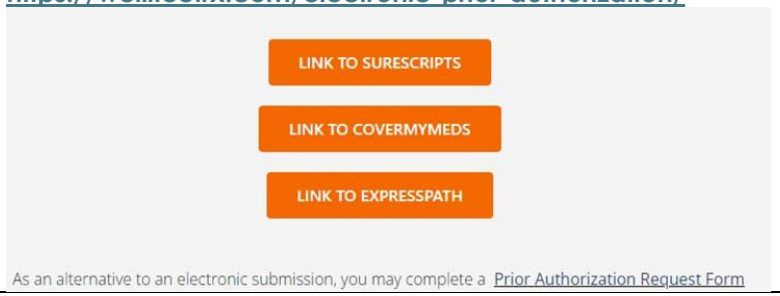
TO INITIATE PRIOR AUTHORIZATION PROCESS FOR PHARMACY:
https://wellfleetrx.com/electronic-prior-authorization/



TO INITIATE PRIOR AUTHORIZATION PROCESS FOR MEDICAL:
https://wellfleetstudent.com/providers/



TO INITIATE PRIOR AUTHORIZATION PROCESS FOR PHARMACY:
https://wellfleetrx.com/electronic-prior-authorization/



(b) Identify whether the Prior Authorization Review Process NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies to all services within the classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies (e.g., "Yes for the following services:"). Similarly, response should be explicit whether the "Yes" applies to both M/S and MH/SUD.

Classifications and Sub-Classifications							
Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **Out of Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient-Office** sub-classification?	Is NQTL applied to **Out of Network Outpatient-Office** sub-classification?	Is NQTL applied to **In Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Out of Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?
Yes – all for M/S and MHSUD	Yes – all for M/S and MHSUD	No	No	Yes – for the following services for M/S and MHSUD Surgeries Home health care Acupuncture Chiropractic Diagnostic Imaging High Radiological Scans Infusions DME	Yes – for the following services for M/S and MHSUD: Wellfleet does not require PA for therapies for the state of MD Surgeries Home health care Acupuncture Chiropractic Diagnostic Imaging High Radiological Scans Infusions DME	No	Yes- for the following drugs located in the attached **Covered Services V3** for prescription drugs that require prior authorization and their MS or MH/SUD classification

				Infertility Treatment			

				Fertility Preservation Prosthetic Devices	Infertility Treatme nt Fertility Preservation Prosthetic Devices		

Step 2

Identify the factors and the source for each factor used to determine that it is appropriate to apply the Prior Authorization Review Process NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Benefit Classification/Sub-classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
In Network Inpatient (MHSUD and MedSurg)	**Factors (same for M/S and MH/SUD):** Wellfleet delegates Utilization Management, including Prior Authorization, to Cigna. As such, Wellfleet utilizes Cigna's factors for determining when to apply PA. 1. Experimental/Investigational/Unproven service 2. Potential benefit exclusion 3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse	1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by

Benefit Classification/Sub-classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
	6. Estimated average cost **Factors considered but rejected:** There are no factors that were considered but rejected. **Weight (same for M/S and MH/SUD):** There is no other factor to establish differentiation of weight	professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Member, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data
Out of Network Inpatient(MHSUD and MedSurg)	Wellfleet delegates Utilization Management, including Prior Authorization, to Cigna. As such, Wellfleet utilizes Cigna's factors for determining when to apply PA. 1. Experimental/Investigational/Unproven service 2. Potential benefit exclusion 3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse 6. Estimated average cost **Factors considered but rejected:** There are no factors that were considered but rejected. **Weight (same for M/S and MH/SUD):** There is no other factor to establish differentiation of weight	1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link

		Analysis; Multiple Control Models; Special Investigation Resource and

Benefit Classification/Sub-classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
		Intelligence System (SIRIS); Member, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data
In Network Outpatient-Office	NA	NA
Out of Network Outpatient-Office	NA	NA
In Network Outpatient-All Other (MHSUD and MedSurg)	Wellfleet delegates Utilization Management, including Prior Authorization, to Cigna. As such, Wellfleet utilizes Cigna's factors for determining when to apply PA. 1. Experimental/Investigational/Unproven service 2. Potential benefit exclusion 3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse 6. Estimated average cost **Factors considered but rejected:** There are no factors that were considered but rejected. **Weight (same for M/S and MH/SUD):** There is no other factor to establish differentiation of weight	1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Member, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data

Benefit Classification/Sub-classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
Out of Network Outpatient-All Other (MedSurg and MHSUD)	Wellfleet delegates Utilization Management, including Prior Authorization, to Cigna. As such, Wellfleet utilizes Cigna's factors for determining when to apply PA. 1. Experimental/Investigational/Unproven service 2. Potential benefit exclusion 3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse 6. Estimated average cost **Factors considered but rejected:** There are no factors that were considered but rejected. **Weight (same for M/S and MH/SUD):** There is no other factor to establish differentiation of weight	1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Member, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data
Emergency	NA	NA

Prescription	**Factors (same for M/S and MH/SUD):** Factors for determining whether a prescription drug product will have Prior Authorization or not: 1. Lack of adherence to quality standards 2. High variability in cost within drugs in a given therapeutic class 3. Anticipated excessive utilization 4. Member Impact (this factor is used only to determine when PA should not be applied)	These sources are applied identically for both M/S & MH/SUD classifications. 1. Lack of adherence to quality standards a. Sources: FDA Prescribing Information, professionally recognized treatment guidelines used to define clinically appropriate standards of care,

Benefit Classification/Sub-classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
	These factors are applied identically for both M/S & MH/SUD classifications. **Factors Considered but rejected:** No other factors were considered and rejected. **Weight (same for M/S and MH/SUD):** Weighting of factors is described below in Step 3. There is no Artificial Intelligence application utilized for prescription prior authorization.	nationally recognized Compendia - Truven Health Analytics Micromedex DrugDEX (DrugDEX), and peer-reviewed medical literature (located within the PubMed on the NIH database). 2. High variability in cost within drugs in a given therapeutic class a. Sources: First Databank (FDB), MediSpan (MS), internal market and competitive analysis, therapeutic class total net cost analysis 3. Anticipated excessive utilization a. Source: Aggregated data or non- identifiable utilization reports, FDA Prescribing Information, professionally recognized treatment guidelines used to define clinically appropriate standards of care such as nationally recognized Compendia - Truven Health Analytics Micromedex DrugDEX (DrugDEX), and peer-reviewed medical literature (located within the PubMed on the NIH

		database).

Benefit Classification/Sub-classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
		4. Member Impact (this factor is used only to determine when PA should not be applied) a. Source: Internal claims data, internal market and competitive analysis

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
In Network Inpatient MED/SURG MH/SUD	1. Experimental/Investigational/ Unproven service 2. Potential benefit exclusion 3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse 6. Estimated average cost	1. Inadequate volume of existing peer-reviewed, evidence- based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; When subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use; The subject of review or approval by an Institutional Review Board for the proposed use except	1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents

		CIS	

Benefit Classification/Sub -classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials 2. CMS.gov: "CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage" 3. Inadequate volume of existing peer-reviewed, evidence- based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed. While there is no formulaic way in which to measure the volume of data needed, study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible. 4. Variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). 5. An automated peer based model that compares a provider's billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted. As evidenced by increased volume.	3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence- based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Member, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data

Benefit Classification/Sub -classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		6.Any service where the average unit cost, based on an assessment of Cigna Healthcare's historical paid claims, exceeds $500	
Out of Network Inpatient(MHSUD and MedSurg)	1. Experimental/Investigational/ Unproven service 2. Potential benefit exclusion 3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse 6. Estimated average cost	1.Inadequate volume of existing peer-reviewed, evidence- based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; When subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use; The subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials 2. CMS.gov: "CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage" 3.Inadequate volume of existing peer-reviewed, evidence- based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed. While there is no formulaic way in which to measure the volume of data needed, study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and	1.FDA clearance/approval; peer- reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2.Plan documents 3.FDA clearance/approval; peer- reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4.Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5.Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Member, Pharmacy and Prescriber

		unpublished evidence related to a specific	Analytics; Cigna claims data 6. Cigna claims data

Benefit Classification/Sub -classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible. 4. Variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). 5. An automated peer based model that compares a provider's billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted. As evidenced by increased volume. 6. Any service where the average unit cost, based on an assessment of Cigna Healthcare's historical paid claims, exceeds $500	
In Network Outpatient-Office	NA	NA	NA
Out of Network Outpatient-Office	NA	NA	NA
In Network Outpatient-All Other(MHSUD and MedSurg)	1. Experimental/Investigational/Un proven service 2. Potential benefit exclusion 3. Serious safety risk	1. Inadequate volume of existing peer-reviewed, evidence- based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; When subject to U.S. Food and Drug Administration (FDA) or other	1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies

		appropriate	2. Plan documents

Benefit Classification/Sub -classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
	4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse 6. Estimated average cost	regulatory agency review, not approved to be lawfully marketed for the proposed use; The subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials 2. CMS.gov: "CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage" 3. Inadequate volume of existing peer-reviewed, evidence- based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed. While there is no formulaic way in which to measure the volume of data needed, study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible. 4. Variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). 5. An automated peer based model that compares a	3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart (Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Member, Pharmacy and Prescriber Analytics; Cigna claims data 6. Cigna claims data

		provider's billing behavior to their peers and those who score differently	

Benefit Classification/Sub -classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		are reviewed to determine if an investigation is warranted. As evidenced by increased volume. 6.Any service where the average unit cost, based on an assessment of Cigna Healthcare's historical paid claims, exceeds $500	
Out of Network Outpatient- All Other(MHSUD and MedSurg)	1.Experimental/Investigational/ Un proven service 2. Potential benefit exclusion 3. Serious safety risk 4. Significant variation in Evidence-based practice 5. Potential for Fraud, Waste or Abuse 6. Estimated average cost	1.Inadequate volume of existing peer-reviewed, evidence- based, scientific literature to establish whether or not a technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed; When subject to U.S. Food and Drug Administration (FDA) or other appropriate regulatory agency review, not approved to be lawfully marketed for the proposed use; The subject of review or approval by an Institutional Review Board for the proposed use except as provided in a clinical trial; The subject of an ongoing phase I, II or III clinical trial, except for routine patient care costs related to qualified clinical trials 2. CMS.gov: "CMS PUB. 100-02 Medicare Benefit Policy Manual, Chapter 16 – General Exclusions from Coverage" 3.Inadequate volume of existing peer-reviewed, evidence- based, scientific literature to establish whether or not a	1. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 2. Plan documents 3. FDA clearance/approval; peer-reviewed publications; clinical trials and studies; professional opinion; publications by professional societies or government agencies 4. Greater frequency of deviation from evidence-based practice compared to Cigna's book of business 5. Dedicated Data-Mart

		technology, supplies, treatments, procedures, or devices is safe and effective for treating or diagnosing the condition or sickness for which its use is proposed. While there is no formulaic way in which to measure the volume of data needed, study detail is scrutinized using the scientific method of evidence review which is defined by the U.S. General Services	(Healthcare Fraud Shield); Geospatial Analytics; Social Media Monitoring; Link Analysis; Multiple Control Models; Special Investigation Resource and Intelligence System (SIRIS); Member, Pharmacy and

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		Administration as: systematic evidence review attempts to find all published and unpublished evidence related to a specific research or policy question, using literature search methodologies designed to be transparent, unbiased, and reproducible. 4. Variation(s) shall be measured against a documented baseline or standard for the specific service or service bundle of codes. Significant variation should be assessed at the service bundle level, and not necessarily in the variation between individual code(s). 5. An automated peer based model that compares a provider's billing behavior to their peers and those who score differently are reviewed to determine if an investigation is warranted. As evidenced by increased volume. 6. Any service where the average unit cost, based on an assessment of Cigna Healthcare's historical paid claims, exceeds $500	Prescriber Analytics; Cigna claims data 6. Cigna claims data
Emergency	NA	NA	NA
Prescription (MHSUD and MedSurg)	1. Lack of adherence to quality standards 2. High variability in cost within drugs in a given therapeutic class	1. Factor 1: lack of adherence to quality standards – This factor carries more weight due to the safety concerns. Ensuring the safety and wellbeing of our members is of upmost importance. a. Evidentiary Standard: P&T Committee members discuss safety	1. Factor 1: lack of adherence to quality standards a. Source for Evidentiary Standard: Sections 1-14 of

	3. Anticipated excessive utilization	of newly released products to determine if they have potential	the FDA label (Indications &

Benefit Classification/Sub -classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
	4. Member Impact (this factor is used only to determine when PA should not be applied)	for unsafe use. Sources listed above are compiled by Wellfleet's Clinical Pharmacist into New Drug Reviews and Therapeutic Class Reviews. These reviews contain information on indications, dosing & administration, clinical and comparative efficacy, clinical guidelines, contraindications & special populations, etc. These are forwarded to the P&T committee prior to the meetings for their review. Meeting discussions include an analysis of: appropriate dosing, potential overdose, prescribing by particular specialty provider, adherence or potential non-adherence to guidelines, etc. 2. Factor 2: high variability in cost within drugs in a given therapeutic class a. Evidentiary Standard: High cost is defined as $670/month supply for both the MS and MH/SUD classifications. Also taken into account are the availability of alternate therapies (brand/generic) & lowest total net cost for course of therapy for given conditions. 3. Factor 3: anticipated excessive utilization a. Evidentiary Standard: Clinical Pharmacist reviews claims data	Usage, Dosage & Administration, Dosage Forms and Strengths, Contraindications, Warnings & Precautions, Adverse Reactions, Drug Interactions, Use in Specific Populations, Overdosage, Description, Clinical Pharmacology, Nonclinical Toxicology, and Clinical Studies), Minutes from Pharmacy and Therapeutics Committee Discussions, and professional treatment algorithm's from the medical literature

		every 6 months and compares actual utilization against the recommendations in the sources identified	

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		above (e.g. FDA prescribing information, dosing schedules, etc.) to determine whether a drug is being used excessively or inappropriately. "Excessive utilization" is defined as anything above the FDA approved dosing schedule or recommended dosage in peer-reviewed medical journals. If the Clinical Pharmacist determines a drug is subject to potential excessive utilization due to 'ceiling' or 'max' dosage listed in labeling, the Clinical Pharmacist or the P&T Committee may recommend applying prior authorization to the Value Assessment Committee (VAC). The VAC reviews the Clinical Pharmacist's and the P&T Committee recommendation to approve the decision of applying prior authorization. 4. Factor 4: Member Impact (this factor is used only to determine when PA should not be applied and is not weighted more than other factors) a. Evidentiary Standard: The Value Assessment Committee utilizes a claims report for the past year to determine the impact and number of members that maybe be using a particular benefit that is being considered for PA application. This claims data is sourced	2. Factor 2: high variability in cost within drugs in a given therapeutic class a. Source for Evidentiary Standard: Generic Therapeutic Classification (GTC), Specific Therapeutic Classification (STC) and Hierarchal Ingredient Code (HIC) are utilized through FDB and MediSpan to classify 'therapeutic class' for both MS and MH/SUD medications. Costs are determined based on Average Wholesale Price from FDB for

		from our contracted PBM, Express Scripts, and encompasses all paid claims for the plan year that have not been returned to stock. The VAC	comparison, based on a normal month supply

Benefit Classification/Sub -classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		determines the number of members that will be negatively impacted by prior authorization additions. Threshold for 'negative member impact' is 5% of total membership utilizing the product that a PA is being considered for. The VAC makes a decision based on their professional judgement as to whether PA should not be applied to avoid negative member impact. This is only taken into account to decide *not* to apply or to remove a Prior Authorization requirement from a medication and is not used in the *application* process for PA. If factors 1, 2, and 3 suggest the addition of PA, but we anticipate significant member or client impact based on our covered demographic, we would put the interest of our members first and not assign a PA designation.	3. Factor 3: Anticipated Excessive Utilization a. Source for Evidentiary Standard: Dosage & Administration section from FDA labeling 4. Factor 4: Member Impact a. Source for Evidentiary Standard: Internal paid claims data from Express Scripts, excluding reversed claims

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

MEDICAL

To ensure that Cigna's policies are consistently applied, Cigna conducts a thorough review of policies and procedures at least annually. The annual review includes an analysis of applicable M/S and MH/SUD policies and procedures to identify potential gaps or inconsistencies. In its 2023 review as set forth in the policy comparison tables below, Cigna identified opportunities for adjustments to ensure comparability and equivalent stringency in application the Prior Authorization NQTL. Cigna is providing the below examples of Utilization Management policies used in the application of the Prior Authorization to demonstrate comparability and consistency. These Cigna policies were developed and reviewed in accordance with URAC and NCQA standards, as well as state mandates.

The *UM-12: Qualified Health Professionals Render UM Decisions* and the *HM-CLN-039: Utilization Management Decisions – Appropriate Professional Assessment* policies are reflective of Cigna's consistent parameters to identify medical directors' and other licensed clinicians' roles and responsibilities. Both policies require reviewers to be appropriately licensed and act within the scope of their license. As noted in the scope of these policies below, both indicate accountability in the review and determination of denials.

M/S	**MH/SUD**
UM-12: Qualified Health Profe Render UM Decisions	**HM-CLN-039: Utilization Man Decisions – Appropriate Professional Assessment**
1. Qualified health professionals assess the clinical information used to support UM decisions. Non- clinical staff may provide assistance by performing administrative tasks only. 2. RN's provides clinical oversight to non-clinical and LPN/LVN staff and/or reviews inpatient and outpatient UM services using established, approved, medical criteria, tools and references as well as own clinical training and	1. Behavioral Health's po that appropriately licensed behavioral health professionals assess and supervise utilization management decisions. Only psychologists, addictionologists or board-certified psychiatrists are allowed to assess and make medical necessity denial decisions. To ensure that qualified licensed health professionals assess the clinical information used to make

education in making necessity coverage "approval" decisions. RN staff includes Inpatient Case Manager (IPCM) and Pre-service/Post Service Utilization Review Nurse (UM) roles. 3. Licensed Physician (i.e. Medical Director) – provides clinical oversight to pharmacist staff where indicated, nurse staff and makes medical necessity UM decisions using medical necessity guidelines, new technologies information and board-certified specialty (same or similar) consultants for additional medical expertise as required as well as own clinical training and education in making medical necessity coverage decisions. Medical Director qualification requirements include: o Hold an active unrestricted license or certification to practice medicine in a state or territory of the United States o Unless expressly allowed by state or federal regulations, are located in a state or territory of the United States	appropriate utilization management decisions. 2. Care managers collect data for pre-service, concurrent, and post- service utilization decisions and have the authority to approve but not to deny medical necessity services. In the event that a care manager cannot approve the utilization request, the case is forwarded to an appropriate peer reviewer for assessment and the decision to approve or deny services. 3. Behavioral Peer Reviewers are Board Certified Psychiatrists, Licensed Clinical Psychologists and Certified Addictionologists who may have the following job titles: • Senior Medical Director • Medical Officer • Medical Director • Medical Principal a. Qualifications: Board certified psychiatrist, addictionologists, or doctoral level psychologists with current unrestricted license in the United States or its territories.

when conducting clinical review o Are qualified as determined by the Senior Medical Director to render a clinical opinion about the medical condition, procedure and treatment under review o Hold a current and valid license in the same category as the ordering provider or as a Doctor of Medicine, or as a Doctor of Osteopathic Medicine. • <u>Medical Director Areas of Responsibility for UM Decisions; includes, but not limited to the following:</u> o Review and render all medical necessity denials. o Make medical necessity decisions in accordance with state licensure requirements as applicable. o Provide specific reason(s) for denials in case documentation and letter content.	b. Responsibilities include: o Conducting Pre-service o Concurrent reviews o Post-service o Medical necessity determinations including: ▪ Approvals including cases not meeting criteria guidelines and ▪ Denials

○ Provide oversight and ongoing consultation to clinical and non-clinical staff. ○ Complete ongoing education to maintain licensure and update professional skills.	

UM-09: Precertification of Inpatient, Outpatient and Ambulatory Services and *HM-CLN-002: Advocates and Care Coordinators* outline the responsibilities of administrative staff in the application of the Prior Authorization NQTL. As noted below, these policies outline the scope of administrative staff who perform administrative tasks only. The scope of responsibilities are comparable and include pre-review screening. Additionally, *UM-09: Precertification of Inpatient, Outpatient and Ambulatory Services* and *HM-CLN-012: Clinical Review* reflect the role of non-physician clinicians (i.e. nurses or care managers) in the application of the Prior Authorization NQTL. These policies outline the comparable roles and responsibilities of Cigna's M/S nurses and MH/SUD care managers each of which are independently licensed clinicians with the ability to approve utilization management decisions. The denial of a utilization management decision, including Prior Authorization requires medical director/peer review for both M/S and MH/SUD benefits. Prior to issuance of a denial, a peer-to-peer is available and offered for any MH/SUD coverage request.

M/S	**MH/SUD**
UM-09: Precertification of Inpatient, Outpatient and Ambulatory Services	**HM-CLN-002: Advocates and Care Coordinators; HM-CLN-012: Clinical Review**
The purpose of this policy is to establish a consistent process for responding to precertification of inpatient, outpatient, and ambulatory service requests that: • Proactively reviews requested medical services and/or supplies to determine whether they are covered based upon application of appropriate clinical criteria and other benefit plan provisions	**HM-CLN-002 Advocates and Care Coordinators** Non-clinical staff: Any staff of Behavioral Health who do not hold a license or certification for independent clinical practices in a behavioral health profession. Examples of non-clinical staff include Personal Advocates and Care Coordinators among others. The roles of the Advocate and Care Coordinator can include assisting customers and practitioners with

(refer to Cigna National Coverage and Benefit Policy); **Non-Clinical Staff scope of responsibilities (Pre-Review Screening)** 1. Non-clinical staff is responsible for the initial intake process, which includes creation of the system file, collection of basic demographic information and documenting information regarding the service being requested into the system. The central system provides guidance to the non-clinical staff as to the information necessary to be collected. 2. Cases are reviewed to evaluate if the provider is in the network if the customer is currently eligible for coverage and if coverage is available for the service under the terms of the plan. The non-clinical teams have access to a Benefit Specialist to support eligibility and benefit reviews and to the prior authorization nurses for any clinical questions that may arise in the process. **Initial clinical review scope of responsibilities:** Cases requiring medical necessity/precertification review are reviewed by a nurse, using the clinical information provided at the time of the request, to the appropriate guideline as defined in the Cigna Benefit and Coverage Tool policy. The nurse approves services for those customers whose clinical information meets the guidelines and generates an authorization notification within the timelines and notification requirements outlined in the Timeliness policy.	information related to service requests, collecting non- clinical data, acquiring structured clinical data and offering supplemental educational materials that do not require evaluation or interpretation of clinical information. All Advocate and Care Coordinator staff shall have access to a clinical resource with at least a Master's degree and an unrestricted clinical license to practice from a licensing agency within the United States. The Advocate Department and Care Coordinators associated with Outpatient and Inpatient behavioral service provision are permitted to make authorization determinations based upon clinical rules and/or logic developed by a licensed behavioral health care clinician with a minimum of a Master's degree and five years of post- Master's clinical experience. **HM-CLN-012 Clinical Review** Behavioral Health's care managers shall be responsible for documenting the results of their Clinical Reviews in Behavioral Health's care management intake system documenting sufficient clinical and administrative information to support their care management determinations including referencing relevant plan document language used in making any adverse determinations in accord with Clinical and Administrative Information for Making a Determination of Coverage. Behavioral Health's care managers/consultants shall notify provider staff and specify last covered day (LCD) in the case notes. The care manager shall also include the number of extended days, the next review date, the new total number of days or services approved and the date

All services that do not meet the criteria in the guideline and cannot be approved are referred to the Medical Director for review and determination.	of admission or onset of any new services. See Policy and Procedure on Continuity and Coordination of Behavioral Care. During review of a case, Behavioral Health shall discuss the relevant information and guidelines upon which decisions are based and upon request by a customer, practitioner or provider shall make written copies of the guidelines available. Whenever a Behavioral Health care manager is unable to approve a request for service based on medical necessity the care manager shall refer the case to a peer reviewer as per the Peer Review Policy.

Review of *UM-32: Emergency Services* in comparison with *HM-OPS-023: Prudent Layperson - Emergency Services* reflects Prior Authorization not required for emergency services.

M/S	**MH/SUD**
UM-32: Emergency Services	**HM-OPS-023: Prudent Layperson - Emergency Services**
Cigna HealthCare covers all emergency services, does not require pre-certification of emergency services, nor does it conduct retrospective emergency service medical necessity review or deny emergency service claims absent evidence of fraud.	Behavioral Health shall **not** require prior authorization for any emergency stabilization services believed by a Prudent Layperson to be required for an emergent need. Behavioral Health shall cover emergency services covered individuals receive, which meet the Prudent Layperson Standard, when emergency claims come from a covered individual, facility, Psychiatrist, therapist, or their Representatives within or outside of the defined service area as part of pre-service, concurrent, or post service reviews.

During the analysis of both *UM-39: Timeliness of Health Services Decisions* and *HM-CLN-035: Timeliness of Utilization Management Decisions and Notifications*, Cigna has identified a difference in timeframe to send written notification of the decision to the treating practitioner and member. Through Cigna's review, it was identified that notice of Prospective Non-Urgent approvals/denials reflected different timeframes, policies are in the process of being updated for consistency and applicable with federal and state law.

M/S

UM-39: Timeliness of Health Services Decisions

CATEGORY *(APPROVALS AND DENIALS)*	Timeline to make Decisio	Verbal or Electronic Notificati on	Timefra m e	Written Notificat i on	Timefra m e
PROSPEC TI VE	within 2 busines s days of all on received date	verbal notificati o n to the provider	within 2 busines s days of all on received date	provider and custom er	within 2 busines s days of all on received date
PROSPEC TI VE NON	within 2 business days of all informat i on received date	verbal notificati o n to the provider	within 2 business days of all informat i on received date	provider and custom	within 2 business days of all informat i on received date

MH/SUD

HM-CLN-035: Timeliness of Utilization Management Decisions and Notifications

CATEGORY *(APPROVALS AND DENIALS)*	Timeline to make Decision	Verbal or Electronic Notification	Timeframe	Written Notification	Timeframe
PROSPECTIV E URGENT	within 2 hours of all information received date	verbal notification to the provider	within 1 business day of all informatio n received	provider and custom er	within 1 business day of date of all informatio n
PROSPECTI VE NON URGENT	within 2 business days of all information received date	verbal notification to the provider	within 2 business days of all informatio n date	provider and custom	within 2 business days of all informatio n date

After completion of the comparative analysis, it was noted that MH/SUD had a different timeframe allocated. Because of this, the Cigna policy *HM-CLN-035: Timeliness of Utilization Management Decisions and Notifications* has been rectified.

The above referenced policies are illustrative of the annual review conducted to ensure comparability in writing of the application of the Prior Authorization NQTL to M/S and MH/SUD services in all benefit classifications. The process by which services are considered for application of Prior Authorization is comparable in writing across MH/SUD and M/S benefits. As reflected in its written policies, a committee of Cigna-employed Medical Directors determines which M/S and MH/SUD services are subject to Prior Authorization. Cigna utilizes a single Healthcare Medical Assessment Committee("HMAC") in the development of clinical guidelines and medical necessity criteria (collectively "Coverage Policies") of M/S and MH/SUD services. HMAC reviews Coverage Policies, annually to ensure their continued appropriateness based on prevailing clinical standards of care. The team is made up of 13 board certified medical doctors, which 4 members are dedicated to MH/SUD.

Internal Medicine
Psychiatry, Neurology
Internal Medicine
Family Medicine
Surgery
Thoracic and Cardiac Surgery, Surgery
Pediatrics, Internal Medicine, Clinical Genetics
Physical Medicine and Rehabilitation
Family Medicine
Internal Medicine, Nephrology
Psychiatry
Psychiatry
Psychiatry, Addiction Psychiatry, Child and Adolescent Psychiatry, Forensic Psychiatry

Additionally, the Precertification Team, also known as the Precertification Workgroup, a committee of Cigna-employed Medical Directors for M/S (MDs with unrestricted license to practice medicine in a state or territory of the United States and located in a state or territory of the United States when conducting a peer clinical review, are qualified as determined by the Senior Medical Director to render a clinical opinion about the medical condition, procedure and treatment under review, hold a current and valid license in the same category as the ordering provider or as a Doctor of Medicine, or as a Doctor of Osteopathic Medicine) and MH/SUD professionals (Board certified psychiatrists, addictionologists, or doctoral level psychologists with current unrestricted license in the United States or its territories) may recommend additions/deletions of services requiring the application of Prior Authorization NQTL to HMAC based upon the

factors of Experimental/Investigational/Unproven, benefit exclusions, safety risk, evidence based practice, FWA, and cost. These qualified professionals utilize the applicable thresholds and sources cited in Step 3 to make their recommendations. The committee has 7 members with 3 being MH/SUD.

Surgery
Anesthesiology
Surgical Oncology
Family Medicine
Psychiatry & Neurology
Behavioral Neurology & Neuropsychiatry
Neurology-Psychiatry, Child and Adolescent Psychiatry

Rx – All information below is applicable to both M/S and MH/SUD classifications

Key steps in the process for developing prior authorization standards:

- After determination is made by the P&T Committee and Value Assessment Committee to assign Prior Authorization to a particular drug product based on factors, sources, and evidentiary standards listed above, the prior authorization criteria to accompany this designation must be made.
- When a new drug product or new indication is approved by the FDA, a clinical pharmacist is assigned to review the drug. A clinical pharmacist will be assigned as the author to complete the new drug review and is responsible for creating a PA policy base criterion. The author will create a draft policy, which will be discussed at the next P&T Committee meeting for review, feedback, and approval. The author will revise the PA policy, if necessary, based on input from specialists. This criterion will be based off of the FDA-approved indication, dosage, and administration information in the package insert, as well as pertinent demographic information from the pivotal study leading to the approval of the drug product.
- In the period of time between designation and finalization of the specific criteria, the guideline entitled "Guidelines for Drugs Without PA Criteria" is used for approval/denial of all prior authorization requests. This guideline requires the drug to be FDA approved for the indication the provider is attempting to use it for, and that the patient meets any standards within the "Indications and Usage" section of the FDA label (age, gender, genetic phenotype, etc.)
- In most cases, a drug-specific base criteria to potentially use in the future is presented during the P&T Committee New Drug Review and discussed. There are a few exceptions to the utilization of a drug specific criteria. For

example, medication class guidelines may group many medications under one large umbrella (ex. Fertility Drugs). The creation of these guidelines follows the same procedure listed here.

- Wellfleet's Clinical Pharmacist utilizes base criteria and updates based on any new information released since the drug was last discussed at P&T. If a base criteria is not available, the medical necessity criteria shall be based on FDA labeling information, relevant clinical treatment guidelines, peer-reviewed medical literature, and national compendia.
    - Wellfleet's Clinical Pharmacist utilizes the sources listed above in the creation of this criteria.
- After finalization of the drug-specific medical necessity criteria, it is presented to the P&T Committee for final approval prior to use.

Policy Review Analysis:

- In review of the MH/SUD in comparison to M/S written prior authorization policies, a sample set of 6 policies from each classification were reviewed. Both sets of PA criteria included the following: FDA indication, age restrictions, and alignment with package insert. The MH/SUD policies included language to ensure a patient was monitored within a setting for safety (example: REMS program). Some of the policies required the medication to be prescribed by or in consultation with a particular physician specialty. One instance, a policy did require a trial of two medications from different classes before the requested drug could be used. This language was in alignment with the inclusion criteria used from the clinical trial that was used for FDA approval. The M/S policies required certain clinical parameters to be met for Prior Authorization. Examples include: hepatitis C viral load, blood eosinophil level, lesion volume/count for multiple sclerosis, confirmation of gene mutation), included trial and failure language of 1 to 2 agents prior to the use of the requested agent, included a list of reasons why the medication would not be approved, and listed renewal criteria required for each subsequent approval. Some of the policies required the medication to be prescribed by or in consultation with a particular physician specialty. Sources used to develop PA criteria for both MH/SUD and M/S policies included FDA approved prescriber Information, nationally recognized compendia, and established clinical guidelines, as listed above in Step 2. This analysis finds the two sets of criteria (MH/SUD and M/S)from the same sources to be similar in clinical requirements for medical necessity. All policies were reviewed and approved by the same P&T Committee. An overview of the analysis and the medications reviewed is below (see full PA requirements on the Wellfleet Rx site, listed in Step 1):

		Does the Criteria Include:

Policy Name	Class	FDA Approved Indication	Age restrictions	Alignment with package insert	Particular Specialty
Lucemyra	MHSUD	Yes	Yes, mirroring FDA approval	Yes	No
Probuphine	MHSUD	Yes	No, mirroring FDA approval	Yes	Yes (REMS certified)
Sublocade	MHSUD	Yes	No, mirroring FDA approval	Yes	No
Sunosi	MHSUD	Yes	Yes, mirroring FDA approval	Yes	Yes (neurologist or sleep medicine specialist)
Addyi	MHSUD	Yes	Yes, mirroring FDA approval	Yes	No
Hetlioz	MHSUD	Yes	Yes, mirroring FDA approval	Yes	Yes (sleep medicine specialist)
Taltz	MS	Yes	Yes, mirroring FDA approval	Yes	Yes (dermatologist, rheumatologist
Takhzyro	MS	Yes	Yes, mirroring FDA approval	Yes	Yes (hematologist, allergist, immunologist)
Zolgensma	MS	Yes	Yes, mirroring FDA approval	Yes	Yes (neuromuscular specialist or SMA specialist)
Isturisa	MS	Yes	Yes, mirroring FDA approval	Yes	Yes (endocrinologist)
Kevzara	MS	Yes	Yes, mirroring FDA approval	Yes	Yes (rheumatologist)
Jynarque	MS	Yes	Yes, mirroring FDA approval	Yes	Yes (nephrologist)

Ongoing Monitoring Activities:

- All policies are reviewed and updated based on clinical guidelines, FDA labeling, safety, etc. updates at least annually (see sources, above). A quarter of all medical necessity criteria are reviewed each quarter, with updates

brought to the P&T Committee for approval. Selection of the criteria to be updated each quarter is based strictly on last update date to ensure an even selection of updates and that each guideline is reviewed at an appropriate time.

Timelines and deadlines, including the frequency with which re-authorizations are required:

- An audit was conducted of both MS and MH/SUD prior authorization approvals to check the length of approval. Authorizations for both M/S and MH/SUD drugs are valid for 365 days from approval. Approvals may be for a shorter duration if the FDA labeling guidelines have strict duration of therapy limits or monitoring requirements after initiation. Other exceptions are for products that have regulatory implications, which will be approved based on the regulatory statute. An audit was conducted of both MS and MH/SUD prior authorization approvals to check length of approval. In all instances, both MS and MHSUD, approved prior authorizations lasted for exactly 365 days from the day of approval. Appeals turnaround times are the same for all drugs and are dependent on federal and state regulations to ensure compliance.

Forms and/or other information required to be submitted by the provider:

- Providers can request Prior Authorizations by calling Express Scripts Prior Authorization department directly, utilizing CoverMyMeds, Express Path, or SureScripts ePA software, or by completing a Prior Authorization Request Form and faxing directly to Express Scripts Prior Authorization department.
- Providers may be required to submit lab/test results for approval. This requirement is based off of requirements laid out in the FDA labeling information or Clinical Guidelines specific to the diagnoses that the particular drug product in question is indicated for. For example, the use of Humira has a weight minimum for particular indications. Documentation of the patient's weight is required in order to get approval for this product. Also, narcolepsy without cataplexy should be confirmed via Epworth Sleepiness Scales. Xyrem, a product indicated for this diagnosis, requires documentation of this test being performed and indicating the correct diagnosis.

Utilization management manuals and any other documentation of UM processes that are relied upon to make a determination:

- All Prior Authorization guidelines (M/S and MH/SUD) are gathered into one PDF document that is available to members, providers, and the general public. It is posted at https://wellfleetrx.com/students/formularies/. This publication is updated at least quarterly.
- The P&T Policy & Procedures and Formulary Management Policy are reviewed by Wellfleet's Chief Medical Officer, Director of Clinical Programs, and Clinical Pharmacist, at least annually to ensure there is no verbiage indicating a bias towards any particular subset of drugs. These policies dictate that all decisions should be based off of the clinical merits of the drug, not the classification of drug itself. Prior authorization is imposed on drug products based

on the factors presented previously for both classifications of drugs. In the review of the P&T policy, it is stated that "The clinical decisions made by the P&T Committee are based on sound scientific evidence and standards of practice that include: 1. Assessing peer-reviewed medical literature. 2. Referencing published practice guidelines.
3. Comparing efficacy, side effects, and potential drug interactions among alternative drug therapies. 4. Assessing impact of formulary decisions to patient compliance." There is also the presence of a non-discriminatory section, stating that members shall not "discriminate based on age, disability, race, ethnicity, gender, sexual orientation, or health status." Members non-adhering to either of these statements will be recused from the committee. No recusals have been a result of non-adherence to these policies.

Relevant Decision Making Committees

- P&T Committee
    - The P&T Committee is responsible for assessing the clinical merits of drug therapies. The committee shall provide clinical rationale and guidance on formulary placement. The Value Assessment Committee (VAC) follows the P&T Committee recommendations to finalize formulary placement decisions.
    - The P&T Committee is responsible for approving any new Utilization Management policies (guidelines) or negative changes (any change creating a larger barrier to member access) to these guidelines. If a guideline change includes any criteria that differs from the FDA approved labeling information, it will also require justification and approval from the P&T Committee. All guidelines shall also be reviewed annually for approval. At each P&T meeting, the new, updated, and a quarter of all other guidelines will be discussed and approved/denied. All guidelines are reviewed and approved by the same committee.
    - The P&T committee is composed of at least 80% external members that have no affiliation or employment with Wellfleet. These members are expected to disclose any Conflict of Interest, bias, etc. They are required to sign a Conflict of Interest statement annually. External Subject Matter Experts are allowed per the P&T Policy to attend meetings for discussion purposes, however none joined during the 2023 Calendar Year. P&T utilizes professional expertise, along with the sources listed above (FDA Prescribing Information, professionally recognized treatment guidelines used to define clinically appropriate standards of care, nationally recognized Compendia - Truven Health Analytics Micromedex DrugDEX (DrugDEX), and peer-reviewed medical literature), for discussions.
    - P&T is currently composed of licensed and practicing physicians and pharmacists. Specialties that are represented include: Family Medicine, Internal Medicine, Psychiatry, Child Psychiatry, Neurology, Oncology, Dermatology, Pediatrics, Gastroenterology, Specialty Pharmacy, and Obstetrics. There are currently 12 voting members of the committee, who meet quarterly. Quarterly time allotted for meeting materials is four hours.

- Value Assessment Committee (VAC)
    - The VAC is responsible for determining tiering and Utilization Management decisions for drugs that are designed as 'include' by the P&T Committee. These drugs shall not be removed from formulary without prior approval from the P&T Committee. Also, determining coverage, tiering, and Utilization Management decisions for drugs that are designated as 'optional' by the P&T Committee. This committee is comprised of 8 members, representing the Healthcare Optimization/Clinical teams, finance teams, executive leadership, client relations team, CMO, Medical Economics, and Member Experience teams. The VAC is not split between MS and MHSUD classifications; the same team reviews all medications. At least quarterly, the team will receive notes from P&T meetings for review. Meetings will be conducted ~1 week after materials are distributed to the committee and will be 1-2 hours in length to discuss new medications and alterations to prior authorization strategy of existing medications. Minutes will be distributed for review after the meetings and a vote shall be conducted to ensure all members are in agreement with the proposed changes to utilization/formulary strategy.

Minimum qualifications for reviewers:

- To become members of the P&T Committee, the physicians must be board certified licensed physicians with over 5 years of experience in their respective fields. We use the clinical expertise of the P&T Committee members along with published clinical guidelines and scientific evidence to achieve consensus in order to set Prior Authorization.
- Every PAR, UMP, Nurse, and Medical Director goes through extensive training to make sure we are providing the most complete and comprehensive service for each one of our members. The training consists of both in classroom, on the job shadowing, monthly quality reviewing of cases, and weekly meetings to provide any new/updated information that needs to be shared with the teams.

Minimum standards to issue a denial (e.g. sign-off from a physician with relevant board certification):

- In lieu of drug specific Prior Authorization criteria, or prior to the creation of drug specific criteria, if a drug is designated as "PA Required", we will utilize our "Guideline for Drugs without PA Criteria" to make a determination of approval. This guideline requires that the requested medication be used for an indication that is approved by the FDA or listed in the package insert, and that the patient meets any additional requirements listed in the "Indications and Usage" section of the FDA-approved prescribing information.
- If a member does not meet requirements laid out in Prior Authorization guidelines, they will be issued a denial. If the member elects to appeal, they will be asked to submit further documentation in support of use of the product (ex. case-studies supporting use, off-label usage recommended in clinical guidelines, etc.). This process is the same for both M/S and MH/SUD drugs.

- Depending on state requirements, a denial may only be issued by certain individuals with particular qualifications (e.g. physician with same/similar specialty licensed in the same state, pharmacist, etc.). This is kept consistent for M/S and MH/SUD.

As written conclusion: The process for creating a prior authorization policy for a drug is the same for both M/S and MH/SUD drugs. The P&T Policy & Procedures and Formulary Management Policy are reviewed by Wellfleet's Chief Medical Officer, Director of Clinical Programs, Head of Pharmacy and Clinical Pharmacist, at least annually to ensure there is no verbiage indicating a bias towards any particular subset of drugs. These policies dictate that all decisions should be based off of the clinical merits of the drug, not the classification of drug itself. Prior authorization is imposed on drug products based on the factors presented previously for both classifications of drugs.

Prior authorization is imposed on drug products based on the factors presented in Steps 2 &3 for both classifications of drugs. These include the drug's lack of adherence to quality standards, high variability in cost within drugs in a given therapeutic class, anticipated excessive utilization and member Impact. Whether each factor is met is based upon defined evidentiary standards, which are based upon FDA Prescribing Information, professionally recognized treatment guidelines used to define clinically appropriate standards of care, nationally recognized Compendia - Truven Health Analytics Micromedex DrugDEX (DrugDEX), peer-reviewed medical literature, internal market and competitive analysis, therapeutic class total net cost analysis, aggregated data or non-identifiable utilization reports, internal claims data, internal market and competitive analysis. Wellfleet's audit of MHSUD vs MS drugs showed that all sampled PAs required FDA indication, had an age restriction if applicable per the FDA, and aligned with requirements included in the FDA approved drug packaging label. A greater percentage of MS PA's required a particular specialist to be the prescribing healthcare provider compared to MHSUD (100% vs 50%, respectively). The factors, standards and sources for those standards are the same regardless of whether a drug is a M/S or MH/SUD drug.

Moreover, a request for prior authorization is subject to the same review process for both M/S and MH/SUD drugs. Authorizations for both M/S and MH/SUD drugs are valid for 365 days from approval. Appeals turnaround times are the same for all drugs and are dependent on federal and state regulations to ensure compliance.

Thus, we conclude that the processes, strategies, evidentiary standards, and other factors used to apply Prior Authorization to MH/SUD drugs, as written, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Prior Authorization to M/S drugs.

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

MEDICAL

2023 Data – Wellfleet delegates Utilization Management, including Prior Authorization, to Cigna. The data shown in the DS1 Prior Auth – for MD shows minimal PA activity for MHSUD to make a comparison of data, therefore the below data represents an analysis of prior authorization requests across Wellfleet's Book of Business from January 1, 2023 – December 31, 2023. As set forth in the prior authorization policies noted in Step 4, above, Wellfleet performed an audit of prior authorization outcomes for its book of business performed by Cigna to ensure that the denial and approval rates for prior authorization was comparable to and no more stringently applied to MH/SUD benefits. Wellfleet also reviewed the appeals data as another data point to assure the policies were applied no more stringently for MHSUD than that of M/S.

Authorizations													
UR Service Level	Inpt	Inpt	Inpt	Inpt	Inpt	Inpt	TOTAL	UR Service Level	Outpt	Outpt	Outpt	Outpt	
NETWORK	INN	OON	INN	OON	INN	OON	INPT	NETWORK	INN	OON	INN	OON	TOTAL INPT
Auth Type	Precert	Precert	Concurrent	Concurrent	Retro	Retro	REVIEWS	Auth Type	Precert	Precert	Retro	Retro	REVIEWS
MED SURG	64	3	628	6	348	4	1,055	MED SURG	4,843	159	104	16	5122
Approvals	48	1	505	4	255	3	816	Approvals	3,700	95	62	7	3864
Denials	16	2	123	2	93	1	237	Denials	1,143	64	42	9	1258
MedSurg % Denied	25%	67%	20%	33%	27%	25%	22%	MedSurg % Denied	24%	40%	40%	56%	25%
MH	8	3	713	146	22	5	897	MH	30	0	0	0	30
Approvals	8	3	709	141	20	5	886	Approvals	23	0	0	0	23
Denials	0	0	4	5	2	0	11	Denials	7	0	0	0	7
MH % Denied	0%	0%	1%	3%	9%	0%	1%	MH % Denied	23%	0%	0%	0%	23%
SUD	2	2	33	65	1	0	103	SUD	0	0	0	0	0
Approvals	2	2	33	64	1	0	102	Approvals	0	0	0	0	0
Denials	0	0	0	1	0	0	1	Denials	0	0	0	0	0
SUD % Denied	0%	0%	0%	2%	0%	0%	1%	SUD % Denied	0%	0%	0%	0%	0%

APPEALS													
UR Service Level	Inpt	Inpt	Inpt	Inpt	Inpt	Inpt	TOTAL	UR Service Level	Outpt	Outpt	Outpt	Outpt	
Network	INN	OON	INN	OON	INN	OON	INPT	Network	INN	OON	INN	OON	TOTAL INPT
Auth Type	Precert	Precert	Concurrent	Concurrent	Retro	Retro	REVIEWS	Auth Type	Precert	Precert	Retro	Retro	REVIEWS
MedSurg	0	1	0	0	29	11	41	MedSurg	6	6	26	13	51
Denials Upheld	0	0	0	0	21	2	23	Denials Upheld	2	2	19	4	27
Denials Overturned	0	1	0	0	8	9	18	Denials Overturned	4	4	7	9	24
MedSurg % Upheld	0	0%	0	0	72%	18%	56%	MedSurg % Upheld	33%	33%	73%	31%	53%
MH	0	2	0	0	0	1	3	MH	0	3	0	1	4
Denials Upheld	0	2	0	0	0	1	3	Denials Upheld	0	2	0	1	3
Denials Overturned	0	0	0	0	0	0	0	Denials Overturned	0	1	0	0	1
MH % Upheld	0%	100%	0%	0%	0%	100%	100%	MH % Upheld	0%	66%	0%	100%	75%
SUD	0	0	0	0	0	0	0	SUD	0	0	0	0	0
Denials Upheld	0	0	0	0	0	0	0	Denials Upheld	0	0	0	0	0
Denials Overturned	0	0	0	0	0	0	0	Denials Overturned	0	0	0	0	0
SUD % Upheld	0%	0%	0%	0%	0%	0%	0%	SUD % Upheld	0%	0%	0%	0%	0%

Rx -

To ensure that the processes, strategies, evidentiary standards, and other factors used to apply prior authorization to MH/SUD drugs, in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply prior authorization to M/S drugs, prior authorization (PA) for prescription drugs is analyzed semi-annually. One analysis we completed was a review of the percentage of drugs in the M/S and MH/SUD classifications that are subject to prior authorization.

M/S PA Requirements	
Total M/S Drugs	8,443
Total M/S Drugs Requiring PA	1,422
PA Required Rate	17%

MH/SUD PA Requirements	
Total MH/SUD Drugs	780
Total MH/SUD Drugs Requiring PA	23
PA Required Rate	3%

- We also completed an analysis at the Wellfleet National book of business level of the turnaround times for PA requests to be issued either an approval or denial. On average, the turnaround times from submission to determination of approval/denial for M/S & MH/SUD drugs were less than 1 day. Results are below:

Class	Total Cases	Approved Cases	Approved Turnaround Time	Denied Cases	Denied Turnaround Time	Total Average Turnaround
MS	1836	1570	0.3 days	266	1.2 days	0.4 days
MHSUD	67	42	0.5 days	25	1.4 days	0.9 days

- Wellfleet also completed an analysis of denial rates for requests for Prior Authorization in calendar year 2023. Results can be seen on the table below. A selection of denials were scrutinized to ensure that the denials were appropriate based on prior authorization policies listed at www.wellfleetrx.com/formularies. All denials under MH/SUD were reviewed due to the higher denial rate. All denials (for both MS and MH/SUD) were deemed appropriate and were based on lack of evidence to support medically appropriate use (un-approved diagnosis, outside of approved age range, lack of acknowledgment or documentation of confirmatory testing for diagnosis).

Global M/S PA Analysis	
Total PA Requests	1836
Total PA Approvals	1570
Total PA Denials	266
PA Approval Rate	85.5%
PA Denial Rate	14.5%

Global MH/SUD PA Analysis	
Total PA Requests	67
Total PA Approvals	42
Total PA Denials	25
PA Approval Rate	63%
PA Denial Rate	37%

- Wellfleet completed analysis of MD exclusive Prior Authorizations as shown in *Data Supplement (DS)1 Prior Auth* for 2023, showing only 2 prior authorizations performed for M/S drugs out of 575 prescriptions. Comparably, 423 prescriptions for MH/SUD were noted with no prior authorizations performed. Due to the limited number of prior authorizations performed for MD, there is no statistical significance to compare.
- There were 35 appeals for M/S PA requests that were originally denied. Of these 35, 17 were denied upon appeal and 18 were approved upon appeal. For MH/SUD, there were no appeals for denied PA requests.

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

M/S and MH/SUD:
Wellfleet's Mental Health and Substance Use Disorder Parity Compliance Program sets the processes and procedures of establishing parity compliance, identifies discrepancies in coverage of services for the treatment of MH/SUD, and ensures appropriate identification and remediation of improper practices internally and with its delegates. Wellfleet assigned each benefit classification and has defined M/S and MH/SUD conditions as required by MHPAEA. Wellfleet's *Identification and Classification of Benefit Policy* is used for all NQTLs comparative analysis documentation. Wellfleet has established methodologies for the identification and testing, including a comparative analysis, of all NQTLs that are imposed on MH/SUD benefits. Wellfleet monitors for and detects improper practices by conducting ongoing and periodic reviews of Wellfleet's policies and procedures as well as the activities of any of Wellfleet's agents or representatives providing benefit management services or performing utilization reviews. Wellfleet has not identified any discrepancies in operational policies between MH/SUD and M/S benefits where the discrepancies present a comparability or stringency problem within the context of the NQTL requirement.

Wellfleet delegates its non-Pharmacy Utilization Management to Cigna Healthcare Management (Cigna). Cigna is responsible for determining which non-Pharmacy benefits are eligible for PA. Wellfleet Delegation Oversight Committee performs oversight with our delegated vendor Cigna. Delegation means that an outside entity may perform certain functions on behalf of Wellfleet such as utilization management, case management, appeals, and disease management. The authority to perform the functions is delegated only if the entity can demonstrate the ability to conform to and maintain accreditation and regulatory standards. Utilization Management data received from Cigna is reviewed no less than semiannually for comparability of M/S vs MH/SUD reviews. Variables in data analyzed are further reviewed for adequacy of literature, reviewer type, level of care reviewed, TAT and outcome. Any discrepancies of data are evaluated with Cigna. If discrepancies are identified, and corrective action is needed for any opportunities identified, the Delegation Oversight Committee will apply a corrective action plan to the delegate.
Oversight and monitoring of the delegation oversight program is approved through the Quality Management Program. The committee process includes reviewing and approving the delegation annual program documents and tools.

With regards to Cigna's delegates (ASH and EviCore), Cigna promotes and applies systematic assessments and Continuous Quality Improvement (CQI) to internal processes and workflows. Cigna achieves this by adhering to common

principles for the delivery of services and coverage to clients, members, and participating practitioners consistent with state and federal laws. The CQI process, a problem-solving approach, is applied when an opportunity for improvement is identified through monitoring performance indicators or from other sources. This process is applied consistently across M/S and MH/SUD services, and includes:

- collection of data
- systematic measurement of data
- analysis to identify opportunities for improvement
- identification of possible root causes or barriers
- selection of opportunities to pursue
- planning of interventions
- implementation of interventions
- remeasurement and analysis to determine effectiveness of interventions
- reviewing performance against key indicators as specifically identified in the quality work plan
- promoting quality clinical care and service, including both inpatient and outpatient services, provided by hospitals and providers
- evaluating and analyzing satisfaction information, including survey data and complaints and appeals
- evaluating access to services provided by the plan or its contracted providers
- identifying strategies to improve the health and reduce health care disparities of the members we serve

Cigna has a Delegation Oversight program that is a methodical, comprehensive process to ensure Cigna customers receive the same high level of quality care and service regardless of whether Cigna or a delegated entity is providing the Prior Authorization medical necessity review.

Cigna retains the ultimate responsibility for ensuring that the delegated functions are carried out properly. Cigna delegates the application of Prior Authorization to

(1) eviCore for the medical necessity review of M/S services for high tech imaging and cardiology, radiation and medical oncology, musculoskeletal management, and gastrointestinal endoscopic procedures; and

(2) American Specialty Health ("ASH") for the medical necessity review of M/S and MH/SUD physical therapy and occupational therapy.

Each of these delegated vendors adhere to Cigna's policies and procedures when performing utilization review. All of the data included in Cigna's Prior Authorization NQTL comparative analysis is inclusive of the Prior Authorization medical necessity reviews of the applicable delegated services.

The following quality activities are in place to ensure effective monitoring and ongoing adherence to the quality and accreditation requirements established by the program:

.

Cigna maintains a robust Delegation Policy and Quality Programs to ensure Cigna's delegates are adhering to Cigna's policies and procedures when performing utilization review and the application of the Prior Authorization NQTL. The processes include regular monitoring and auditing, reviewing performance against key indicators, regular reporting through standardized committees, and root cause analysis.

RX:

Specifically, with respect to Rx prior authorization, Wellfleet performs a review of data, at least annually, using the following steps (results above in step 4):

1. Select random sampling of prior authorization guidelines for MH/SUD and for M/S medications.
2. Compare factors and evidentiary standards used for the development of each guideline.
3. Confirm restrictions based on provider specialty are not applied more stringently for MH/SUD drugs as compared to M/S drugs.
4. Review Prior Authorization guidelines to confirm that they do not include language that would result in MH/SUD drug reviews to be more stringent than M/S review.

Factors and evidentiary standards are utilized identically between the classifications. A greater percentage of MS PA's required a particular specialist to be the prescribing healthcare provider compared to MHSUD (100% vs 50%, respectively).

Also, upon internal determination and P&T approval of Prior Authorization requirements, decision-tree mapping is submitted to Express Scripts for coding and implementation in their system. Turnaround time from submission to 'go-live' is set to 14 days for both MS and MHSUD medications. This is monitored upon submission and verified by Express Scripts clinical team upon coding completion. There were no instances of delayed coding in 2023. Time from internal approval for prior authorization requirements and them going live for our members is consistent for both MS and MHSUD medications, showing operational implementation parity.

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15- 144(e)(6)).

Medical

Wellfleet, along with its utilization review agent, Cigna has assessed several components of its utilization management program for NQTL compliance, including the methodology for determining which services will be subject to utilization management, the process for reviewing utilization management requests, and the process for applying coverage criteria. A review of Cigna's written policies and processes reveals the comparable process by which MH/SUD and M/S services are selected for application of prior authorization within the applicable benefit classification that evidences comparability and equivalent stringency in-writing and in-operation.

The sources for each evidentiary standard for 2023 data have demonstrated that the prior authorization data shows that 25% of inpatient in-network prior authorizations were denied and 67% of inpatient out-of-network prior authorizations were denied for M/S and 0% of MH/SUD prior authorizations were denied in both inpatient in-network and out-of-network classifications. This is less stringent compared to the 25% of M/S inpatient in-network prior authorizations denied, and also to the 67% of M/S inpatient out-of-network prior authorizations denied. Therefore, the percentage of denials for MH/SUD services is comparable to, and not more stringent than, the percentage of denials for M/S prior authorization requests. The appeals data analysis ensures comparable design for M/S with one denial overturned and two denials upheld for MH/SUD. The Maryland exclusive prior authorization data as shown in *DS 1 Prior Auth* shows no MH/SUD reviews denied in all benefit classifications with 3 denials shown for M/S. This demonstrates that the prior authorization is applied no more stringently for MH/SUD than that of M/S.

Cigna 's specific findings and conclusions reached with respect to the Prior Authorization NQTL, including results of the analyses described in the previous steps, indicate that Cigna is in compliance with the MHPAEA requirements. As demonstrated in this comparative analysis, for the application of Prior Authorization, Prior Authorization applies to both M/S and MH/SUD and is noted in the plan benefit language. The same factors are utilized for both M/S and MH/SUD services to determine which services are subject to Prior Authorization. Cigna has assessed the processes for application of the Prior Authorization NQTL to MH/SUD and M/S benefits and reviews annually operational policies governing utilization review, including medical necessity as well as policies governing clinical coverage policy development to ensure

comparability and equivalent stringency in application, comparable representation of qualified individuals who develop or participate in medical necessity decision-making, and the methodology for the application Prior Authorization.

Rx

In operation: In operation, the percentage of MH/SUD drugs requiring prior authorization (6.2%) is much lower than the percentage of M/S drugs requiring prior authorization (20%). The denial rate for MH/SUD drug requests (37%) is higher than the denial rate for M/S drug requests (14.5%). However, the volume of requests was very low for MH/SUD drugs, as the PA requirement was removed from a large amount of MH/SUD medications. The virtual material absence of appeals for MH/SUD drugs and M/S drugs indicates that benefit determinations and denials for MH/SUD drugs are in fact performed in a manner that is equally as stringent as determinations and denials for M/S drugs.

Thus, we conclude that the processes, strategies, evidentiary standards, and other factors used to apply Prior Authorization to MH/SUD drugs, in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Prior Authorization to M/S drugs.

Conclusion: Wellfleet has determined that PA is applied for MH/SUD drugs in a manner that is comparable to and no more stringent than that of M/S drugs, both as written and in operation, based on the information presented above that describes in detail the evidentiary standards, processes, strategies, and factors used to impose PA.

1. Prescription Drug Formulary Design

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits in Prescription Classification	NQTL's Applicable to MH/SUD Benefits in Prescription Classification
Formulary – Formulary is defined on our website as: "A formulary is a list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. It may also be referred to as a drug list. Your formulary provides detailed information on what drugs are covered under your pharmacy benefits...". The attached formulary is the version that was utilized for this review and was effective starting 1/1/2023. **Formulary Design**: Wellfleet uses a prescription drug formulary, which is a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost- effective medications. Formulary design refers to the process that the plan uses to develop the approved list of drugs covered under the pharmacy benefit plan. This is also called formulary placement. Drugs that are not on the formulary may be covered on an exception basis if they are excluded and if medical necessity can be established based on plan-approved prior authorization criteria or applicable regulations. Please see guideline named "Excluded Formulary Drug Exception" within the prior authorization guidelines on www.wellfleetrx.com/students/formularies. **Formulary Tiering** : Formulary tiering refers to the placement of particular drug products on various cost-sharing tiers, ranging from 1 to 3. Wellfleet uses the following formulary tiers: • Tier 1 (preferred generics): Lowest copayment for select drugs that offer the greatest value compared to other drugs used to treat similar conditions. • Tier 2 (non-preferred generics and preferred brands): Medium copayment covers brand name drugs that are generally more affordable or may be	**Formulary –** Formulary is defined on our website as: "A formulary is a list of prescription drugs covered by a prescription drug plan or another insurance plan offering prescription drug benefits. It may also be referred to as a drug list. Your formulary provides detailed information on what drugs are covered under your pharmacy benefits..." The attached formulary is the version that was utilized for this review and was effective starting 1/1/2023. **Formulary Design**: Wellfleet uses a prescription drug formulary, which is a list of medications designed to manage prescription costs without affecting the quality of care by identifying and encouraging use of the most clinically effective and cost- effective medications. Formulary design refers to the process that the plan uses to develop the approved list of drugs covered under the pharmacy benefit plan. This is also called formulary placement. Drugs that are not on the formulary may be covered on an exception basis if they are excluded and if medical necessity can be established based on plan-approved prior authorization criteria or applicable regulations. Please see guideline named "Excluded Formulary Drug Exception" within the prior authorization guidelines on www.wellfleetrx.com/students/formularies. **Formulary Tiering** : Formulary tiering refers to the placement of particular drug products on various cost-sharing tiers, ranging from 1 to 3. Wellfleet uses the following formulary tiers: • Tier 1 (preferred generics): Lowest copayment for select drugs that offer the greatest value compared to other drugs used to treat similar conditions. • Tier 2 (non-preferred generics and preferred brands): Medium copayment covers brand name drugs that are generally more affordable or may be

preferred compared to other drugs to treat the same conditions. This tier also covers non-preferred generic drugs. • Tier 3 (non-preferred brands): High copayment covers higher cost brand name drugs. Specialty drugs fall under the same tiering structure but may subject to a specialty tier copay. Specialty drugs are pharmaceutical, biotech or biological drugs that are used in the management of chronic, orphan or rare diseases and have a monthly cost > $670 for a 30-day supply. These injectable or non-injectable medications may possess more than one of the following attributes: Requires specialized storage, distribution, and/or handling; Frequent dosing adjustments and clinical monitoring to decrease potential for drug toxicity and improve clinical outcomes; Involves additional patient education, adherence, and/or support; May include generic or biosimilar products; and/or limited or exclusive drug distribution restrictions. These drugs are denoted on the formulary by "SP". **Step Therapy:** From Wellfleet's standard Certificate of Coverage Template: Step therapy (ST) is a process in which the Member may need to use one (1) or more types of Prescription Drug before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for a Member's medical condition. Wellfleet delegates the act of Utilization Review to Express Scripts (ESI), however the application of the Step Therapy NQTL and the guidelines that drive the decisions by ESI are approved by Wellfleet's internal Pharmacy and Therapeutics Committee (P&T) and Value Assessment Committee (VAC). Step Therapy is defined, in the Wellfleet Pharmacy and Therapeutics Committee Policy, as "Step Therapy: A process in which the member may need to use one (1) or more types of Prescription Drug before coverage of a second Prescription Drug." **Quantity Limits:** Quantity Limit is defined in the Wellfleet Rx Student Formulary as: "Coverage may be limited to specific quantities per prescription and/or time period."	preferred compared to other drugs to treat the same conditions. This tier also covers non-preferred generic drugs. • Tier 3 (non-preferred brands): High copayment covers higher cost brand name drugs. Specialty drugs fall under the same tiering structure but may subject to a specialty tier copay. Specialty drugs are pharmaceutical, biotech or biological drugs that are used in the management of chronic, orphan or rare diseases and have a monthly cost > $670 for a 30-day supply. These injectable or non-injectable medications may possess more than one of the following attributes: Requires specialized storage, distribution, and/or handling; Frequent dosing adjustments and clinical monitoring to decrease potential for drug toxicity and improve clinical outcomes; Involves additional patient education, adherence, and/or support; May include generic or biosimilar products; and/or limited or exclusive drug distribution restrictions. These drugs are denoted on the formulary by "SP". **Step Therapy:** From Wellfleet's standard Certificate of Coverage Template: Step therapy (ST) is a process in which the Member may need to use one (1) or more types of Prescription Drug before We will Cover another as Medically Necessary. A "step therapy protocol" means Our policy, protocol or program that establishes the sequence in which We approve Prescription Drugs for a Member's medical condition. Wellfleet delegates the act of Utilization Review to Express Scripts (ESI), however the application of the Step Therapy NQTL and the guidelines that drive the decisions by ESI are approved by Wellfleet's internal Pharmacy and Therapeutics Committee (P&T) and Value Assessment Committee (VAC). Step Therapy is defined, in the Wellfleet Pharmacy and Therapeutics Committee Policy, as "Step Therapy: A process in which the member may need to use one (1) or more types of Prescription Drug before coverage of a second Prescription Drug." **Quantity Limits:** Quantity Limit is defined in the Wellfleet Rx Student Formulary as: "Coverage may be limited to specific quantities per prescription and/or time period."

Quantity Limits restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply and are applied to ensure members receive clinically appropriate and medically necessary drugs. Wellfleet delegates the act of Utilization Review to Express Scripts (ESI), however the application of the Quantity Limit NQTL and the guidelines that drive the decisions by ESI are approved by Wellfleet's internal Pharmacy and Therapeutics Committee (P&T) and Value Assessment Committee (VAC). Quantity Limit is defined, in the Wellfleet Pharmacy and Therapeutics Committee Policy, as "Quantity Limit: A limitation on the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply".	Quantity Limits restrict the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply and are applied to ensure members receive clinically appropriate and medically necessary drugs. Wellfleet delegates the act of Utilization Review to Express Scripts (ESI), however the application of the Quantity Limit NQTL and the guidelines that drive the decisions by ESI are approved by Wellfleet's internal Pharmacy and Therapeutics Committee (P&T) and Value Assessment Committee (VAC). Quantity Limit is defined, in the Wellfleet Pharmacy and Therapeutics Committee Policy, as "Quantity Limit: A limitation on the amount dispensed per Prescription Order or Refill and/or the amount dispensed per month's supply".

(b) For each distinct component of the Prescription Drug Formulary Design NQTL listed in Step 1 (a), identify whether the NQTL is applicable to all medical/surgical benefits or all MH/SUD benefits for the Prescription classification, or only to certain medications/items within such classification, in the table above. If the NQTL applies only to certain medications/items within the Prescription classification, list each covered medication/item to which the NQTL applies (e.g., "Yes for the following medications:"). Attached separate pages if necessary. Similarly, response should be explicit whether the "Yes" applies to both M/S and MH/SUD.

a. Both Formulary Design and Formulary Tiering are applicable to all Medical/surgical benefits and all MH/SUD benefits, including drugs considered 'non-formulary'. Step Therapy and Quantity Limits are applicable to some Medical/surgical benefits and some MH/SUD benefits. Please see attachment 'Covered Services V3' for a full listing of prescription drug products that require step therapy or have a quantity limit.

Step 2

For each distinct component of the Prescription Drug Formulary Design **NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to the entire Prescription classification or only to certain services within such classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).**

Factors (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
Factors (same for M/S and MH/SUD): 1. Formulary Design & Formulary Tiering a. Availability of Cost-Effective alternatives b. High variability in cost within drugs in a given therapeutic class c. Member Impact (this factor is used only to determine when a negative shift in formulary placement or tiering should be applied) ***Use of Factors – Formulary Design*** For determining formulary design (i.e. inclusion on the formulary) the P&T committee first assesses the clinical efficacy and availability of cost effective alternative as described in Factor 1. Then, the Value Assessment Committee will assess the Cost as described in Factor 2 and makes a recommendation for final determination for inclusion on the formulary. In determining whether to remove a drug from the formulary, the VAC considers Factor 3 (in light of the committees analysis of Factors 1 and 2) for final determination. ***Use of Factors – Formulary Tiering*** For determining formulary tiering (i.e. which tier a drug is assigned to on the formulary), the P&T committee assesses Factors 1 and 2 to determine where the drug should be assigned, and makes a recommendation to the Value Assessment Committee for final determination. If the committee is considering moving the drug to a higher-cost tier, then Factor 3 is considered (in light of the committee's findings on Factors 1 and 2) to determine whether member impact cuts against assigning that particular drug to a higher cost tier. A recommendation is then made by the Value Assessment Committee for final approval. 2. Step Therapy a. High variability in cost within drugs in a given therapeutic class	1. Formulary Design & Formulary Tiering a. Factor 1: Availability of Cost-Effective alternatives i. **Source**: First Databank (FDB), FDA Prescribing Information, professionally recognized treatment guidelines (through the AMA, APA, ASAM, ACC, etc., or within the PubMed from NIH), peer-reviewed medical literature (within the PubMed from NIH) b. Factor 2: High variability in cost within drugs in a given therapeutic class i. **Source**: First Databank (FDB), internal market and competitive analysis, therapeutic class total net cost analysis. c. Factor 3: Member Impact (this factor is used only to determine when a negative shift in formulary placement or tiering should be applied) i. **Source**: Internal claims data, internal market and competitive analysis 2. Step Therapy a. Factor 1: High variability in cost within drugs in a given therapeutic class i. **Source:** First Databank (FDB), internal market and competitive analysis, therapeutic class total net cost analysis. b. Factor 2: Availability of Cost-Effective alternatives i. **Source:** First Databank (FDB), FDA Prescribing Information, professionally recognized treatment guidelines, peer-reviewed medical literature c. Factor 3: Member Impact (this factor is used only to determine when ST should not be applied) i. **Source:** Internal claims data, internal market and competitive analysis 3. Quantity Limits

Factors (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
b. Availability of Cost-Effective alternatives c. Member Impact (this factor is used only to determine when ST should not be applied) 3. Quantity Limits a. Safety - This factor carries more weight due to the member safety concerns. Ensuring the safety and wellbeing of our members is of upmost importance. b. Anticipated excessive utilization c. Member Impact (this factor is used only to determine when QL should not be applied) **Factors Considered but rejected (same for M/S and MH/SUD):** No other factors were considered and rejected. **Weight (same for M/S and MH/SUD):** Weighting of factors is described below in Step 3. There is no Artificial Intelligence application utilized for prescription formulary design.	a. Factor 1: Safety - This factor carries more weight due to the member safety concerns. Ensuring the safety and wellbeing of our members is of upmost importance. i. **Source**: FDA Prescribing Information, professionally recognized treatment guidelines used to define clinically appropriate standards of care, nationally recognized Compendia - Truven Health Analytics Micromedex DrugDEX (DrugDEX), and peer- reviewed medical literature. b. Factor 2: Anticipated excessive utilization i. **Source**: Aggregated data or non-identifiable utilization reports, FDA Prescribing Information, professionally recognized treatment guidelines used to define clinically appropriate standards of care such as nationally recognized Compendia - Truven Health Analytics Micromedex DrugDEX (DrugDEX), and peer-reviewed medical literature. c. Factor 3: Member Impact (this factor is used only to determine when QL should not be applied) i. **Source**: Internal claims data, internal market and competitive analysis

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Factors (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
1. Formulary Design & Formulary Tiering a. Availability of Cost-Effective alternatives b. High variability in cost within drugs in a given therapeutic class c. Member Impact (this factor is used only to determine when a negative shift in formulary placement or tiering should be applied) 2. Step Therapy a. High variability in cost within drugs in a given therapeutic class b. Availability of Cost-Effective alternatives c. Member Impact 3. Quantity Limits a. Safety - This factor carries more weight due to the member safety concerns.	1. Formulary Design & Formulary Tiering a. Factor 1: Availability of Cost-Effective alternatives i. **Evidentiary Standard**: Availability of alternate therapies (brand/generic). This is determined through discussions at P&T Committee meetings, that are based on therapeutic class reviews and new drug reviews. These are created using the sources above by Wellfleet's Clinical Pharmacist. These reviews contain information on indications, dosing & administration, clinical and comparative efficacy, clinical guidelines, contraindications & special populations, etc. The P&T Committee reviews clinical guidelines and nationally accepted standards of care to assess whether recommended alternative therapies exist. The P&T Committee discussions may determine that two or more drugs are expected to achieve clinically equivalent therapeutic outcomes. Having two or more drugs that are expected to achieve a clinically equivalent therapeutic outcome constitutes a potential 'cost-effective alternative'. If the net cost per day supply is greater than 20% different between the two medications, the lower cost option is the 'cost-effective alternative'. These discussions, along with the other factors listed in this section, guide the recommendations that are brought to the Value Assessment	1. Formulary Design & Tiering a. Factor 1: Availability of Cost-Effective alternatives i. **Source for Evidentiary Standard:** P&T minutes, therapeutic class reviews, nationally accepted standards of care (through the AMA, APA, ASAM, ACC, etc., or within the PubMed from NIH) b. Factor 2: High variability in cost within drugs in a given therapeutic class i. **Source for Evidentiary Standard:** Generic Therapeutic Classification (GTC), Specific Therapeutic Classification (STC) and Hierarchal Ingredient Code (HIC) are utilized through FDB and MediSpan to classify 'therapeutic class' for both MS and MH/SUD medications. Costs are determined based on Average Wholesale Price from FDB for comparison, based on a normal month supply, and internal claims data. High-cost variability is defined as a 20% monthly cost difference for all medication categories. c. Factor 3: Member Impact i. **Source for Evidentiary Standard:** Internal paid claims data from Express Scripts, excluding reversed claims 2. Step Therapy

Factors (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
Ensuring the safety and wellbeing of our members is of upmost importance. b. Anticipated excessive utilization c. Member Impact (this factor is used only to determine when QL should not be applied)	Committee for final determination on formulary status and tiering. b. Factor 2: High variability in cost within drugs in a given therapeutic class i. **Evidentiary Standard**: High cost is defined as anything over $670/month supply. Also taken into account are the availability of alternate therapies (brand/generic) & lowest total net cost for course of therapy for given conditions. If the drug is considered to have a high variability in cost, the VAC makes a recommendation for assignment to preferred or non-preferred tiers based on its evaluation of comparative net cost, comparing to other drugs in those tiers. c. Factor 3: Member Impact (this factor is used only to determine when a negative shift in formulary placement or tiering should be applied and is not weighted more than other factors). Member Impact, in this context, is defined as a negative shift in cost sharing or formulary placement for members that are currently utilizing the product being reviewed. i. **Evidentiary Standard**: The number of members that will be negatively impacted by either removing a drug product from formulary or shifting from 'preferred' tier to 'non-preferred'. This is only taken into account to decide *not* to apply a negative shift for members. If both factors 1 & 2 suggest removing a drug product from formulary	a. Factor 1: High variability in cost within drugs in a given therapeutic class i. **Source for Evidentiary Standard:** Generic Therapeutic Classification (GTC), Specific Therapeutic Classification (STC) and Hierarchal Ingredient Code (HIC) are utilized through FDB and MediSpan to classify 'therapeutic class' for both MS and MH/SUD medications. Costs are determined based on Average Wholesale Price from FDB for comparison, based on a normal month supply, and internal claims data. High-cost variability is defined as a 20% monthly cost difference for all medication categories. b. Factor 2: Availability of Cost-Effective alternatives i. **Source for Evidentiary Standard:** P&T minutes, therapeutic class reviews, nationally accepted standards of care(through the AMA, APA, ASAM, ACC, etc., or within the PubMed from NIH) ii. c. Factor 3: Member Impact i. **Source for Evidentiary Standard**: Internal paid claims data from Express Scripts, excluding reversed claims 3. Quantity Limits

Factors (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
	or shifting from 'preferred' tier to 'non-preferred', but there would be a large member impact, we would put the interest of our members first and not make changes. Threshold for 'negative member impact' is 5% of total membership utilizing the product that a negative formulary change is being considered for. 2. Step Therapy a. Factor 1: High variability in cost within drugs in a given therapeutic class i. **Evidentiary Standard**: High cost is defined as anything over $670/month supply. Also taken into account are the availability of alternate therapies (brand/generic) & lowest total net cost for course of therapy for given conditions. If the drug is considered to have a high variability in cost, the VAC makes a recommendation for assignment to preferred or non-preferred tiers based on its evaluation of comparative net cost, comparing to other drugs in those tiers. b. Factor 2: Availability of Cost-Effective alternatives i. **Evidentiary Standard**: Availability of alternate therapies (brand/generic). This is determined through discussions at P&T Committee meetings, that are based on therapeutic class reviews and new drug reviews. These are created using the sources above by Wellfleet's Clinical Pharmacist. These reviews contain information on indications,	a. Factor 1: Safety i. **Source for Evidentiary Standard:** New Drug Reviews & Therapeutic Class Reviews, P&T Minutes, FDA Labeling sections entitled 'Dosage and Administration', 'Contraindications', 'Warnings & Precautions', 'Adverse Reactions', 'Drug Interactions', 'Use in Specific Populations', and 'Overdosage' b. Factor 2: Anticipated excessive utilization i. **Source for Evidentiary Standard:** P&T minutes, therapeutic class reviews, nationally accepted standards of care(through the AMA, APA, ASAM, ACC, etc., or within the PubMed from NIH) ii. c. Factor 3: Member Impact i. **Source for Evidentiary Standard**: Internal paid claims data from Express Scripts, excluding reversed claims

Factors (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
	dosing & administration, clinical and comparative efficacy, clinical guidelines, contraindications & special populations, etc. The P&T Committee reviews clinical guidelines and nationally accepted standards of care to assess whether recommended alternative therapies exist. The P&T Committee discussions may determine that two or more drugs are expected to achieve clinically equivalent therapeutic outcomes. Having two or more drugs that are expected to achieve a clinically equivalent therapeutic outcome constitutes a potential 'cost-effective alternative', if the net cost per day supply is greater than 20% different. These discussions, along with the other factors listed in this section, guide the recommendations that are brought to the Value Assessment Committee for final determination on formulary status and tiering. c. Factor 3: Member Impact(this factor is used only to determine when a negative shift in formulary placement or tiering should be applied and is not weighted more than other factors). Member Impact, in this context, is defined as a potential addition of step therapy for members that are currently utilizing the product being reviewed. i. **Evidentiary Standard**: The number of members that will be negatively impacted by adding a step therapy. This is only taken into account to decide *not* to apply a step therapy requirement. If both	

Factors (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
	factors 1 & 2 suggest removing a drug product from formulary or shifting from 'preferred' tier to 'non-preferred', but there would be a large member impact, we would put the interest of our members first and not make changes. The threshold for 'negative member impact' is 5% of total membership utilizing the product that an addition would affect. 3. Quantity Limits a. Factor 1: Safety i. **Evidentiary Standard**: P&T Committee members discuss safety of newly released products to determine if they have potential for unsafe use. Sources listed above are compiled by Wellfleet's Clinical Pharmacist into New Drug Reviews and Therapeutic Class Reviews. These reviews contain information on indications, dosing & administration, clinical and comparative efficacy, clinical guidelines, contraindications & special populations, etc. These are forwarded to the P&T committee prior to the meetings for their review. Meeting discussions include an analysis of: appropriate dosing, potential overdose, prescribing by particular specialty provider, adherence or potential non-adherence to guidelines, etc. The threshold for 'safety' as a factor for a quantity limit will be met if any of the following apply for the medication being	

Factors (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
	reviewed: FDA lists a maximum recommended dose in labeling information, there is a Black Box Warning present on the labeling information, there are two or more serious adverse effects listed in the labeling information, there is a toxicity or poisoning potential. b. Factor 2: Anticipated excessive utilization i. Evidentiary Standard: Wellfleet's Clinical Pharmacist performs reviews of claims data every 6 months and compares actual utilization against the recommendations in the sources identified above (e.g. FDA prescribing information, dosing schedules, etc.) to determine whether a drug is being used excessively or inappropriately. "Excessive utilization" is defined as anything above the FDA approved dosing schedule or recommended dosage in peer-reviewed medical journals, or utilization of multiple unit doses to equal a total dosage that is commercially available (e.g. utilizing two 10mg tablets to get a single 20mg dose). The factor of Anticipated Excessive Utilization will indicate the necessity of a quantity limit if 10% or more of examined claims are above the threshold set by FDA prescribing information, dosing schedules, etc. In the instance of a medication not having internal claims history, or for new to market medications, the description of a maximum recommended dosage on the FDA	

Factors (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
	labeling information or dosing schedule would indicate the necessity for a quantity limit. This limit would mirror the recommendations in the labeling information. If the Clinical Pharmacist determines a drug is subject to potential excessive utilization, the Clinical Pharmacist or the P&T Committee may recommend applying a quantity limit to the Value Assessment Committee (VAC). The VAC reviews the Clinical Pharmacist's and the P&T Committee recommendation to approve the decision of applying such limitation. c. Factor 3: Member Impact (this factor is used only to determine when a negative shift in quantity limit requirements should be applied and is not weighted more than other factors). Member Impact, in this context, is defined as an application of a quantity limit on a product previously without one i. Evidentiary Standard: The Value Assessment Committee reviews a cost report for the past year to determine the impact and number of members that may be using a particular benefit that is being considered for QL application. The VAC determines the number of members that will be negatively impacted by quantity limit additions. The VAC makes a decision based on their professional judgement as to whether QL should not be applied to avoid negative member	

Factors (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
	impact. This is only taken into account to decide *not* to apply or to remove a quantity limit requirement from a medication and is not used in the application process for QL. If factors 1 and 2 suggest the addition of QL, but we anticipate significant member or client impact based on our covered demographic, we may put the interest of our members first and not assign a QL designation. Threshold for 'negative member impact' is 5% of total membership utilizing the product that a quantity limit is being considered for.	

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Formulary Design & Formulary Tiering – All information is the same for M/S & MH/SUD unless otherwise noted

Timelines/ frequency of review:

- Formulary design and tiering are analyzed semi-annually, unless otherwise prohibited by state law.

Formulary Tiering Designation Process:

- The P&T Committee reviews all newly approved drugs and newly-approved indications and dosage forms for formulary status and recommendations for utilization management. The P&T Committee make recommendations for the final version of the formulary and related documents.
- The P&T Committee documents are presented to the health plan Value Assessment Committee (VAC). The VAC is tasked to maintain and approve recommended changes to the formulary, drug prior authorization guidelines, and any programs/procedures that affect the utilization of drugs. For formulary decisions on drugs used to treat mental health or substance use disorders, the P&T Committee utilizes appropriate experience and knowledge in treating patients with the specific disease state. The P&T Committee has at least one member in the psychiatry specialty. VAC Committee meetings are held at least semi-annually. First the VAC committee reviews the P&T Committee recommendation, then the VAC Committee makes a final clinical decision.
- The VAC reviews the clinical decision and evaluates financial and operational impacts to make final determinations for formulary placement.
- Finally, this final formulary placement decision is reviewed by the health plan VAC committee to confirm alignment with clinical decisions.

Formulary Design Management:

- Tiered drug formularies involve groupings of drugs subject to different levels of cost-sharing which are referred to as Tiers. The Student Formulary is a three-tier benefit design, where the member shares the cost of prescription drug therapy at three levels of copayment. In most instances, generically available drugs will be covered under the first or lowest copay tier, branded drugs listed on the Formulary will be covered under the second copay tier, and branded drugs not on the Formulary will be covered under the third or highest copay tier.

Formulary Development & Maintenance Process (Role of P&T Committee):

- The process, strategies, and evidentiary standards used in applying Formulary Design and tiering are the same for both MH/SUD and M/S drugs, as written. The factors identified in Step Two and the sources identified in Step Three apply equally to MH/SUD and M/S drugs.
- Additionally, to become members of the P&T Committee, the physicians must be board certified licensed physicians or pharmacists with over 5 years of practicing in their respective fields. We use the clinical expertise of the P&T Committee members along with published clinical guidelines and scientific evidence to achieve consensus in order to set Formulary recommendations.
- As written, Formulary Design processes are the same for both M/S and MH/SUD drugs. The Formulary Management Policy is applied equally to both types of drugs and is reviewed annually for biased verbiage by the Director of Clinical Programs, Clinical Pharmacist, and Chief Medical Officer, and any updates required are made. The current formulary management policy states:
    - "In order to comply with the Mental Health Parity and Addiction Equity Act (MHPAEA) and other applicable mental health parity laws, no aspect of the Formulary design, including tiering and UM decisions, shall be based on policies, processes, and operations that are more stringent for medications used to treat mental health conditions and substance use disorders (MH/SUD) as compared to medications used to treat medical or surgical conditions. At least annually, Wellfleet and [P&T Vendor] will complete analysis on the Non-Quantitative Treatment Limitations (NQTLs) that apply to the Formulary, which includes identifying each NQTL, identifying the factors considered in the design of the NQTLs, identifying the sources used to define the factors considered in the design of the NQTLs, and analyzing whether the processes, strategies, and evidentiary standards used in applying the NQTLs are comparable and no more stringently applied to medications used to treat MH/SUD conditions as compared to medications used to treat medical or surgical conditions, as written and in operation."

- The most recent review of this policy was conducted over the course of 8 working hours. Particular attention was put on the classifications of "Mental Health/Substance Use Disorder" in order to most appropriately identify the medications that should be in this bucket. Additional Hierarchal Ingredient Codes (HICL) were added as cross-over medications (medications that can be utilized for both mental health and med/surg diagnoses. The additional HICL's were: 01608, 01621, 01629, 01641, 01642, 01643, 01656, 01745, 01884, 01893, 07378, and 26521. Other edits included updating titles for staff impacted by the policy and inclusion of definitions for GTC, STC, and HICL. The only other instances of calling out mental health medications is to reference MHPAEA and to describe that an annual analysis must be conducted. Snips of updates are included below.

- ~~b.~~i. Mental Health/Substance Use Disorder medications shall be classified as any product with either a First DataBank Generic Therapeutic Class (GTC) Identifier of 80 or 83, or Specific Therapeutic Class (STC) Identifier of 00274, 00292, 00253,17889,07261, 00164, 03624, or 17391. Drugs that can be utilized for both Mental Health/Substance Use Disorder and Medical/Surgical conditions shall be considered 'cross-over' and shall be bucketed into both 'MH/SUD' and 'M/S' for any MHPAEA analysis performed. These medications shall be identified by Hierarchal Ingredient Code (HICL). Cross-over medications have a HICL of 01608, 01621, 01629, 01641, 01642, 01643

- **Generic Therapeutic Class (GTC):** Broad class identification for medications. Provided by First DataBank.
- **Hierarchal Ingredient Code (HICL):** Generic ingredient identification for medications. Provided by First DataBank.

- **Specific Therapeutic Class (STC):** Narrow class identification for medications. Provided by First DataBank.

- The same Non-Formulary Exceptions policy is used for all medication classifications to provide medical necessity overrides of formulary status. This policy, entitled 'Excluded Formulary Drug Exception Criteria', is reviewed at least annually by the Pharmacy and Therapeutics Committee and approved. An annual audit is also conducted to ensure that the policy does not have differences in intent between classifications of medications. To date, no instances of verbiage that would require or insinuate discriminatory practices towards MH/SUD medications have been found, as the requirements are the same across the board for all non-formulary medications. The most recent audit found that the exception policy is the same for all classifications, and requires the following information to be granted approval:
    - Product being requested for either an FDA approved indication or an indication that is considered safe and effective for the diagnosis by peer-reviewed medical literature or standards of medical practice
    - Patient has met one of the following:
        - Tried and failed 3 appropriate formulary options, if available. If less than 3, they have tried all formulary options
        - Has contraindications to all formulary options
        - Provider has given justifications for the absolute clinical need of the requested medication without trial or failure of alternatives
    - If the request is for a multi-source brand, the patient has tried & failed the generic alternative or has a contraindication to the generic
    - If the request is for a combination product, the provider has given justification that the individual drug products would not be appropriate

Role of the P&T Committee and VAC Committee:

- To become members of the P&T Committee, the physicians must be board certified licensed physicians with over 5 years of experience in their respective fields. P&T is made up of varying specialties that cover a wide range of diagnoses and care settings. Current specialties represented are: family medicine, internal medicine, hematology/oncology pharmacy, psychiatric pharmacy, OB/GYN, psychiatry, oncology, and pulmonology.
- The VAC is composed of internal leadership and key employees at Wellfleet. Membership covers the clinical & pharmacy team, finance team, sales team, and member experience team.
- The P&T committee determines include/exclude/optional formulary status based upon the evidentiary standards set forth in Step 3 without regard as to whether the drug is used to treat a medical condition or a MH/SUD condition. The Value Assessment Committee (VAC), considers the value of drugs by evaluating both factors set forth in Step 3, including net cost, market share, brand and generic pipeline, drug utilization trends and cost effectiveness of clinically similar medications. Based on the recommendations of the P&T Committee, the VAC decides on formulary tiering. The processes, strategies, and evidentiary standards the VAC uses in Formulary Design for MH/SUD drugs are comparable to, and not more stringently applied than, the processes, strategies, and evidentiary standards used in tiering for M/S drugs. The P&T Charter and VAC charter are reviewed at least annually for parity. There is no language indicating a bias towards one classification of drugs of the other, and the same standards (as seen above) are used for both.

Factors influencing non-preferred formulary placement analysis:

- An audit was conducted for a random subset of formulary medications that are put on a non-preferred tier, to ensure that the factors utilized to make this determination were used consistently. The findings from this audit are below. All products sampled had several cost-effective alternatives with AWP / unit at a statistically lower value. Alternatives were all sourced based on clinical practice guidelines pertinent to the medication analyzed and FDA prescribing information, and AWP was based on values found in First Databank.

			Factors Utilized for Formulary Placement		
Medication Name	**Classification**	**Tier**	**Availability of Cost-Effective alternatives**	**High variability in cost within drugs in a given therapeutic class**	**Member Impact**
Eletriptan tablets	M/S	2	X - Naratriptan Rizatriptan Sumatriptan	X - Eletriptan AWP / unit - $62 Naratriptan AWP / unit - $29 Rizatriptan AWP / unit - $33 Sumatriptan AWP / unit - $25	
Fluvastatin Capsule	M/S	2	X - Atorvastatin Simvastatin Rosuvastatin	X - Fluvastatin AWP / unit - $6 Atorvastatin AWP / unit - $4 Simvastatin AWP / unit - $0.50 Rosuvastatin AWP / unit - $2	
Ketoprofen Capsule	M/S	2	X - Diclofenac Ibuprofen Indomethacin	X - Ketoprofen AWP / unit - $25 Diclofenac - AWP / unit - $3 Ibuprofen - AWP / unit - $0.25 Indomethacin - AWP / unit - $0.40	
Levoxyl Tablet	M/S	2	X - Levothyroxine NP Thyroid	X - Levoxyl AWP / unit - $1.50 Levothyroxine AWP / unit - $0.10 NP Thyroid AWP / unit - $1	
Pantoprazole Tablet	M/S	2	X - Esomeprazole Lansoprazole Omeprazole	X - Pantoprazole AWP / unit - $5 Esomeprazole AWP / unit - $0.25 Lansoprazole AWP / unit - $4 Omeprazole AWP / unit - $0.20	
Zafirlukast Tablet	M/S	2	X - Montelukast	X - Zafirlukast AWP / unit - $2 Montelukast AWP / unit - $0.10	
Alprazolam ODT	MH/SUD	2	X - Alprazolam Clonazepam Lorazepam	X - Alprazolam ODT AWP / unit - $2 Alprazolam AWP / unit - $0.75 Clonazepam AWP / unit - $0.85 Lorazepam AWP / unit - $0.65	

Desipramine Tablet	MH/SUD	2	X - Amitriptyline Doxepin Imipramine	X - Desipramine AWP / unit - $2 Amitriptyline AWP / unit - $0.75 Doxepin AWP / unit - $0.85 Imipramine AWP / unit - $0.70	
Fluoxetine Tablet	MH/SUD	2	X - Citalopram Escitalopram Paroxetine	X - Fluoxetine AWP / unit - $3 Citalopram AWP / unit - $2 Escitalopram AWP / unit - $0.25 Paroxetine AWP / unit - $1.50	
Methylphenidate Chew Tablet	MH/SUD	2	X - Amphetamine Salts Methylphenidate	X - Methylphenidate Chew AWP / unit - $4.50 Amphetamine Salts AWP / unit - $0.50 Methylphenidate AWP / unit - $1	
Temazepam Capsule	MH/SUD	2	X - Alprazolam Clonazepam Lorazepam	X - Alprazolam ODT AWP / unit - $2 Alprazolam AWP / unit - $0.75 Clonazepam AWP / unit - $0.85 Lorazepam AWP / unit - $0.65	
Venlafaxine ER Tablet	MH/SUD	2	X - Duloxetine Venlafaxine	X - Venlafaxine ER AWP / unit - $16 Duloxetine AWP / unit - $7 Venlafaxine AWP / unit - $2	

Step Therapy - All information is the same for M/S & MH/SUD unless otherwise noted

Timelines and deadlines, frequency of review:

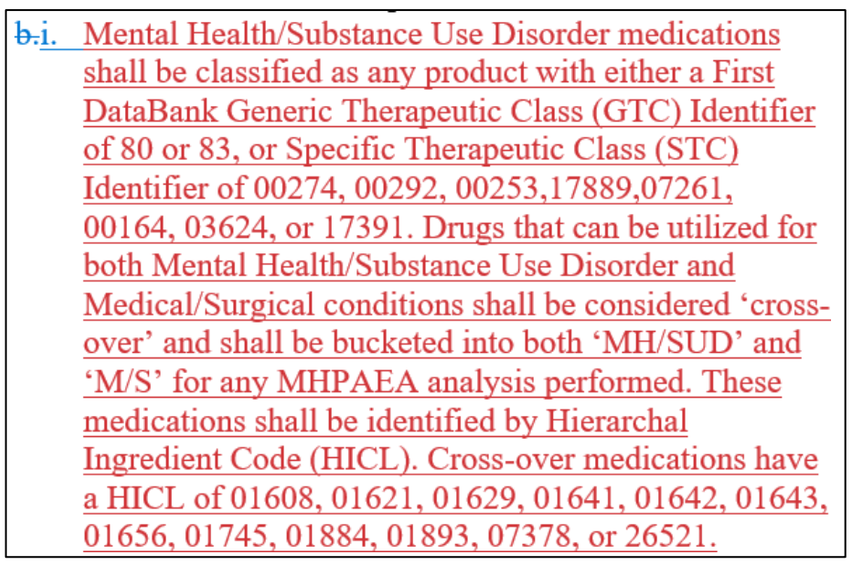
- Turnaround times for review and either approving or denying a ST request are based on state requirements. However, on average across Wellfleet's book of business ST requests are processed within 1 business day.
- Authorizations across the board for both M/S and MH/SUD drugs are valid for 365 days from approval. The only exceptions here are for products that have regulatory implications, which will be approved based on the regulatory statute.
- Appeals turnaround times are the same for all drugs and are dependent on federal and state regulations to ensure compliance.

Forms and/or other information required to be submitted by the provider:

- Providers can request Step Therapy Exceptions by calling Express Scripts Prior Authorization department directly, utilizing CoverMyMeds, Express Path, or SureScripts ePA software, or by completing a standard Prior Authorization Request Form and faxing directly to Express Scripts Prior Authorization department. Submission of medical chart notes / patient drug history may be required for these Step Therapy Exceptions.
- If a member has a history of the required step drugs in their profile with Express Scripts, they will automatically get a paid claim at point-of-sale without the provider being required to submit an exception request. This can be done for all drugs that require Step Therapy, regardless of drug classification.

Utilization management manuals and any other documentation of UM processes that are relied upon to make a determination:

- The P&T Policy & Procedures and Formulary Management Policy are reviewed at least annually to ensure there is no verbiage indicating a bias towards any particular subset of drugs. These policies dictate that all decisions should be based off the clinical merits of the drug, not the classification of drug itself.
- The most recent review of this policy was conducted over the course of 8 working hours. Particular attention was put on the classifications of "Mental Health/Substance Use Disorder" in order to most appropriately identify the medications that should be in this bucket. Additional Hierarchal Ingredient Codes (HICL) were added as cross- over medications (medications that can be utilized for both mental health and med/surg diagnoses. The additional HICL's were: 01608, 01621, 01629, 01641, 01642, 01643, 01656, 01745, 01884, 01893, 07378, and 26521. Other edits included updating titles for staff impacted by the policy and inclusion of definitions for GTC, STC, and HICL. The only other instances of calling out mental health medications is to reference MHPAEA and to describe that an annual analysis must be conducted. Snips of updates are included below.

  - 
    ~~b.~~i. Mental Health/Substance Use Disorder medications shall be classified as any product with either a First DataBank Generic Therapeutic Class (GTC) Identifier of 80 or 83, or Specific Therapeutic Class (STC) Identifier of 00274, 00292, 00253,17889,07261, 00164, 03624, or 17391. Drugs that can be utilized for both Mental Health/Substance Use Disorder and Medical/Surgical conditions shall be considered 'cross-over' and shall be bucketed into both 'MH/SUD' and 'M/S' for any MHPAEA analysis performed. These medications shall be identified by Hierarchal Ingredient Code (HICL). Cross-over medications have a HICL of 01608, 01621, 01629, 01641, 01642, 01643, 01656, 01745, 01884, 01893, 07378, or 26521.

- **Generic Therapeutic Class (GTC):** Broad class identification for medications. Provided by First DataBank.
- **Hierarchal Ingredient Code (HICL):** Generic ingredient identification for medications. Provided by First DataBank.

- **Specific Therapeutic Class (STC):** Narrow class identification for medications. Provided by First DataBank.

Relevant Decision Making Committees

- P&T Committee
  - The P&T Committee is responsible for assessing the clinical merits of drug therapies. The committee shall provide clinical rationale and guidance on formulary placement. The Value Assessment Committee (VAC) follows the P&T Committee recommendations to finalize formulary placement decisions.
  - The P&T Committee is responsible for approving any new Utilization Management policies (guidelines) or negative changes (any change creating a larger barrier to member access) to these guidelines. If a guideline change includes any criteria that differs from the FDA approved labeling information, it will also require justification and approval from the P&T Committee. Guidelines shall also be reviewed annually for approval. At each P&T meeting, the new, updated, and a quarter of all other guidelines will be discussed and approved/denied. Current specialties represented are: family medicine, internal medicine, hematology/oncology pharmacy, psychiatric pharmacy, OB/GYN, psychiatry, oncology, and pulmonology.

- Value Assessment Committee (VAC)
  - The VAC is responsible for determining tiering and Utilization Management decisions for drugs that are designed as 'include' by the P&T Committee. These drugs shall not be removed from formulary without prior approval from the P&T Committee. Also, determining coverage, tiering, and Utilization Management decisions for drugs that are designated as 'optional' by the P&T Committee.

Minimum qualifications for reviewers:

- To become members of the P&T Committee, the physicians must be board certified licensed physicians with over 5 years of experience in their respective fields. We use the clinical expertise of the P&T Committee members along with published clinical guidelines and scientific evidence to achieve consensus in order to set Quantity Limits.

- Every PAR, UMP, Nurse, and Medical Director goes through extensive training to make sure we are providing the most complete and comprehensive service for each one of our members. The training consists of both in classroom, on the job shadowing, monthly quality reviewing of cases, and weekly meetings to provide any new/updated information that needs to be shared with the teams.

Minimum standards to issue a denial:

- The same Exceptions policy, which is reviewed annually by the Pharmacy & Therapeutics Committee, is used for both MH/SUD and M/S drugs. It is also reviewed in order to determine whether there is any verbiage that would cause decisions regarding exceptions to the application of step therapy to be made out of parity. To date, no instances of verbiage that would require or insinuate discriminatory practices towards MH/SUD medications have been found, as the requirements are the same across the board for all medications that require step therapy. The exceptions policy currently requires one of four main points for approval, none of which are biased toward M/S or MH/SUD drugs:
    - 1. The patient has a contraindication to the required Step drug;
    - 2. The prescriber suspects the required Step drug to be ineffective for the patient;
    - 3. The patient has tried a therapeutically equivalent dose of the required Step drug under the current or previous health plan for a long enough period of time to reach a therapeutic improvement and was discontinued due to lack of improvement;
    - 4. The patient is currently receiving a positive outcome on the requested drug and should not discontinue.
- If a member has not met criteria for Step therapy exception and provider cannot provide documentation as described above for an exception, they will be issued a denial
- Depending on state requirements, a denial may only be issued by certain individuals with particular qualifications (e.g. physician with same/similar specialty licensed in same state, pharmacist, etc.). This is kept consistent for M/S and MH/SUD

Interrater Reliability Scores

- Interrater Reliability (IRR) analyses are conducted by Express Scripts on a semi-annual basis. Most recent Interrater reliability results for reviews performed were 98.48% for M/S reviews and 99.24% for MH/SUD reviews. There have been no instances of an IRR under 95%. If either classification dropped below the 95% threshold, a corrective action plan would be created and followed by the PBM to ensure compliance.

Factors influencing Step Therapy Determination analysis:

- An audit was conducted for a random subset of formulary medications that have a step therapy requirement, to ensure that the factors utilized to make this determination were used consistently. The findings from this audit are below. All products sampled had several cost-effective alternatives with AWP / unit at a statistically lower value. Alternatives were all sourced based on clinical practice guidelines pertinent to the medication analyzed and FDA prescribing information, and AWP was based on values found in First Databank.

			Factors Utilized for Step Therapy Determination		
Medication Name	**Classification**	**Step Therapy**	**Availability of Cost-Effective alternatives**	**High variability in cost within drugs in a given therapeutic class**	**Member Impact**
Almotriptan Tablet	M/S	X	X - Rizatriptan Sumatriptan	X - Almotriptan AWP / unit - $42 Rizatriptan AWP / unit - $33 Sumatriptan AWP / unit - $25	
Carisoprodol Tablet	M/S	X	X - Baclofen Cyclobenzapri ne Methocarbamol	X - Carisoprodol AWP / unit - $3.30 Baclofen AWP / unit - $2 Cyclobenzaprine AWP / unit - $1 Methocarbamol AWP / unit - $0.25	
Neupro Patch	M/S	X	X - Pramipexole Ropinirole	X - Neupro AWP / unit - $34 Pramipexole AWP / unit - $3 Ropinirole AWP / unit - $0.75	
Pancreaze Capsule	M/S	X	X - Creon Zenpe p	X - Pancreaze AWP / unit - $7.50 Creon AWP / unit - $5 Zenpep AWP / unit - $5	
Risedronate Tablet	M/S	X	X - Alendronate Ibandronate	X - Risedronate AWP / unit - $320 Alendronate AWP / unit - $58 Ibandronate AWP / unit - $165	
Travatan Z Eye Drop	M/S	X	X - Bimatoprost Latanoprost	X - Travatan Z AWP / unit - $120 Bimatoprost AWP / unit - $30 Latanoprost AWP / unit - $8	
Adzenys Tablet	MH/SUD	X	X - Amphetamine Salts Methylphenidate	X - Adzenys AWP / unit - $21 Amphetamine Salts AWP / unit - $2 Methylphenidate AWP / unit - $1	
Belsomra Tablet	MH/SUD	X	X - Zolpidem Eszopiclone	X - Belsomra AWP / unit - $18 Zolpidem AWP / unit - $5 Eszopiclone AWP / unit - $12	
Emsam Patch	MH/SUD	X	X - Rasagaline Selegiline	X - Emsam AWP / unit - $86 Rasagaline AWP / unit - $22 Selegiline AWP / unit - $2	

Latuda Tablet	MH/SUD	X	X - Aripiprazole Risperidone Quetiapine	X - Latuda AWP / unit - $57 Aripiprazole AWP / unit - $5 Risperidone AWP / unit - $5 Quetiapine AWP / unit - $4	
Ramelteon Tablet	MH/SUD	X	X - Eszopiclone Temazepam Zolpidem	X - Eszopiclone AWP / unit - $12 Temazepam AWP / unit - $1 Zolpidem AWP / unit - $5	
Viibryd Tablet	MH/SUD	X	X - Citalopram Fluoxetine Sertraline	X - Viibryd AWP / unit - $14 Citalopram AWP / unit - $2 Fluoxetine AWP / unit - $2.50 Sertraline AWP / unit - $0.50	

Quantity Limits - All information is the same for M/S & MH/SUD unless otherwise noted

Timelines and deadlines, frequency of review:

- Turnaround times for review and either approving or denying a QL exception request are based on state requirements. However, on average across Wellfleet's book of business QL exception requests are processed within 1 business day.
- Authorizations for both M/S and MH/SUD drugs are valid for 365 days from approval. Approvals may be for a shorter duration if the FDA labeling guidelines have strict duration of therapy limits or monitoring requirements after initiation. Other exceptions are for products that have regulatory implications, which will be approved based on the regulatory statute.
- Appeals turnaround times are the same for all drugs and are dependent on federal and state regulations to ensure compliance.

Forms and/or other information required to be submitted by the provider:

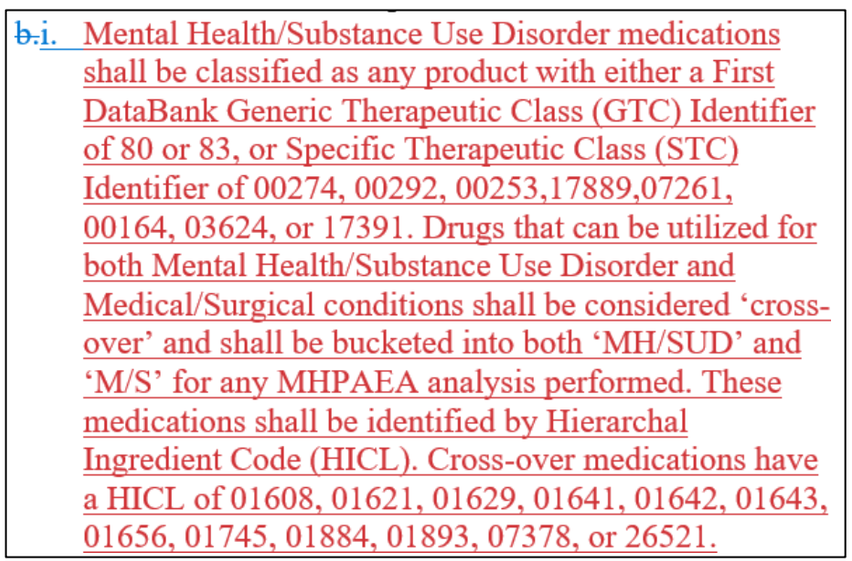
- Providers can request Quantity Limit Exceptions by calling Express Scripts Prior Authorization department directly, utilizing CoverMyMeds, Express Path, or SureScripts ePA software, or by completing a Prior Authorization Request Form and faxing directly to Express Scripts Prior Authorization department.

Utilization management manuals and any other documentation of UM processes that are relied upon to make a determination:

- The P&T Policy & Procedures and Formulary Management Policy are reviewed by Wellfleet's Chief Medical Officer, Director of Clinical Programs, and Clinical Pharmacist, at least annually to ensure there is no verbiage indicating a bias towards any particular subset of drugs. These policies dictate that all decisions should be based off of the

clinical merits of the drug, not the classification of drug itself. Quantity Limit is imposed on drug products based on the factors presented previously for both classifications of drugs. In the review of the P&T policy, it is stated that "The clinical decisions made by the P&T Committee are based on sound scientific evidence and standards of practice that include: 1. Assessing peer-reviewed medical literature. 2. Referencing published practice guidelines. 3. Comparing efficacy, side effects, and potential drug interactions among alternative drug therapies. 4. Assessing impact of formulary decisions to patient compliance." There is also the presence of a non-discriminatory section, stating that members shall not "discriminate based on age, disability, race, ethnicity, gender, sexual orientation, or health status." Members non-adhering to either of these statements will be recused from the committee. No recusals have been a result of non-adherence to these policies.

- The most recent review of the Formulary Management policy was conducted over the course of 8 working hours. Particular attention was put on the classifications of "Mental Health/Substance Use Disorder" in order to most appropriately identify the medications that should be in this bucket. Additional Hierarchal Ingredient Codes (HICL) were added as cross-over medications (medications that can be utilized for both mental health and med/surg diagnoses. The additional HICL's were: 01608, 01621, 01629, 01641, 01642, 01643, 01656, 01745, 01884, 01893, 07378, and 26521. Other edits included updating titles for staff impacted by the policy and inclusion of definitions for GTC, STC, and HICL. The only other instances of calling out mental health medications is to reference MHPAEA and to describe that an annual analysis must be conducted. Snips of updates are included below.



~~b.~~i. Mental Health/Substance Use Disorder medications shall be classified as any product with either a First DataBank Generic Therapeutic Class (GTC) Identifier of 80 or 83, or Specific Therapeutic Class (STC) Identifier of 00274, 00292, 00253,17889,07261, 00164, 03624, or 17391. Drugs that can be utilized for both Mental Health/Substance Use Disorder and Medical/Surgical conditions shall be considered 'cross-over' and shall be bucketed into both 'MH/SUD' and 'M/S' for any MHPAEA analysis performed. These medications shall be identified by Hierarchal Ingredient Code (HICL). Cross-over medications have a HICL of 01608, 01621, 01629, 01641, 01642, 01643, 01656, 01745, 01884, 01893, 07378, or 26521.

- **Generic Therapeutic Class (GTC):** Broad class identification for medications. Provided by First DataBank.
- **Hierarchal Ingredient Code (HICL):** Generic ingredient identification for medications. Provided by First DataBank.

- **Specific Therapeutic Class (STC):** Narrow class identification for medications. Provided by First DataBank.

Relevant Decision Making Committees

- P&T Committee
  - The P&T Committee is responsible for assessing the clinical merits of drug therapies. The committee shall provide clinical rationale and guidance on appropriate quantities/dosing. The Value Assessment Committee (VAC) follows the P&T Committee recommendations to finalize any quantity limit decisions.
  - The P&T Committee is responsible for approving any new Utilization Management policies (guidelines) or negative changes (any change creating a larger barrier to member access) to these guidelines. If a guideline change includes any criteria that differs from the FDA approved labeling information, it will also require justification and approval from the P&T Committee. Guidelines shall also be reviewed annually for approval. At each P&T meeting, the new, updated, and a quarter of all other guidelines will be discussed and approved/denied. Current specialties represented are: family medicine, internal medicine, hematology/oncology pharmacy, psychiatric pharmacy, OB/GYN, psychiatry, oncology, and pulmonology.

- Value Assessment Committee (VAC)
  - The VAC is responsible for determining tiering and Utilization Management decisions for drugs that are designated as 'include' by the P&T Committee. These drugs shall not be removed from formulary without prior approval from the P&T Committee. Also, determining coverage, tiering, and Utilization Management decisions for drugs that are designated as 'optional' by the P&T Committee. The VAC shall use clinical notes from P&T, along with other sources listed above, to make quantity limit determinations.

Minimum qualifications for reviewers:

- To become members of the P&T Committee, the physicians must be board certified licensed physicians with over 5 years of experience in their respective fields. We use the clinical expertise of the P&T Committee members along with published clinical guidelines and scientific evidence to achieve consensus in order to set Quantity Limits.
- Every PAR, UMP, Nurse, and Medical Director goes through extensive training to make sure we are providing the most complete and comprehensive service for each one of our members. The training consists of both in classroom, on the job shadowing, monthly quality reviewing of cases, and weekly meetings to provide any new/updated information that needs to be shared with the teams.

Minimum standards to issue a denial:

- If a prescription exceeds the designated quantity limit, the filling pharmacy will be issued a denial. If the member and provider elect to request an exception, they will be asked to submit documentation in support of use of the product. The exact process can be seen in Wellfleet's PA guideline packet at www.Wellfleetrx.com/formularies. This process is the same for both M/S and MH/SUD drugs. This exception policy is also reviewed in order to determine whether there is any verbiage that would cause decisions regarding exceptions to the application of quantity limits to be made out of parity. To date, no instances of verbiage that would require or insinuate discriminatory practices towards MH/SUD medications have been found, as the requirements are the same across the board for all medications that require quantity limits. The exceptions policy currently requires one of three main points for approval, none of which are biased toward M/S or MH/SUD drugs:
    - There is at least one piece of medical literature supporting the quantity requested and the quantity allowed under the formulary has been ineffective in treating the condition per the providers judgement OR
    - Based on clinical evidence and medical literature, the known relevant physical or mental characteristics of the member, and the known characteristics of the drug regimen, the lower quantity is likely to be ineffective OR
    - Patient is currently on the requested dose and no higher dosage strength can be used to achieve the same total daily dose

Interrater Reliability Scores

- Interrater Reliability (IRR) analyses are conducted by Express Scripts on a semi-annual basis. Most recent Interrater reliability results for reviews performed were 98.48% for M/S reviews and 99.24% for MH/SUD reviews. There have been no instances of an IRR under 95%. If either classification dropped below the 95% threshold, a corrective action plan would be created and followed by the PBM to ensure compliance.

Factors influencing Quantity Limit Determination analysis:

- An audit was conducted for a random subset of formulary medications that have a quantity limit requirement, to ensure that the factors utilized to make this determination were used consistently. The findings from this audit are below. All products sampled had several safety concerns. One product from each classification showed excessive utilization, passing the threshold for anticipated excessive utilization in the future. All safety concerns were sourced from the FDA approved labeling information, and all claims data were sourced from internal databases of paid claims.

			Factors Utilized for Quantity Limit Application		
Medication Name	**Classification**	**Quantity Limit**	**Safety**	**Anticipated Excessive Utilization**	**Member Impact**
Aripiprazole	MH/SUD	X	X - Black box warning, Severe adverse effects, max dose of 15mg/day	X - 12% of claims utilizing greater than 15mg / day	

Atomoxetine	MH/SUD	X	X - Black box warning, Severe adverse effects, max dose of 100mg/day		
Clozapine	MH/SUD	X	X - Black box warning, Severe adverse effects, max dose of 900mg/day		
Eszopiclone	MH/SUD	X	X - Severe adverse effects, max dose of 3mg/day		
Modafinil	MH/SUD	X	X - Serious adverse effects, max dose of 200mg/day		
Paliperidone	MH/SUD	X	X - Black box warning, Severe adverse effects, max dose of 12mg/day		
Accutane	MS	X	X - Black box warning, Severe adverse effects, max dose of 200mg/day	X – 11% of claims utilizing multiple dosages to equal one daily dose that is commercially available	
Clopidogrel	MS	X	X - Black box warning, Severe adverse effects, max dose of 75mg/day		
Everolimus	MS	X	X - Severe adverse effects, max dose of 10mg/day		
Glyxambi	MS	X	X - Severe adverse effects, max dose of 25/5mg/day		
Oxycodone-Acetaminophen	MS	X	X - Black box warning, Severe adverse effects, max dose of 60mg/day oxycodone, 4g/day acetaminophen		

Timolol	MS	X	X - Max dose 1 drop/day		

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Formulary Design & Formulary Tiering –

- To ensure that the processes, strategies, evidentiary standards, and other factors used in formulary design and tiering for MH/SUD drugs, in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used in formulary design and tiering for M/S drugs, we completed a review of the percentage of drugs in the M/S and MH/SUD classifications that are subject to each copay tier. See table below for M/S & MH/SUD results.

MedSurg	Active Tier Status	% of Products
Y	1	52%
Y	2	17%
Y	3	31%

MHSU	Active Tier Status	% of Products
Y	1	74%
Y	2	12%
Y	3	15%

Step Therapy -

- To ensure that the processes, strategies, evidentiary standards, and other factors used to apply prior authorization to MH/SUD drugs, in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply step therapy to M/S drugs, step therapy for prescription drugs is analyzed semi-annually. One analysis we completed was a review of the percentage of drugs in the M/S and MH/SUD classifications that are subject to step therapy. See tables below for results.

M/S ST Requirements	
Total M/S Drugs	8,443
Total M/S Drugs Requiring ST	470

ST Required Rate	5.6%

MH/SUD ST Requirements	
Total MH/SUD Drugs	780
Total MH/SUD Drugs Requiring ST	80
ST Required Rate	10.2%

- We also completed an analysis of the turnaround times for ST requests to be issued either an approval or denial. On average, the turnaround time for M/S & MH/SUD drugs was less than 1 day. . Results are included in the table below. The value differences (0.2 days) is not statistically significant (CI -0.5% ; 0.7%)

- We also completed an analysis of denial rates for requests for Step Therapy in calendar year 2023. Results can be seen in the table below.

Global M/S ST Analysis	
Total ST Requests	1175
Total ST Approvals	1015
Total ST Denials	160
ST Approval Rate	86%
ST Denial Rate	14%
Average Turnaround Time	0.3 Calendar Days

Global MH/SUD ST Analysis

Total ST Requests	352
Total ST Approvals	336
Total ST Denials	16
ST Approval Rate	95%
ST Denial Rate	5%
Average Turnaround Time	0.2 Calendar Days

- We also completed an audit of any Step Therapy changes that took place during 2023 to ensure that the addition or removal of step requirements was supported by the factors, sources, and evidentiary standards written in policy. The summary of changes that took place in 2023 are listed below, directly form the Value Assessment Committee minutes. As can be seen, there was only one addition to the QL listing in 2023 for MH/SUD medications. All recommended QL additions were due to Safety or Anticipated Excessive Utilization.

Drug	Current Status	Recommendation	Classification	Reason	Negative Member Impact	Factors taken into consideration
PANCREAZE	NO ST	ADD ST THROUGH LOW COST ALTERNATIVES	MS	HIGH COST WITH ALT'S AVAILABLE	0	AVAILABILITY OF COST EFFECTIVE ALTERNATIVES, HIGH VARIABILITY IN COST
PERTZYE	NO ST	ADD ST THROUGH LOW COST ALTERNATIVES	MS	HIGH COST WITH ALT'S AVAILABLE	0	AVAILABILITY OF COST EFFECTIVE ALTERNATIVES, HIGH VARIABILITY IN COST
VTAMA	NO ST	ADD ST THROUGH LOW COST ALTERNATIVES	MS	HIGH COST WITH ALT'S AVAILABLE	0	AVAILABILITY OF COST EFFECTIVE ALTERNATIVES, HIGH VARIABILITY IN COST

Quantity Limits -

To ensure that the processes, strategies, evidentiary standards, and other factors used to apply quantity limit to MH/SUD drugs, in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply quantity limit to M/S drugs, QL for prescription drugs is analyzed semi- annually. One analysis we completed was a review of the percentage of drugs in the M/S and MH/SUD classifications that are subject to a quantity limit. See table below for M/S & MH/SUD results.

M/S QL Requirements	
Total M/S Drugs	8,443

Total M/S Drugs Requiring QL	1,819
QL Required Rate	22%

MH/SUD QL Requirements	
Total MH/SUD Drugs	780
Total MH/SUD Drugs Requiring QL	328
QL Required Rate	42%

- Although the percentage of MH/SUD drugs is slightly higher than the M/S drugs, the selection process of drugs for the QL NQTL are still considered comparable to that for M/S drugs. The factors and sources used are the same for both MH/SUD and M/S drugs. One reason for the higher percentage seen in the MH/SUD drugs is due to safety concerns. MH/SUD drugs can have serious side effects, and many have potential for abuse, so quantity limits would help ensure patients are not taking more than what is approved by the FDA. Some examples of these limits, from the FDA labeling information, are below:
    - Atomoxetine: Initial dose: 40 mg ; Target dose: 80 mg ; **Maximum Total Dose: 100 mg**
    - Symbyax: **The safety of doses above 18 mg per 75 mg has not been evaluated in clinical studies.**
    - Olanzapine: **Olanzapine is not indicated for use in doses above 20mg/day**
    - Belsomra: **The maximum recommended dose of Belsomra is 20 mg taken no more than once per night.**
    - Clozapine: **Maximum daily dose: 900 mg**

  Many drugs in the M/S class have similar concerns, but since the M/S category is so broad, it is a much smaller percentage compared to the MH/SUD category. This is mainly due to dilution of the class by products like OTC's, weight-based dosing antibiotics, antivirals, and antifungals, supplements, and compounding supplies. These products, generally, are very safe and require modified dosing based on many different patient specific variables. There are also many more subcategories within the M/S class compared to the MH/SUD class of drugs. Many of those subcategories do not or rarely have Quantity Limit edits (i.e. Allergenic Extracts, Antidotes, Detergents, Diagnostic Agents, etc.). Also, the much smaller percentage of the total medications in the MH/SUD category skews the percentage of applied QL. Lastly, an effort was

recently conducted (early 2024, after this time period being reviewed), to remove any quantity limits that may be construed as 'red-tape' for our members. In total, 37 QL's were removed from MH/SUD medications, bringing the QL required rate down to 37%.

- We also completed an analysis of the turnaround times for QL exception requests to be issued either an approval or denial. On average, the turnaround time for M/S & MH/SUD drugs was less than 1 day. Results are included in the table below. The value differences (0.2 days) is not statistically significant (CI -1.57% ; 1.18%)

- We also completed an analysis of denial rates for requests for quantity limit exceptions in calendar year 2023. Results can be seen in the table below.

Global M/S QL Analysis	
Total QL Requests	470
Total QL Approvals	340
Total QL Denials	130
QL Approval Rate	72%
QL Denial Rate	28%
Average Turnaround Time	0.5 Calendar Days

Global MH/SUD QL Analysis	
Total QL Requests	180
Total QL Approvals	90
Total QL Denials	90
QL Approval Rate	50%
QL Denial Rate	50%
Average Turnaround Time	0.7 Calendar Days

- Since the percentage of Denials is higher in the MH/SUD classification, an audit was performed to ensure parity. 25% of denials were examined to ensure that they were true denials and were issued according to an accurate application of coverage criteria . All of the 23 denials were upheld after audit, and were originally denied due to the following reasons: Requested dosage over FDA recommended 'max' without trial and failure of recommended dosage, Requested dosage can be provided as a single strength tablet/capsule (eg Vyvanse 30 mg requested as 2 capsules once daily when a 60 mg strength is available), & Failure to provide medical literature that supports the increased dosage above standard quantity limit.
- We also completed an audit of any Quantity Limit changes that took place during 2023 to ensure that the addition or removal of quantity limits was supported by the factors, sources, and evidentiary standards written in policy. The summary of changes that took place in 2023 are listed below, directly form the Value Assessment

Committee minutes. As can be seen, there was only one addition to the QL listing in 2023 for MH/SUD medications. All recommended QL additions were due to Safety or Anticipated Excessive Utilization.

Drug	Current Status	Recommendation	Classification	Reason	Negative Member Impact	Factors taken into consideration
FLECTOR PATCH	NO QLL	QLL PER FDA LABEL	MS	Safety/Waste	0	Safety; anticipated excessive utilization
DICLOFENAC PATCH	NO QLL	QLL PER FDA LABEL	MS	Safety/Waste	6	Safety; anticipated excessive utilization
SCOPALAMINE PATCH	NO QLL	QLL PER FDA LABEL	MS	Safety/Waste	87	Safety; anticipated excessive utilization
TRANSDERM-SCOP	NO QLL	QLL PER FDA LABEL	MS	Safety/Waste	0	Safety; anticipated excessive utilization
BREXAFEMME	NO QLL	QLL PER FDA LABEL	MS	Safety/Waste	1	Safety; anticipated excessive utilization
OSTEOPOROSIS WEEKLY/MONTHLY TABS	NO QLL	QLL PER FDA LABEL	MS	Safety/Waste	7	Safety; anticipated excessive utilization
BUPROPION SR	NO QLL	QLL PER FDA LABEL	MHSUD	Safety/Waste	85	Safety; anticipated excessive utilization
BUTALBITAL	NO QLL	QLL PER FDA LABEL	MS	Safety/Waste	44	Safety; anticipated excessive utilization
CELECOXIB TABS	NO QLL	QLL PER FDA LABEL	MS	Safety/Waste	105	Safety; anticipated excessive utilization
CHLORHEXIDINE RINSE	NO QLL	QLL PER FDA LABEL	MS	Safety/Waste	571	Anticipated excessive utilization
CLONIDINE PATCH	NO QLL	QLL PER FDA LABEL	MS	Safety/Waste	2	Safety; anticipated excessive utilization
GABAPENTIN CAP	NO QLL	QLL PER FDA LABEL	MS	Safety/Waste	646	Safety; anticipated excessive utilization
SYMDEKO	NO QLL	QLL PER FDA LABEL	MS	Safety/Waste	1	Safety; anticipated excessive utilization

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Wellfleet's Mental Health and Substance Use Disorder Parity Compliance Program sets the processes and procedures for parity compliance, identifies discrepancies in coverage of services for the treatment of MH/SUD, and ensures appropriate identification and remediation of improper practices internally and with its delegates. Wellfleet assigned each benefit classification and has defined M/S and MH/SUD conditions as required by MHPAEA. Wellfleet's *Identification and Classification of Benefit Policy* is used for all NQTLs comparative analysis documentation. Wellfleet has established methodologies for the identification and testing, including a comparative analysis, of all NQTLs that are imposed on MH/SUD benefits. Wellfleet monitors for and detects improper practices by conducting ongoing and periodic reviews of Wellfleet's policies and procedures as well as the activities of any of Wellfleet's agents or representatives providing benefit management services or performing utilization reviews. Wellfleet has not identified any discrepancies in operational policies between MH/SUD and M/S benefits where the discrepancies present a comparability or stringency problem within the context of the NQTL requirement.

Instances where discrepancies between the process of administering MH/SUD and M/S benefits do not present an NQTL issue include, for example, situations where a discrepancy in process is

more advantageous to the administration of MH/SUD benefits than M/S benefits such as the pro-active behavioral health peer-to-peer review process.

Wellfleet performs delegation oversight review of Formulary activities performed by Express Scripts on a routine basis, no less than quarterly. These reviews are performed by the Delegation Oversight Committee and the Quality Management Committee, as well as Wellfleet's Pharmacy Department. The Committees are comprised of internal individuals

representing departments within Wellfleet, at a minimum, a member of the Clinical, Pharmacy, Provider Relations, Legal, Claims, and Finance Team. From the Delegation Oversight Policy: "Delegation oversight shall be performed by the delegate's business owner(s) or designee(s), working collaboratively with the DOC… If the delegate does not meet expectations as defined in the delegation agreement, or fails to comply with internal standards, legal or regulatory requirements, the delegate will be requested to provide a remediation plan to be approved by the delegate's business owner(s)…In the event of egregious non-compliance, the committee will discuss options up to and including termination of services with the delegate." To date, no instances of not meeting expectations have been observed for Express Scripts. Wellfleet and Express Scripts engage in several regularly cadenced oversight meetings, including bi-weekly clinical meetings, bi-weekly account team meetings, bi-weekly regulatory meetings, and weekly operations meetings.

Wellfleet also has a MHSUD Parity Policy that outlines the Annual NQTL Assessment. Express Scripts is responsible for providing data to help support analyses, if and when needed. Express Scripts has complied with all requested information within 2 weeks of the request. Pertinent to Express Scripts, from the policy:

> "At least annually, Wellfleet and its applicable pharmacy benefit manager(s) and formulary management vendor(s) will complete analyses on the NQTLs that apply to the prescription drug benefit… As part of the analyses, Wellfleet and its applicable pharmacy benefit managers and formulary management vendors will review the following:
>
> A. The formulary design and utilization management requirements, as follows:
>
> 1. Formulary design, including utilization management requirements, should be reviewed at least semi-annually for parity.
>
> i) The formulary is updated on a monthly basis so that coverage accurately reflects new national drug codes of covered drugs. These updates do not require additional parity oversight because the scope of what is covered is not impacted through this process.
>
> ii) Semi-annual formulary changes that result in changes in coverage within drug classes, utilization management requirement changes, new exclusions, and tier changes will be included in the semi-annual review.
>
> 2. The formulary design analysis includes a semi-annual review of percentages of MH/SUD and M/S drugs on each tier and their applicable utilization management requirements for comparability.
>
> i) A current version of the formulary file containing GTC/STC codes is used for the analysis. Using the GTC/STC indicators, drugs are classified as MH/SUD vs. M/S.
>
> ii) All covered MH/SUD and M/S drugs are categorized by tier and each utilization management (prior authorization, quantity limits, and step therapy).
>
> iii) The review will include a determination of the percentage of MH/SUD and M/S drugs in each tier. In addition, the review will determine the percentage of MH/SUD and M/S drugs that require each utilization management requirement.
>
> iv) Further analysis may need to be performed to (i) validate whether there is a rationale in the percentage differences, (ii) review additional samples, or (iii) review the clinical rationale.
>
> B. Prior Authorization and Exception Criteria
>
> 1. Prior authorization criteria will be analyzed at least annually to determine compliance using the following steps:
>
> i) Select random sampling of prior authorization guidelines for MH/SUD and for M/S medications.
>
> ii) Compare factors and evidentiary standards used for the development of each guideline.
>
> iii) Confirm restrictions based on provider specialty are not applied more stringently for MH/SUD drugs as compared to M/S drugs.

iv) Review quantity limit and step therapy exception guidelines to confirm that they do not include language that would result in MH/SUD drug reviews to be more stringent than M/S review.

C. Denial Rates

1. Prior authorization and appeals denial rates should be assessed annually in order to compare denial rates for MH/SUD and M/S drugs.
2. If the sample size is not statistically significant, it may be difficult to assess comparability in operation. However, if denial rates are high for MH/SUD reviews, further analysis on the information considered and the denial reasons on a sampling of reviews should be completed to ensure criteria is objectively followed and the same level of scrutiny is being used for both groups of drugs. This may entail further review of acceptable clinical criteria, such as FDA labeling data, safety data, and relevant clinical trial information."

Since Express Scripts is not making formulary or utilization management decisions for Wellfleet, as our pharmacy benefits are completely custom, oversight is generally around ensuring our intent coded correctly and followed to the letter. In order to do this, we perform several audits of Express Scripts. Upon internal determination and P&T approval of Formulary design changes, intent is submitted to Express Scripts for coding and implementation in their system. Turnaround time from submission to 'go-live' is 14 days. This is monitored upon submission and verified by Express Scripts clinical team upon coding completion. Monthly, the completion of these intent changes is audited by Wellfleet's Clinical Pharmacist. In order to audit, a completed coding file is provided by Express Scripts which is compared with the submitted intent changes for each individual NDC. An example of this is included below. There were no instances of delayed coding or incomplete/incorrect coding in 2023 for both MS and MH/SUD medications. Also, upon internal determination and P&T approval of Formulary UM (Step Therapy and Quantity Limit) requirements, decision-tree mapping is submitted to Express Scripts for coding and implementation in their system. Turnaround time from submission to 'go-live' is 14 days. This is monitored upon submission and verified by Express Scripts clinical team upon coding completion. Monthly, the completion of these intent changes is audited by Wellfleet's Clinical Pharmacist. There were no instances of delayed coding or incomplete/incorrect coding in 2023. In order to audit, a completed coding file is provided by Express Scripts which is compared with the submitted intent changes for each individual NDC. An example of this is included below.

Referenc e NDC	* Trade Name	Updated Formulary Status Y/N	Update d tier	Client Intent/Comments
41163051402	ACETAMINOPHEN	N = Non-Formulary	1	Change to N tier 1
63102020410	ACTIFLOVIT	N = Non-Formulary	1	Change to N tier 1
13709023001	CLEARCANAL EARWAX SOFTENER	N = Non-Formulary	1	Change to N tier 1
50580072697	ZYRTEC OTC	N = Non-Formulary	3	Change to N tier 3
41163049000	VITAMIN B-12	N = Non-Formulary	1	Change to N tier 1
62332061831	CYCLOPHOSPHAMIDE	Y = Formulary	2	Change to Y tier 2
62332061931	CYCLOPHOSPHAMIDE	Y = Formulary	2	Change to Y tier 2

13107026947	DICLOFENAC SODIUM	N = Non-Formulary	1	Change to N tier 1
51672136908	DICLOFENAC SODIUM	N = Non-Formulary	1	Change to N tier 1
00078086225	DUREZOL	N = Non-Formulary	3	Change to N tier 3
41163032908	ALLERGY RELIEF	N = Non-Formulary	1	Change to N tier 1
41163058544	CHILDREN'S ALLERGY RELIEF	N = Non-Formulary	1	Change to N tier 1
72205005230	DOXEPIN HCL	N = Non-Formulary	1	Change to N tier 1
72205005330	DOXEPIN HCL	N = Non-Formulary	1	Change to N tier 1
41163040001	CHEST RUB	N = Non-Formulary	1	Change to N tier 1
81565020501	FENTANYL CITRATE	N = Non-Formulary	1	Change to N tier 1
28105042140	TOLAK	N = Non-Formulary	3	Change to N tier 3
62332075150	FLUOROURACIL	N = Non-Formulary	1	Change to N tier 1
41163049048	ROLLED GAUZE	N = Non-Formulary	1	Change to N tier 1
00113202360	MUCUS ER	N = Non-Formulary	1	Change to N tier 1
24689012301	GUAIFENESIN W/DEXTROMETHORPHAN	N = Non-Formulary	1	Change to N tier 1
58552013304	CHILDREN'S GILTUSS COUGH-CHEST	N = Non-Formulary	1	Change to N tier 1
71399002504	MAXTUSSIN	N = Non-Formulary	1	Change to N tier 1
50090639100	LEVEMIR FLEXPEN	Y = Formulary	2	Change to Y tier 2
50428037201	DRY SKIN THERAPY	N = Non-Formulary	1	Change to N tier 1
75854060203	BALCOLTRA	Y = Formulary	3	Change to Y tier 3
82347000504	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347001004	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347001504	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2

82347002004	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347002504	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347003004	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347003504	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347004004	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347004504	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347005004	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347005504	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347006004	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
61959000101	LIDODERM	N = Non-Formulary	3	Change to N tier 3

70860050181	MAGNESIUM SULFATE	N = Non-Formulary	1	Change to N tier 1
70860050281	MAGNESIUM SULFATE	N = Non-Formulary	1	Change to N tier 1
10939095370	MELATONIN	N = Non-Formulary	1	Change to N tier 1
42023023901	METHYLPREDNISOLONE ACETATE	N = Non-Formulary	1	Change to N tier 1
55150031301	METHYLPREDNISOLONE ACETATE	N = Non-Formulary	1	Change to N tier 1
55150031401	METHYLPREDNISOLONE ACETATE	N = Non-Formulary	1	Change to N tier 1
72485050110	MILRINONE LACTATE	N = Non-Formulary	1	Change to N tier 1
33342018710	NIACIN ER	N = Non-Formulary	1	Change to N tier 1
33342018910	NIACIN ER	N = Non-Formulary	1	Change to N tier 1
41163040263	NON-STICK PAD	N = Non-Formulary	1	Change to N tier 1
62135054190	PAROXETINE HCL	Y = Formulary	1	Change to Y tier 1
62135054290	PAROXETINE HCL	Y = Formulary	1	Change to Y tier 1
62135054390	PAROXETINE HCL	Y = Formulary	1	Change to Y tier 1
62135054490	PAROXETINE HCL	Y = Formulary	1	Change to Y tier 1
73606002001	SYFOVRE	Y = Formulary	2	Change to Y tier 2
11822004130	SINUS CONGESTION & PAIN	N = Non-Formulary	1	Change to N tier 1
41163045830	EARLY RESULT PREGNANCY TEST	N = Non-Formulary	3	Change to N tier 3
71288070005	ROCURONIUM BROMIDE	N = Non-Formulary	1	Change to N tier 1
49035001709	WART REMOVER	N = Non-Formulary	1	Change to N tier 1
65649070141	OSMOPREP	Y = Formulary	3	Change to Y tier 3
72603013901	THIAMINE HCL	N = Non-Formulary	1	Change to N tier 1
00536137801	VITAMIN B COMPLEX	N = Non-Formulary	1	Change to N tier 1
51754010201	ZINC CHLORIDE	N = Non-Formulary	1	Change to N tier 1
41163051402	ACETAMINOPHEN	N = Non-Formulary	1	Change to N tier 1

63102020410	ACTIFLOVIT	N = Non-Formulary	1	Change to N tier 1
13709023001	CLEARCANAL EARWAX SOFTENER	N = Non-Formulary	1	Change to N tier 1
50580072697	ZYRTEC OTC	N = Non-Formulary	3	Change to N tier 3
41163049000	VITAMIN B-12	N = Non-Formulary	1	Change to N tier 1
62332061831	CYCLOPHOSPHAMIDE	Y = Formulary	2	Change to Y tier 2
62332061931	CYCLOPHOSPHAMIDE	Y = Formulary	2	Change to Y tier 2
13107026947	DICLOFENAC SODIUM	N = Non-Formulary	1	Change to N tier 1
51672136908	DICLOFENAC SODIUM	N = Non-Formulary	1	Change to N tier 1

00078086225	DUREZOL	N = Non-Formulary	3	Change to N tier 3
41163032908	ALLERGY RELIEF	N = Non-Formulary	1	Change to N tier 1
41163058544	CHILDREN'S ALLERGY RELIEF	N = Non-Formulary	1	Change to N tier 1
72205005230	DOXEPIN HCL	N = Non-Formulary	1	Change to N tier 1
72205005330	DOXEPIN HCL	N = Non-Formulary	1	Change to N tier 1
41163040001	CHEST RUB	N = Non-Formulary	1	Change to N tier 1
81565020501	FENTANYL CITRATE	N = Non-Formulary	1	Change to N tier 1
28105042140	TOLAK	N = Non-Formulary	3	Change to N tier 3
62332075150	FLUOROURACIL	N = Non-Formulary	1	Change to N tier 1
41163049048	ROLLED GAUZE	N = Non-Formulary	1	Change to N tier 1
00113202360	MUCUS ER	N = Non-Formulary	1	Change to N tier 1
24689012301	GUAIFENESIN W/DEXTROMETHORPHAN	N = Non-Formulary	1	Change to N tier 1
58552013304	CHILDREN'S GILTUSS COUGH-CHEST	N = Non-Formulary	1	Change to N tier 1
71399002504	MAXTUSSIN	N = Non-Formulary	1	Change to N tier 1
50090639100	LEVEMIR FLEXPEN	Y = Formulary	2	Change to Y tier 2
50428037201	DRY SKIN THERAPY	N = Non-Formulary	1	Change to N tier 1
75854060203	BALCOLTRA	Y = Formulary	3	Change to Y tier 3
82347000504	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347001004	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347001504	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347002004	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347002504	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2

82347003004	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347003504	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347004004	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347004504	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347005004	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347005504	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
82347006004	LEVOTHYROXINE SODIUM	N = Non-Formulary	2	Change to N tier 2
61959000101	LIDODERM	N = Non-Formulary	3	Change to N tier 3
70860050181	MAGNESIUM SULFATE	N = Non-Formulary	1	Change to N tier 1
70860050281	MAGNESIUM SULFATE	N = Non-Formulary	1	Change to N tier 1

10939095370	MELATONIN	N = Non-Formulary	1	Change to N tier 1
42023023901	METHYLPREDNISOLONE ACETATE	N = Non-Formulary	1	Change to N tier 1
55150031301	METHYLPREDNISOLONE ACETATE	N = Non-Formulary	1	Change to N tier 1
55150031401	METHYLPREDNISOLONE ACETATE	N = Non-Formulary	1	Change to N tier 1
72485050110	MILRINONE LACTATE	N = Non-Formulary	1	Change to N tier 1
33342018710	NIACIN ER	N = Non-Formulary	1	Change to N tier 1
33342018910	NIACIN ER	N = Non-Formulary	1	Change to N tier 1
41163040263	NON-STICK PAD	N = Non-Formulary	1	Change to N tier 1
62135054190	PAROXETINE HCL	Y = Formulary	1	Change to Y tier 1
62135054290	PAROXETINE HCL	Y = Formulary	1	Change to Y tier 1
62135054390	PAROXETINE HCL	Y = Formulary	1	Change to Y tier 1
62135054490	PAROXETINE HCL	Y = Formulary	1	Change to Y tier 1
73606002001	SYFOVRE	Y = Formulary	2	Change to Y tier 2
11822004130	SINUS CONGESTION & PAIN	N = Non-Formulary	1	Change to N tier 1
41163045830	EARLY RESULT PREGNANCY TEST	N = Non-Formulary	3	Change to N tier 3
71288070005	ROCURONIUM BROMIDE	N = Non-Formulary	1	Change to N tier 1
49035001709	WART REMOVER	N = Non-Formulary	1	Change to N tier 1
65649070141	OSMOPREP	Y = Formulary	3	Change to Y tier 3
72603013901	THIAMINE HCL	N = Non-Formulary	1	Change to N tier 1
00536137801	VITAMIN B COMPLEX	N = Non-Formulary	1	Change to N tier 1
51754010201	ZINC CHLORIDE	N = Non-Formulary	1	Change to N tier 1

NDC11	Label Name	WF ACTIVE FORMULARY INTENT
71104097801	ALTUVIIIO 250 UNIT VIAL	ADD PA
71104097901	ALTUVIIIO 500 UNIT VIAL	ADD PA

71104098101	ALTUVIIIO 1,000 UNIT VIAL	ADD PA
71104098201	ALTUVIIIO 2,000 UNIT VIAL	ADD PA
71104098301	ALTUVIIIO 3,000 UNIT VIAL	ADD PA
71104098401	ALTUVIIIO 4,000 UNIT VIAL	ADD PA
71104098508	ALTUVIIIO 250 UNIT VIAL	ADD PA
71104098608	ALTUVIIIO 500 UNIT VIAL	ADD PA
71104098808	ALTUVIIIO 1,000 UNIT VIAL	ADD PA

71104098908	ALTUVIIIO 2,000 UNIT VIAL	ADD PA
71104099008	ALTUVIIIO 3,000 UNIT VIAL	ADD PA
71104099108	ALTUVIIIO 4,000 UNIT VIAL	ADD PA
71274017060	JOENJA 70 MG TABLET	ADD PA
73179025090	SKYCLARYS 50 MG CAPSULE	ADD PA
00002690230	JAYPIRCA 50 MG TABLET	ADD PA
00002702660	JAYPIRCA 100 MG TABLET	ADD PA
50881000603	ZYNYZ 500 MG/20 ML VIAL	ADD PA
68974020030	FILSPARI 200 MG TABLET	ADD PA
68974040030	FILSPARI 400 MG TABLET	ADD PA
63090066001	DAYBUE 200 MG/ML SOLUTION	ADD PA
10122018001	LAMZEDE 10 MG VIAL	ADD PA
10122018002	LAMZEDE 10 MG VIAL	ADD PA

REQUEST/RULE INTENT *** Each Line represents 1 Rule***	**Rule Type (New or Unlink/Link - PES Only)**	**Rule Category**	
			Wellfleet
Enter PIDs in this Row ==>			**100131**
ALTUVIIIO VIALS REQUIRE A PRIOR AUTHORIZATION	**New**	**MPA**	**Add**
JOENJA TABLETS REQUIRE A PRIOR AUTHORIZATION	**New**	**MPA**	**Add**
SKYCLARYS CAPSULES REQUIRE A PRIOR AUTHORIZATION	**New**	**MPA**	**Add**
JAYPIRCA TABLETS REQUIRE A PRIOR AUTHORIZATION	**New**	**MPA**	**Add**

ZYNYZ VIALS REQUIRE A PRIOR AUTHORIZATION	**New**	**MPA**	**Add**
FILSPARI TABLETS REQUIRE A PRIOR AUTHORIZATION	**New**	**MPA**	**Add**
DAYBUE ORAL SOLUTION REQUIRES A PRIOR AUTHORIZATION	**New**	**MPA**	**Add**
LAMZEDE VIALS REQUIRE A PRIOR AUTHORIZATION	**New**	**MPA**	**Add**

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)). Formulary Design and

Tiering

As written: Wellfleet uses the same formulary tiering decision-making process for M/S and MH/SUD drugs. On a semi-annual basis, drug formulary reviews go through multiple levels of clinical review from the P&T Committee initial evaluation and tiering recommendation to the VAC's final decision. The process is heavily clinically driven using the following factors: availability of cost-effective alternatives, high variability in cost within drugs in a given therapeutic class, and member impact. The sources used in assessing whether each factor has been met include First Databank (FDB), FDA Prescribing Information, professionally recognized treatment guidelines, peer-reviewed medical literature. Moreover, the sources and evidentiary standards used are the same regardless of the drug's MH/SUD or M/S status. An audit was performed to ensure parity, which showed that 100% of sampled M/S and 100% of MH/SUD medications that were non-preferred on the formulary were impacted by the factors and sources equally. An audit & approval of both the Formulary Management Policy and Excluded Formulary Drug Exception Criteria, by both internal Wellfleet employees and the external Pharmacy and Therapeutics Committee, showed no discriminatory language or additional requirements surrounding MH/SUD medications.

In operation: In operation, cost-sharing is applied comparably and no more stringently to MH/SUD drugs relative to M/S drugs. We evaluate stringency in operation by analyzing the distribution of M/S and MH/SUD drugs across formulary tiers to ensure that tiering placements are not disproportionately favorable to M/S drugs. Audits performed indicated that Tier 1 (preferred generics) includes a significantly higher percentage of MH/SUD drugs (74% of all formulary MH/SUD drugs) compared to M/S drugs (52% of all formulary M/S drugs). For Tier 2 (non-preferred generics and preferred brands), a lower percentage of formulary MH/SUD drugs are available (12%) compared to formulary M/S drugs (17%), however, the lower percentage of preferred brand MH/SUD drugs is explained by the disproportionately high rate of availability of MH/SUD generic drugs. Tier 3 (non-preferred brands) includes a significantly lower percentage of MH/SUD drugs (15% of all formulary MH/SUD drugs) compared to the percentage of M/S drugs (31% of all formulary M/S drugs).

Thus, we conclude that the processes, strategies, evidentiary standards, and other factors used to apply Formulary Design and Tiering to MH/SUD drugs, *as written and in operation*, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Formulary Design and Tiering to M/S drugs.

Conclusion: Both as written and in operation the processes, strategies, evidentiary standards, and other factors used to apply Formulary Design and Tiering to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Formulary Design and Tiering to M/S benefits in the prescription drug classification. Therefore, the plan finds that the comparative analysis demonstrates its Formulary Design and Tiering practices are compliant with MHPAEA.

Step Therapy

As Written: The process for creating a step therapy policy for a drug is the same for both M/S and MH/SUD drugs. Providers can request Step Therapy Exceptions by calling Express Scripts Prior Authorization department directly, utilizing CoverMyMeds, Express Path, or SureScripts ePA software, or by completing a standard Prior Authorization Request Form and faxing directly to Express Scripts Prior Authorization department. Submission of medical chart notes / patient drug history may be required for these Step Therapy Exceptions. Wellfleet delegates the act of Utilization Review to Express Scripts (ESI), however the application of the Step Therapy NQTL and the guidelines that drive the decisions by ESI are approved by Wellfleet's internal Pharmacy and Therapeutics Committee (P&T) and Value Assessment Committee (VAC). They are reviewed by the P&T Committee, and ultimately subject to approval by the VAC Committee on an annual basis.

Whether to recommend a step therapy policy for a drug is based on three factors: 1) high variability in cost within drugs in a given therapeutic class, 2) availability of cost- effective alternatives, and 3) member impact. These factors are based on First Databank (FDB), internal market and competitive analysis, therapeutic class total net cost analysis, FDA prescribing information, professionally recognized treatment guidelines, peer-reviewed medical literature, internal claims data, internal market and competitive analysis. These factors, standards and sources are the same regardless of whether a drug is a M/S or MH/SUD drug. An audit was performed to ensure parity, which showed that 100% of sampled M/S and 100% of MH/SUD medications that were indicated to have a step therapy on the formulary were impacted by the factors and sources equally. An audit & approval of the Step Therapy Exception Criteria, by both internal Wellfleet employees and the external Pharmacy and Therapeutics Committee, showed no discriminatory language or additional requirements surrounding MH/SUD medications.

In Operation: In operation, for both M/S and MH/SUD drugs, authorization approval rates are highly similar, and timelines adhere to NCQA and state standards. Finally, the percentage of MH/SUD drugs subject to Step Therapy (10.2%) is slightly higher than the percentage of M/S drugs subject to Step Therapy (5.6%), though a fewer number of MH/SUD drugs require Step Therapy vs M/S drugs and, overall, very few drugs in general require Step Therapy. Moreover, given that MH/SUD drugs have a lower denial rate (5%) compared to the step therapy denial rate for M/S drugs (14%), the data demonstrates that a higher percentage of step therapy requests are approved for MH/SUD drugs.
Therefore, MH/SUD drugs are not being treated more stringently compared to M/S drugs.

Express Scripts conducts routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) testing and is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Corrective action is initiated if a score falls below 95%. As described previously in Step 4, IRR scores for both M/S and MH/SUD classifications were above 98%. These very high scores support that exception criteria is clear & easy to follow, and also that reviews are being conducted consistently for both classifications of prescription drugs.

Thus, we conclude that the processes, strategies, evidentiary standards, and other factors used to apply Step Therapy to MH/SUD drugs, *as written and in operation*, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Step Therapy to M/S drugs.

Conclusion: Wellfleet has determined that step therapy is applied for MH/SUD drugs in a manner that is comparable to and no more stringent than that of M/S drugs, both as written and in operation, based on the information presented above that describes in detail the evidentiary standards, processes, strategies, and factors used to impose step therapy.

Quantity Limits

As written: The process for creating quantity limits for a drug is the same for both M/S and MH/SUD drugs. The P&T Policy & Procedures and Formulary Management Policy are reviewed by Wellfleet's Chief Medical Officer, Director of Clinical Programs, and Clinical Pharmacist, at least annually to ensure there is no verbiage indicating a bias towards any particular subset of drugs. These policies dictate that all decisions should be based off of the clinical merits of the drug, not the classification of drug itself. Quantity limit is imposed on drug products based on the factors presented previously for both classifications of drugs.

Whether to recommend a quantity limit for a drug is based on the drug's safety, anticipated excessive utilization, and member Impact. Whether each factor is met is based upon FDA Prescribing Information, professionally recognized treatment guidelines used to define clinically appropriate standards of care, nationally recognized Compendia - Truven Health Analytics Micromedex DrugDEX (DrugDEX), peer-reviewed medical literature, aggregated data or non-identifiable utilization reports, internal claims data, internal market and competitive analysis. The factors, standards and sources for those standards are the same regardless of whether a drug is a M/S or MH/SUD drug.

Moreover, a request for quantity limits is subject to the same review process for both M/S and MH/SUD drugs, and the same reviewers are used for M/S and MH/SUD drug authorization reviews. Authorizations for both M/S and MHSUD drugs are valid for 365 days from approval. Approvals may be for a shorter duration if the FDA labeling guidelines have strict duration of therapy limits or monitoring requirements after initiation. Other exceptions are for products that have regulatory implications, which will be approved based on the regulatory statute. Appeals turnaround times are the same for all drugs and are dependent on federal and state regulations to ensure compliance. An audit & approval of the Quantity Limit Exception Criteria, by both internal Wellfleet employees and the external Pharmacy and Therapeutics Committee, showed no discriminatory language or additional requirements surrounding MH/SUD medications.

Thus, we conclude that the processes, strategies, evidentiary standards, and other factors used to apply Quantity Limits to MH/SUD drugs, as written, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Quantity Limits to M/S drugs.

In Operation: In operation, the percentage of MH/SUD drugs with approved quantity limits is lower than the percentage of M/S drugs requiring with approved quantity limits. The denial rate for MH/SUD drug requests (50%) is higher than the denial rate for M/S drug requests (28%). However, one reason for the higher percentage seen in the MH/SUD drugs is due to safety concerns. MH/SUD drugs can have serious side effects, and many have potential for abuse, so quantity limits would help ensure patients are not taking more than what is approved by the FDA. Some drugs in the M/S class have similar concerns, but since the M/S category is so broad, it is a much smaller percentage compared to the MH/SUD category. There are also many more subcategories within the M/S class compared to the MH/SUD class of drugs. Many of those subcategories do not or rarely have traditionally have Quantity Limit edits (i.e. Allergenic Extracts, Antidotes, Detergents, Diagnostic Agents, etc.). Wellfleet reviewed the data and associated claims and determined that the application of quantity limits and denial rates were clinically appropriate subject to the factors, sources, and evidentiary standards identified in Step 3.
Moreover, federal parity guidance is clear that metrics alone are not indicative of parity non-compliance so long as the plan has investigated the data, the reasons for the underlying data, and has determined that the same processes, strategies, factors and evidentiary standards were applied to MH/SUD and M/S drugs. Wellfleet has done so here, and has determined MH/SUD and M/S drugs were treated comparably.

Express Scripts conducts routine (occurring no less frequently than annually) Inter-Rater Reliability (IRR) testing and is used to evaluate consistency of clinical decision-making across reviewers and to identify any potential revisions to coverage policies that may be warranted. Corrective action is initiated if a score falls below 95%. As described previously in Step 4, IRR scores for both M/S and MH/SUD classifications were above 98%. These very high scores support that exception criteria is clear & easy to follow, and also that reviews are being conducted consistently for both classifications of prescription drugs.

Thus, we conclude that the processes, strategies, evidentiary standards, and other factors used to apply quantity limits to MH/SUD drugs, in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply quantity limits to M/S drugs.

Conclusion: Both as written and in operation the processes, strategies, evidentiary standards, and other factors used to apply Quantity Limits to MH/SUD benefits are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply Quantity Limits to M/S benefits in the prescription drug classification. Therefore, the plan finds that the comparative analysis demonstrates its Quantity Limits practices are compliant with MHPAEA.

Disclosure Requirements
Identify the process used to comply with the Parity Act Disclosure Requirements for MH benefits, SUD benefits, and M/S benefits. (§15-144(e)(7)):

Describe the process for disclosing the criteria used for a medical necessity determination for MH and SUD benefits to current or potential members, or to a contracting provider, upon request.

Wellfleet delegates medical necessity reviews to Cigna and Express Scripts. Cigna's medical necessity criteria for the treatment of MH/SUD and Coverage Policies are

publicly available on its website at the following link https://static.cigna.com/assets/chcp/resourceLibrary/coveragePolicies/medical_a-z.html. The prescription drug prior authorization criteria are available at the following link: https://wellfleetrx.com/students/formularies/https://wellfleetrx.com/students/formularies/

Cigna Behavioral Health, a division of Evernorth Behavioral Health, employs National Operations Administration (NOA) which is responsible for responding to disclosures for BH medical benefits. The NOA staff will claim the request, determine branding and request type, complete the appropriate letter and send it to the customer or provider via their preferred method of retrieval. For Pharmacy disclosure requests, Express Scripts Prior Authorization Department & Wellfleet's Pharmacy department are responsible for responding to requests for the criteria used for a medical necessity determination for both MH and SUD requests. These are also fully available online at the link provided above. All utilization management requests that are initiated are responded to by Express Scripts Prior Authorization department with the criteria used to determine approval or denial. Wellfleet's Pharmacy Team had no requests for criteria used for medical necessity determinations for MH/SUD medications in 2023.

Cigna and Express Scripts provide medical necessity criteria, or the policies used for appeal decisions upon request.

With regards to any internal review processes used to respond to disclosure requests for medical necessity criteria, the NOA staff will claim the request, determine branding and request type, complete the appropriate letter and send to the customer or provider via the preferred method.

On behalf of Wellfleet, Cigna did not deny any requests for information regarding the criteria used for a medical necessity determination of MH and SUD benefits to current or potential members, or to a contracting provider.

Cigna does not utilize template forms to respond to such requests.

Describe the process for disclosing the reasons for a denial of benefits for MH and SUD.
Wellfleet delegates utilization review for the medical benefit to Cigna. Cigna's medical necessity coverage denial letters cite to the relevant medical necessity criteria or Coverage Policy used in making the coverage determination; include the web address for the relevant criteria or Coverage Policy used in making the determination as referenced above; and include language indicating insureds may request a copy of the relevant medical necessity criteria or Coverage Policy free of charge.
Upon receipt of a written or verbal request from a customer or authorized representative for the clinical criteria used to evaluate the initial adverse determination, the case notes associated with the service/procedure in question are reviewed to identify the guideline/criteria used in the determination decision.

Provider Network Directories Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits
Provider Network Directories are applied to mental health and/or substance use disorder ("MH/SUD") services, and/or providers of such services, and to medical/ surgical ("M/S") services and/or providers of such services, for inpatient and outpatient benefit classifications and is incorporated into plans insured by Cigna Health and Life Insurance Company ("CHLIC"). Evernorth Behavioral Health ("Evernorth" or "EBH," formerly Cigna Behavioral Health), an affiliate of Cigna Health and Life Insurance Company ("CHLIC"), performs all aspects of provider network directories for the MH/SUD Network, while CHLIC performs all aspects of provider network directories for the M/S Network. References to "Cigna" contained herein include Evernorth Behavioral Health unless otherwise noted separately. Wellfleet Insurance Company utilizes Express Scripts INC(ESI) for management of the pharmacy network and pharmacy provider directories, as agreed upon in the vendor contract. Please see the attachments for provider manual references: HM_NET_030_Behavioral_HCP_Directory_Policy MidAtlantic Reference Guide MS and MHSUD Specialities PS_11_Provider_Directory_Content_and_Maintenance_Policy PS_13_Consolidated_Appropriations Act_Medical_Provider_Data_Validation_and_Suppression_Policy Cigna's Provider Directory maintains a network of in-person and virtual providers/facilities that service our membership population. Cigna recruits and maintains a robust network of specialty	Same as M/S.

practitioners and facility types that are separately listed/searchable in the provider network directory (see supporting documentation Specialties for M/S and MH/SUD). Provider Directories are searchable on website PPO: https://hcpdirectory.cigna.com/web/public/consumer/directory/search?consumerCode=HDC001 OAP: https://hcpdirectory.cigna.com/web/public/consumer/directory/search?consumerCode=HDC001 Wellfleet Rx/ESI Pharmacy Network: https://wellfleetrx.com/students/pharmacy-network/ Plan documents: McDaniel College: https://www.studentinsurance.com/Docs/Resources/8032_Final%2023-24%20Mc%20Daniel%20College%20MD%20SHIP%20Cert%207.11.23%20Combined.pdf see page 5- 6. Washington College: https://www.studentinsurance.com/Docs/Resources/8060_FINAL%2023-24%20Washington%20College%20SHIP%20Cert%20Combined%20w%20Notices%2010.9.23%20JR.pdf see page 4-5. St John's College https://www.studentinsurance.com/Docs/Resources/8264_FINAL%2023-24%20St%20John's%20College%20Cert%20combined%20w%20notices%2012.21.23.pdf see page 5- 6.	

(b) For each NQTL listed in Step 1 (a) (e.g., specificity of directory, verification of accuracy, directory navigation assistance, etc.), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies to all services within the classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies (e.g., "Yes for the following services:"). Similarly, response should be explicit whether the "Yes" applies to both M/S and MH/SUD.

Classifications and Sub-Classifications *				
Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient- Office** sub-classification?	Is NQTL applied to **In Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?
Yes both MS and MHSUD (1) All days in a health care facility that meet the medical necessity for an inpatient level of care; (Inpatient Mental Health; Residential Care Treatment Centers) (2) This includes any and all services and supplies utilized during the inpatient days and billed by the facility. Healthcare items or services that meet the definition of Inpatient above, and: (1) are delivered by a network of providers established through direct contract, leased network, or delegation; and (2) are recognized under a plan as providing an in-network benefit.	Yes both MS and MHSUD All covered items or services, including physician administered medications, which are <u>none</u> of the below: (1) An inpatient, emergency, or retail pharmacy item or service (2) An episode of care which took place in a prison or other correctional facility (3) An episode of care which took place in a military treatment facility (4) An episode of care which took place in a custodial care facility This i<u>ncludes</u> any and all services and supplies occurring during the visit and billed by the acility. Any healthcare item, service, or episode, which has ALL the following criteria: 1) It meets the definition for Outpatient 2) The episode is either: a. A general office visit by primary care physician or specialist b. Therapeutic services including Psychotherapy and	Yes both MS and MHSUD Any healthcare item, service, or episode, which has ALL the following criteria: (1) It meets the definition for General Outpatient Classification, and (2) The episode is n o t any of the following: a. A general office visit by primary care physician or specialist b. Therapeutic services including Psychotherapy and applied behavioral analysis in Partial Hospitalization Program and Intensive Outpatient Program c. Family counselling/group therapy d. Telemedicine e. Medication Management	Yes both MS and MHSUD. Any healthcare item, service, or episode on a claim, which occurs in an Emergency Department or ambulance setting. This includes any and all services and/or supplies provided during the visit and billed by the facility or provider	Yes both M/S and MHSUD. Covered medications, drugs, and associated supplies that legally require and are obtained through a medical prescription. However, pharmacies listed in the directory are not broken out into M/S and MHSUD, as all pharmacies carry both classifications of medications. All Prescription Drug claims will process according to their formulary placement and network status (as seen in the Wellfleet Pharmacy Network listing, linked in 1(a)) of the utilized pharmacy.

	applied behavioral analysis in Partial Hospitalization Program and Intensive Outpatient Program c. Family counselling/group therapy d. Telemedicine e. Medication Management 3) It is delivered by a network of providers established through direct contract, leased network, or delegation and are recognized under a plan as providing an in- network benefit.	(3) It is delivered by a network of providers established through direct contract, leased network, or delegation and are recognized under a plan as providing an in- network benefit.		

- Please note response has been adjusted to demonstrate our definitions and classifications for MHSUD.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub- classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Benefit Classification/Sub- classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
In Network Inpatient	**Factors (same for M/S and MHSUD)** 1.) Provider Data- Design & Application 2.) Data Presentation- Design & Application 3.) Data Management- Design & Application 4.) Data Verification & Validation (V&V)- Design & Application 5.) Enrollee Appeals - Design & Application	1.) a) M/S provider directory data resides in Cigna's provider book of record system, Health Care Provider Manager (HCPM); MH/SUD data resides in systems, HCPM and PMRS (Provider Maintenance and Record System). MH/SUD supplemental provider data, such as religion, ethnicity, areas of expertise are sourced from PMRS,

Benefit Classification/Sub- classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
	Factors apply to both M/S and MH/SUD and are weighted equally. Provider Network Directory does not utilize Artificial Intelligence (AI) in design or application. **The following items were considered factors but have since been rejected**: Network participation of a licensed health care provider, facility or ancillary provider. • Onboarding (contracting) • Approval (credentialing) The original submission had included these factors. Onboarding and approval are not factors unto themselves rather a component of the provider data factor.	while standard provider information such as address and phone number are source from HCPM, just as M/S data is. Sourcing MH/SUD data from two systems allows for a greater level of detail to be maintained for MH/SUD providers, allowing customers to have more information necessary to choose a provider that best meets their needs and preferences. b) Provider specialties are sourced from the provider contract. 2.) Online directory data, instructions, and associated regulatory disclosures are presented via web services and browser accessible; Paper directory compiles same source data into PDF format and available on demand 3.) Data is added, updated and deleted in compliance with State law and supported by Cigna's M/S and MH/SUD policies, **PS-11** and **HM_NET-30** respectively. 4.) Data verification and validation is conducted under activities that comply with Consolidated Appropriations Act (CAA) Section 116 supported Cigna Policies **PS-13** and **HM_NET-30.** 5.) An appeals process is supported by Cigna's M/S and MH/SUD policies, **PS-11** and **HM_NET-30** respectively.
In Network Outpatient-Office	See Factors and Sources in the In Network Inpatient classification	See Factors and Sources in the In Network Inpatient classification
In Network Outpatient-All Other	See Factors and Sources in the In Network Inpatient classification	See Factors and Sources in the In Network Inpatient classification
Emergency	See Factors and Sources in the In Network Inpatient classification .	See Factors and Sources in the In Network Inpatient classification

Benefit Classification/Sub- classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
Prescription	1.) Provider Data 2.) Data Management 3.) Data Verification & Validation Factors apply to both M/S and MH/SUD and are weighted equally.	1.) In-network pharmacies are maintained within Express Scripts (ESI) Networks. The intake of pharmacy data includes Store name, address, phone number, provided services, etc. Pharmacy data is transmitted to Wellfleet at least quarterly for updates to our online directory. 2.) Data management is managed by Express Scripts per policy per **CA_0012 Credentialing-Recredentialing Verification**. Express Scripts re-credentials pharmacies every three years to renew their contracts and receive updates. If provider needs to make an update, they would submit a demographic update through ESIPRovider.com. Chains would submit demographic updates through their Retail Account Manager (RAM) or directly to Network Implementation who would validate with RAM. 3.) Notification to Wellfleet of inaccurate information on the Network Listing is forwarded directly to Express Scripts for review. ESI refreshes data and Wellfleet updates Network Listing.

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
In Network Inpatient	1.) Provider Data 2.) Data Presentation 3.) Data Management 4.) Data Verification & Validation 5.) Enrollee Appeals	1.) At a minimum, the following provider data is available: • Name • Address • Types of services provided • Contact Information • Provider Specialty 2.) Cigna User Experience and Digital Product teams ensure that the online directory meets required accessibility standards. Print directory content is reviewed for appropriate reading levels. 3.) Data that is added (new), updated (modified from existing) or deleted (e.g., death, retirement, drop carrier) is managed in the provider book of record, HCPM. a. Provider data is loaded into HCPM after the contracting/credentialing/onboarding process. b. Changes to existing data, i.e., updates or deletion, are captured either through proactive outreach or self-reported by provider c. These changes are sent to the online directory team to refresh the webpages and visual display six days per week excluding holidays, Sundays, and during system maintenance/outages. d. The online directory team sends changes, monthly, to the print directory team. Directory files are then refreshed and ready to distribute on demand. 4.) Data V&V activities follow the CAA Section 116 and Maryland state regulations. a. Cigna validates M/S and MH/SUD provider data accuracy every 90 days.	1. a) Cigna complies with the minimum required provider data set forth in MD Insurance Code 15-112 Subsection (n). These data are sourced during contracting and credentialing following NCQA credentialing accreditation guidelines and other state and federal regulations to validate accuracy. b. **HM_NET_030** 2.) Cigna follows the guidelines set forth in the Web Content Accessibility Guidelines (WCAG) 2.2 effective 10 October 2023. https://www.w3.org/TR/WCAG22/. In doing so, Cigna ensures the content is more accessible to a wider range of customers particularly those with disabilities. 3.) a. Data elements are attested to by the providers in their application and others verified through primary sources in accordance with NCQA credentialing accreditation requirements. **HM_NET_016** and **CR-01** b. Policies **HM_NET-30** (Amending Directory Data on page 3) and **PS-11** (Amending

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		b. Cigna performs random audits of a reasonable sample size of its provider data loads to ensure directory accuracy c. Cigna identifies providers who have not submitted claims with in the last six months to determine whether the provider wishes to remain in the network. 5.) The enrollee may file a complaint, grievance, or appeal with the plan, in the event of a discrepancy between the directory and a provider's current contracting status, or if an enrollee is questioning access or availability of providers in their network.	Provider Directory Data on page 7) set forth that MH/SUD and M/S providers are required to inform Cigna of changes to their demographic information in the Administrative Guidelines referenced in their respective provider agreements. Specifically, M/S Reference Guide and MH/SUD **Evernorth Behavioral Administrative Guidelines** page 13. c. **Policy PS-11** (Provider Directory page 4 Section 5d) explains in detail on how M/S and MH/SUD provider data is updated and refreshed for display. d. Policies **HM_NET-30** and **PS-11** also explain this process. e. Provider Contracts 4) a. Cigna explains its compliance with CAA Section 116 in Policy **PS-13** (Directory Content Validation page 2). b. Cigna explains its compliance with Maryland Insurance Code 15-112 Subsection (p)(3)(i) in Policy **PS-11** (Section B. Quality Assurance page 5) and similarly in Policy **HM_NET-30** (Quality Assurance page 2).

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
			c. Cigna explains its compliance with Per Maryland Insurance Code 15-112 Subsection (p)(3)(ii) within activities undertaken to comply with CAA Section 116 as cited above. 5.) Policies **HM_NET-30** (Complaints and Appeals Involving Directory Discrepancies page 4) and **PS-11** (Complaints and Appeals Involving Directory Discrepancies page 11) set forth Cigna's process
In Network Outpatient-Office	See Factors Evidentiary Standards and Sources in the In Network Inpatient classification	1.) At a minimum, the following provider data is available: • Name • Specialty • If provider is accepting new patients • For each location where the provider participates: Location address and contact information • Gender, if provided by the provider • Languages spoken other than English, if provided by the provider • Additional data is available, e.g., provider's NPI, board certifications, and hospital affiliations, if provided. 2.) Cigna User Experience and Digital Product teams ensure that the online directory meets required accessibility standards. Print directory content is reviewed for appropriate reading levels.	1.) a. Cigna complies with the minimum required provider data set forth in MD Insurance Code 15-112 Subsection (n). These data are sourced during contracting and credentialing following NCQA credentialing accreditation guidelines and other state and federal regulations to validate accuracy. b. **HM_NET_030** 2.) Cigna follows the guidelines set forth in the Web Content Accessibility Guidelines (WCAG) 2.2 effective 10 October 2023. https://www.w3.org/TR/WCAG22/

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		3.) Data that is added (new), updated (modified from existing) or deleted (e.g., death, retirement, drop carrier) is managed in the provider book of record, HCPM. a. Provider data is loaded into HCPM after the contracting/credentialing/onboarding process. b. Changes to existing data, i.e., updates or deletion, are captured either through proactive outreach or self-reported by provider c. These changes are sent to the online directory team to refresh the webpages and visual display six days per week excluding holidays, Sundays, and during system maintenance/outages. d. The online directory team sends changes, monthly, to the print directory team. Directory files are then refreshed and ready to distribute on demand. 4.) Data V&V activities follow the CAA Section 116 and Maryland state regulations. a. Cigna validates M/S and MH/SUD provider data accuracy every 90 days. b. Cigna performs random audits of a reasonable sample size of its provider data loads to ensure directory accuracy c. Cigna identifies providers who have not submitted claims with in the last six months to determine whether the provider wishes to remain in the network. 5.) The enrollee may file a complaint, grievance, or appeal with the plan, in the event of a discrepancy between the directory and a provider's current contracting status, or if an enrollee is questioning access or availability of providers in their network.	In doing so, Cigna ensures the content is more accessible to a wider range of customers particularly those with disabilities. 3.) a. Data elements are attested to by the providers in their application and others verified through primary sources in accordance with NCQA credentialing accreditation requirements. b. Policies **HM_NET-30** (Amending Directory Data on page 3) and **PS-11** (Amending Provider Directory Data on page 7) set forth that MH/SUD and M/S providers are required to inform Cigna of changes to their demographic information in the Administrative Guidelines referenced in their respective provider agreements. Specifically, **MidAtlantic Reference Guide** page 7 & 11 and MH/SUD **Evernorth Behavioral Administrative Guidelines** page 13. c. Policy **PS-11** (Provider Directory page 4 Section 5d) explains in detail on how M/S and MH/SUD provider data is updated and refreshed for display.

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
			d. Policies **HM_NET-30** and **PS-11** also explain this process. 4) a. Cigna explains its compliance with CAA Section 116 in Policy **PS-13** (Directory Content Validation page 2). b. Cigna explains its compliance with Maryland Insurance Code 15-112 Subsection (p)(3)(i) in Policy **PS-11** (Section B. Quality Assurance page 5) and similarly in Policy **HM_NET-30** (Quality Assurance page 2). c. Cigna explains its compliance with Per Maryland Insurance Code 15-112 Subsection (p)(3)(ii) within activities undertaken to comply with CAA Section 116 as cited above. 5.) Policies **HM_NET-30** (Complaints and Appeals Involving Directory Discrepancies page 4) and **PS-11** (Complaints and Appeals Involving Directory Discrepancies page 11) set forth Cigna's process.

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
In Network Outpatient-All Other	See Factors Evidentiary Standards and Sources in the In Network Office classification	See Factors Evidentiary Standards and Sources in the In Network office classification	See Factors Evidentiary Standards and Sources in the In Network Office classification
Emergency	See Factors Evidentiary Standards and Sources in the In Network Inpatient classification	See Factors Evidentiary Standards and Sources in the In Network Inpatient classification	See Factors, Evidentiary Standards and Sources in the In Network Inpatient classification
Prescription	1.) Provider Data 2.) Data Management 3.) Data Verification & Validation	1.) In-network pharmacies are maintained within Express Scripts (ESI) Networks. The intake of pharmacy data includes Store name, address, phone number, provided services, etc. **100%** of this data must be received from the pharmacy in order to be included in the Network & Network Listing. 2.) Data management is managed by Express Scripts per policy per **CA_0012 Credentialing-Recredentialing Verification**. Express Scripts re- credentials pharmacies **every three years** to renew their contracts and receive updates. If provider needs to make an update, they would submit a demographic update through ESIPRovider.com. Chains would submit demographic updates through their Retail Account Manager (RAM) or directly to Network Implementation who would validate with RAM. 3.) Notification to Wellfleet of inaccurate information on the Network Listing is forwarded directly to Express Scripts for review. ESI refreshes data and Wellfleet updates Network Listing. A **single** outreach will trigger this follow up with Express Scripts.	1.) Policy **CA_0012 Credentialing-Recredentialing Verification** 2.) Policy **CA_0012 Credentialing-Recredentialing Verification** 3.) Notice from provider via email or phone

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

1.) Provider Data-Cigna/Evernorth maintain separate, but aligned, policies related to Provider Directory Requirements; **PS-11** Provider Directory Content and Maintenance addresses M/S providers while **HM- NET-030** Behavioral Health Care Provider Directory Content and Maintenance addresses MH/SUD providers. Policies are separate due to different departments and systems used to maintain M/S vs. MH/SUD data. The factors that define this NQTL are supported by the operational processes cited in these policies. These processes are nearly identical between M/S and MH/SUD; and an explanation will be provided where they are not. Most notably, Cigna has constructed and maintains a singular enrollee facing Provider Directory that displays M/S, MH/SUD providers and pharmacies in one location. The factors, sources and evidentiary standards are applied the same, and thus are comparable and no more stringently applied.

New M/S and MH/SUD providers are entered in the online Provider Directory upon contract execution and credentialing approval. Demographic and contract information for credentialed providers are loaded into the source systems. Data elements include those attested to by the provider in their application. Others are verified through primary sources in accordance with Cigna's Credentialing Policy **CR-01**. Many of these data elements are reflected in the Provider Directory, such as name, contact information including phone number and address, current degree/licensure, gender, provider specialties and Board Certification (if applicable), languages available to customers and attending/admitting privileges/institutional affiliations. The majority of M/S and MH/SUD provider data are in the same book of record source, HCPM, utilizing the same data loading and management processes. However, there are a few MH/SUD data elements that are sourced from another system, PMRS. PMRS contains data elements not available in HCPM and thus provides customers with additional information necessary to choose a MH/SUD provider that best meets their needs, such as areas of expertise referred to as "additional specialties" in the provider directory (i.e. Anxiety, Anger Management).

2.) Data Presentation- Once loaded into the sources systems noted above, data is sent to the Online Directory team. This team is responsible for compiling M/S and MH/SUD data into webpages for online display. The team follows the industry standard user accessibility guidelines recommended by the World Wide Web Consortium's (W3C) Web Content Accessibility Guidelines (WCAG) 2.2 (https://www.w3.org/TR/WCAG22/) . Per W3C, "WCAG covers a wide range of recommendations for making Web content more accessible. Following these guidelines will make content more accessible to a wider range of people with disabilities, including accommodations for blindness and low vision, deafness and hearing loss, limited movement, speech disabilities, photosensitivity, and combinations of these, and some accommodation for learning disabilities and cognitive limitations; but will not address every user need for people with these disabilities. These guidelines address accessibility of web content on desktops, laptops, tablets, and mobile devices. Following these guidelines will also often make Web content more usable to users in general." The Print Directory team receives M/S and MH/SUD provider data directly from the Online Team. The Print team compiles the data into document files in the open standard Adobe PDF format. The content is reviewed to be at an appropriate reading level. The print directories are typically distributed to customers during enrollment, but they are also available as needed on demand.

3.) Data Management- The online Provider Directory is updated six days per week, and the print Provider Directory is updated on demand. Providers are obligated to submit changes to their demographic information as outlined in the administrative guidelines incorporated into their agreement by reference. Additionally, providers are notified through various provider communications, including newsletters. Providers can submit changes to demographic data by via email, through the Health Care Professional website, phone outreach to their local Provider Experience team, Customer Service or fax. Cigna/Evernorth does not dictate which specialties are displayed or searchable in the Provider

Directory. Cigna displays providers based on the specialty(ies) represented in the provider agreement. The Provider Directory functions as follows: a) all specialties (M/S and MH/SUD) are searchable by Specialty. All Providers are searchable by name. For MH/SUD, subspecialities are searchable by conditions or diagnosis (i.e. Anxiety). Provider types included in the Provider Directory are included in the Specialties excel spreadsheet included in this submission. As data changes, i.e. new, updated, deleted, are received either proactively from the provider or discovered through Cigna audits, updates are made in the provider book of record systems. Data management processes for M/S and MH/SUD are outlined in Cigna's policies **PS-11** and **HM_NET-30**, respectively. Since updates are managed in the source systems, the flow of data from the system to the online or print directory uses the same process as explained in the paragraph above; hence strengthening data integrity. Again, there are no differences in how Cigna handles amending Cigna's provider data.

4.) Data Verification and Validation- Both M/S and MH/SUD provider information is subject to quality assurance audits and validation prior to information before and after inclusion in the Provider Directory. To ensure quality, Cigna performs audits in compliance with Consolidated Appropriations Act Section 116 (cited in Policy **PS-13**) and Maryland state regulations (cited in M/S Policy **PS-11** and MH_SUD Policy **HM_NET-30**. In compliance with the Consolidated Appropriations Act, Cigna verifies, at minimum, the provider's name, address, telephone number and digital contact information at least every 90 days. However, the Plan recognizes that customers have many clinical needs and preferences when seeking MH/SUD services. Unlike M/S specialties that may be clearly identified by their licensure (i.e. cardiology, endocrinology), Mental Health providers may be more generically licensed such as Clinical Social Workers or Professional Counselors. In an effort to ensure customers receive the care they need from an appropriate provider, MH/SUD providers are asked to provide additional information, such as areas of expertise/experience "additional specialties" (i.e. Post Traumatic Stress Disorder, ADD/ADHD). While this information may be more than what M/S providers are asked to provide/validate, it ensures that customers are referred to providers that can meet their needs, enhancing access to care and also ensures providers don't receive referrals for customers that they are unable to assist, eliminating administrative burden of responding back to customers. Furthermore, in compliance with Maryland Insurance Code 15-112 Subsection (p)(3)(i-ii), Cigna performs audits on the accuracy of randomly selected provider directory data and verifies if any changes regarding in-network status are required for providers who have not submitted a claim in the previous six months. For all these activities, information is verified through direct outreach to the provider or via other external source systems (i.e. CAQH, State Licensing Board). Cigna/Evernorth updates new or inaccurate provider information and may suppress providers from showing up in the Provider Directory that do not respond to verification after (4) four 90-day cycles. If updated provider information is received for validation, the provider information is no longer suppressed.

5.) Enrollee Appeals- In the event Cigna/Evernorth receives a complaint/appeal/grievance regarding the Provider Directory and a provider's current contracting status, the complaint/appeal/grievance will be investigated and handled according to Cigna/Evernorth's policies M/S **PS-11** and MH/SUD **HM_NET-30**. Additionally, both providers and customers may access the Cigna/Evernorth telephone number displayed in the Provider Directory to report a potential Provider Directory inaccuracy or click on a "feedback" link in the online Provider Directory for a form they can use to identify errors. This feedback is validated with the provider and information is updated, as necessary. Lastly, Cigna/Evernorth may initiate changes to provider data because of credentialing, re-credentialing, audits or contracting changes. Cigna removes providers from the Provider Directory when notified of a change in contractual/network status including retirement, death or termination.

Wellfleet concludes that the factors, sources and evidentiary standards are applied the same for both M/S and MH/SUD, and thus are comparable and no more stringently applied, as written.

Express Scripts provides the source data and ongoing management of the pharmacy network available to Wellfleet customers, as agreed upon in our vendor contract. There is no distinction within the Pharmacy Network Listing, online or print, between M/S and MH/SUD related prescriptions, nor are pharmacies generally classified as M/S or MH/SUD. The Wellfleet pharmacy information is housed with the Prescription Drug formulary, Prior Authorization listings, and other pertinent Prescription Drug information and serves as a convenient single point of access for its members. The factors, sources, and evidentiary standards utilized to support the pharmacy network listing are applied in a comparable manner and no more stringently for MHSUD as compared to M/S, as written.

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Cigna/Evernorth's Provider Directory outreach and validation efforts resulted in the verification of 25,413 M/S and 6,937 MH/SUD provider records. Updates requested took on average .2 days to complete for M/S providers and 5 days to complete for MH/SUD providers, as outlined in the table below.

	M/S	**MH/SUD**
# of total Providers audited/ outreached	25,413	34,339
# of Providers information validated (non-unique)	25,413	6,937
# of Providers information update needed (non- unique)	406	2,010
Average TAT for updates	.2 Days	5 days

Cigna/Evernorth proactively validates Provider Directory information through outreach/validations efforts to ensure provider data accuracy. In 2023, there were 6,937 instances where a MH/SUD provider's information was confirmed accurate and 2,010 where provider information required updates. In 2023, 25,407 M/S providers were confirmed accurate, and 406 providers required updates. Although results indicate a higher rate of updates being required for MH/SUD v. M/S data, additional data elements beyond the 5 required by the Consolidated Appropriations (Name, Address, Phone Number, Email Address, Website) are verified for MH/SUD data including: NPI, specialties/areas of expertise, Board Certifications, Hospital Affiliations, and Languages spoken. As a result, the volume of updates and turnaround times for those updates may be larger for MH/SUD compared to M/S. However, the additional verifications aid in data accuracy to ensure that enrollees are relying on up-to-date information when making their care decisions.

The 14,875 M/S specialties , 5294 subspecialties, and 1468 facility types vs 2724 MH/SUD specialties, 7695 subspecialties and 381 facility types listed in the directory and supplied in the Data Supplement 5 Provider Network Directory PPO. Note that on the M/S side encompasses a larger volume of specialties(907) than that of the MHSUD (306). However, Wellfleet's number of covered lives being <1 for each M/S and MH/SUD provider type which demonstrates that the factors, sources and evidentiary standards as noted above are applied the same for both M/S and MH/SUD, and thus are comparable and no more stringently applied.

For enrollees having trouble locating an available MH/SUD provider/appointment, plan offers appointment search services. A Plan representative will collect the enrollee's provider/appointment preferences (i.e. provider gender, time of appointment, etc.) and conduct a search of in-network providers meeting the enrollee's criteria. Once a provider(s) is identified Plan staff will contact the enrollee with the pertinent information so they can schedule the appointment at their convenience

Wellfleet/ESI pharmacy information displays on the Network Listing without distinguishing between M/S and MH/SUD. Pharmacies are never designated as 'MH/SUD' or 'M/S' only. Therefore, there is no comparative analysis to provide.

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

For both its M/S and MH/SUD provider directories, Cigna & Evernorth have aligned policies to establish and monitor appropriate Provider Directory display, search and navigation, management, and appeals process for M/S (Cigna) and MH/SUD(Evernorth). Cigna and Evernorth continuously maintain the Provider Directory and update files. Policies are reviewed on at least an annual basis to ensure compliance with parity and all state/federal regulations. Additionally, annual review ensures appropriate oversight and alignment of Evernorth's policies and procedures to Cigna's.

Alignment includes:

(1) Provider Data: M/S and MH/SUD have identical factors for providers to meet prior to being displayed in directories (executed contracted, approved credentialing)

(2) Data Presentation: Integrated Provider Directory for enrollee ease of use.

(3) Data Management: M/S and MH/SUD follow identical processes for both on-line and in-print directory maintenance

(4) Data Verification & Validation: processes for maintaining and auditing data;

- MH/SUD and M/S are evaluated on a similar cadence (every 90 days) and using similar mechanisms for validation.
    - MH/SUD data is further evaluated for accuracy via a direct outreach to MH/SUD providers to validate with them directly, all demographic data elements displayed in the Provider Directory.
    - Results of directory outreach/audit are reviewed together. Where appropriate, corrective actions are aligned to ensure parity between M/S and MH/SUD results and action plans.
- For both MH/SUD and M/S providers, they are subject to suppression from the directory if they are non-responsive to all outreach/validate attempts made in a calendar year.

(5) Enrollee Appeals: M/S and MH/SUD follow the same process for appeals/compliant in adherence with state/federal mandate

Wellfleet and Wellfleet RX receive monthly termination files from the network and Wellfleet sends provider notices to members when their provider leaves the network.

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

Cigna maintains a robust MH/SUD and M/S network of in person and virtual providers, which are similarly displayed and searchable in a single, combined Provider Directory for enrollee use. Processes to bring a MH/SUD and M/S provider into the network, and available for Provider Directory display are aligned both in writing and operation.
Furthermore, MH/SUD and M/S teams use the same processes to manage data (add, update, delete) and nearly identify validation protocol.

As stated in the Steps above, while the majority of MH/SUD and M/S provider data are stored together in a shared system, MH/SUD does use a second system for a few data elements. Also, as part of its CAA Section 116 auditing process, MH/SUD validates more data elements than M/S. In both instances where MH/SUD processes differ slightly from M/S, an explanation has been provided. Cigna/Evernorth does not interpret the processes applied to MH/SUD to be more restrictive than those to M/S.
Provider data accuracy monitoring is conducted on an ongoing basis and opportunities for improvement or efficiencies in the process are regularly sought out. For example, M/S Provider Directory data is currently able to be verified via First Level (external sources, automated logic). MH/SUD data is currently being piloted through a similar process to determine if this is a successful form of data validation for MH/SUD providers as well. If successful, this would help to further improve MH/SUD data accuracy while lessening the burden on providers of validating their data every 90 days and improving data update turnaround times.

Disclosure Requirements

Identify the process used to comply with the Parity Act Disclosure Requirements for MH benefits, SUD benefits, and M/S benefits. (§15-144(e)(7)):

Describe the process for disclosing the criteria used for a medical necessity determination for MH and SUD benefits to current or potential members, or to a contracting provider, upon request.

Wellfleet delegates medical necessity reviews to Cigna and Express Scripts. Cigna's medical necessity criteria for the treatment of MH/SUD and Coverage Policies are publicly available on its website at the following link https://static.cigna.com/assets/chcp/resourceLibrary/coveragePolicies/medical_a-z.html. The prescription drug prior authorization criteria are available at the following link: https://wellfleetrx.com/students/formularies/https://wellfleetrx.com/students/formularies/

Cigna Behavioral Health, a division of Evernorth Behavioral Health, employs National Operations Administration (NOA) which is responsible for responding to disclosures. The NOA staff will claim the request, determine branding and request type, complete the appropriate letter and send it to the customer or provider via their preferred method of retrieval.

Cigna and Express Scripts provide medical necessity criteria, or the policies used for appeal decisions upon request.

With regards to any internal review processes used to respond to disclosure requests for medical necessity criteria, the NOA staff will claim the request, determine branding and request type, complete the appropriate letter and send to the customer or provider via the preferred method.

On behalf of Wellfleet, Cigna did not deny any requests for information regarding the criteria used for a medical necessity determination of MH and SUD benefits to current or potential members, or to a contracting provider.

Cigna does not utilize template forms to respond to such requests.

Describe the process for disclosing the reasons for a denial of benefits for MH and SUD.

Wellfleet delegates utilization review for the medical benefit to Cigna. Cigna's medical necessity coverage denial letters cite to the relevant medical necessity criteria or Coverage Policy used in making the coverage determination; include the web address for the relevant criteria or Coverage Policy used in making the determination as referenced above; and include language indicating insureds may request a copy of the relevant medical necessity criteria or Coverage Policy free of charge.

Upon receipt of a written or verbal request from a customer or authorized representative for the clinical criteria used to evaluate the initial adverse determination, the case notes associated with the service/procedure in question are reviewed to identify the guideline/criteria used in the determination decision.

A copy of the same version of the guideline is obtained from the Coverage Policy Unit (CPU) website. If a copy of the same version of the guideline is not available, a copy of the "current" guideline (i.e. MCG) is provided with the proper "editorial style reference" documented. (Note; Copies and/or excerpts of external guidelines are unaltered and properly cited.)

The customer/authorized representative may also be referred to:

- Provider.evernorth.com
- Review coverage policies to view the Cigna medical necessity guidelines utilized in making the determination. Guidelines include: MCG, ASAM, LOCUS and CALOCUS-CASII for state specifics only, CareAllies customer/authorized representative may also be referred to Care.Allies.com to view the medical necessity guidelines utilized in making the determination.

A copy of the guideline/criteria is mailed, faxed, or emailed to the requestor.

Copies of guidelines and/or criteria used in medical necessity type decisions will be made available, free of charge, for customers, authorized representatives, government agency and/or providers upon request. This can include guidelines/criteria used to determine a service/procedure as experimental, investigational, or unproven. Copies of the guidelines/criteria are available online or can be faxed or mailed within 10 business days from receipt of the request, unless the requestor states a definitive timeframe is required due to urgency of care. For government agencies, the guideline can be released per the guidelines owner policy. (A non-disclosure agreement may be required between the agency and the guideline owner).

Cigna has not received any disclosure requests nor denied requests from a participant beneficiary, provider, or authorized representative of the beneficiary or participant residing in Maryland. Cigna has not failed to provide a response within 30 days of the request.

Wellfleet delegates utilization review for the pharmacy benefit to Express Scripts. Express Scripts medical necessity coverage denial letters cite to the relevant medical necessity criteria used in making the coverage determination; include the web address for the relevant criteria used in making the determination as referenced above; and include language indicating insureds may request a copy of the relevant medical necessity criteria or Coverage Policy free of charge.

Upon receipt of a written or verbal request from a member or authorized representative for the clinical criteria used to evaluate the initial adverse determination, the case notes associated with the medication in question are reviewed to identify the guideline/criteria used in the determination decision. A copy of the guideline/criteria is mailed, faxed, or emailed to the requestor.

Express Scripts has not received any disclosure requests nor denied requests from a participant beneficiary, provider, or authorized representative of the beneficiary or participant residing in Maryland. Express Scripts has not failed to provide a response within 30 days of the request.

Describe the process for disclosing plan documents that contain information about the processes, strategies, evidentiary standards and any other factors used to apply a NQTL for MH/SUD and M/S benefits in connection with a member's request for group plan information and for purposes of filing an internal coverage or grievance matter and appeals.

Wellfleet discloses plan documents, Maryland NQTL summary form, along with a NQTL disclosure document which outlines the NQTL processes, strategies, evidentiary standards and any other factors on its website https://wellfleetstudent.com/ and are also available upon request. This document sets forth the applicable NQTLs, information regarding applicability, as well as analysis to support the rationale that the NQTL is being applied to both medical/surgical and MH/SUD benefits comparably and no more stringently to MH/SUD benefits than medical/surgical benefits.

As set forth above, and in compliance with 45 C.F.R. 146.136, members, providers, or authorized representatives, may access, free of charge, any plan materials related to a coverage determination. Moreover, as noted above, plan documents and medical necessity criteria are also publicly available.

Cigna and Express Scripts have not received any disclosure requests from a participant beneficiary, provider, or authorized representative of the beneficiary or participant residing in Maryland.

1. Provider (Including Facility) Reimbursement

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits
Provider (including Facility) Reimbursement NQTL applies to benefits in classifications in the IN-Network and Out of Network benefit level. Evernorth Behavioral Health ("Evernorth" or "EBH," formerly Cigna Behavioral Health), an affiliate of Cigna Health and Life Insurance Company ("CHLIC"), performs all aspects of the In Network provider network and facility reimbursement for the MH/SUD Network, while CHLIC performs all aspects of the In Network provider network and facility reimbursement for the M/S Network. References to "Cigna" contained herein include Evernorth Behavioral Health unless otherwise noted separately. Medical Benefit Payments for In-Network Providers & Facilities and Out-of-Network Providers and facilities. The following is included in our plan documents: The Certificate provides benefits based on the type of health care provider You and Your Covered Dependent selects. The Certificate provides access to both In-Network Providers & facilities and Out-of-Network Providers and facilities. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers and facilities versus Out-of-Network Providers and facilities, as shown in the MD SHIP Schedule of Benefits. The Usual and Customary Covered Medical Expense amount paid to an Out-of-Network Provider & Facility will not be less than the Negotiated Charge paid to a similarly licensed In-Network Provider & Facility for the same health care service in the same geographic region. Usual and Customary Charge is the amount of an Out-of-Network provider or facility charges that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage. The Usual and Customary Charge depends on the	Provider (including Facility) Reimbursement NQTL applies to benefits in classifications in the IN-Network and Out of Network benefit level. Evernorth Behavioral Health ("Evernorth" or "EBH," formerly Cigna Behavioral Health), an affiliate of Cigna Health and Life Insurance Company ("CHLIC"), performs all aspects of the In Network provider network and facility reimbursement for the MH/SUD Network, while CHLIC performs all aspects of the In Network provider network and facility reimbursement for the M/S Network. References to "Cigna" contained herein include Evernorth Behavioral Health unless otherwise noted separately. Medical Benefit Payments for In-Network Providers & Facilities and Out-of-Network Providers and facilities. The following is included in our plan documents: The Certificate provides benefits based on the type of health care provider You and Your Covered Dependent selects. The Certificate provides access to both In-Network Providers & facilities and Out-of-Network Providers and facilities. Different benefits may be payable for Covered Medical Expenses rendered by In-Network Providers and facilities versus Out-of-Network Providers and facilities, as shown in the MD SHIP Schedule of Benefits. The Usual and Customary Covered Medical Expense amount paid to an Out-of-Network Provider & Facility will not be less than the Negotiated Charge paid to a similarly licensed In-Network Provider & Facility for the same health care service in the same geographic region. Usual and Customary Charge is the amount of an Out-of-Network provider or facility charges that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage. The Usual and Customary Charge depends on the geographic area where You receive the service or supply. The Usual and Customary Covered Medical Expense amount paid to an Out-of-Network Provider or facility will not be less than the Negotiated Charge paid to a similarly licensed In-Network Provider or facility for the same health care service in the same geographic region.

geographic area where You receive the service or supply. The Usual and Customary Covered Medical Expense amount paid to an Out-of-Network Provider or facility will not be less than the Negotiated Charge paid to a similarly licensed In-Network Provider or facility for the same health care service in the same geographic region. The table below shows the method for calculating the Usual and Customary Charge for specific services or supplies:

Service or Supply	Usual and Customary Charge
Professional services and other services or supplies not mentioned below	The Reasonable amount rate
Services of hospitals and other facilities	The Reasonable amount rate

Geographic area is normally based on the first 3 digits of the U.S. Postal Service zip codes.

For IN-Network, for Hospitals regulated by the Health Services Cost Review Commission (HSCRC), benefits may not exceed the rate set by the HSCRC as noted throughout our plan documents on pages listed below.

Wellfleet reimburses Out-Of-Network providers & facilities through Reasonable and Customary (R&C) methodology dependent upon CPT/HCPCS claims. IF revenue code on claim, it is paid only at benefit level on the plan.

Plan Documents:

McDaniel College: https://www.studentinsurance.com/Docs/Resources/8032_Final%2023-24%20Mc%20Daniel%20College%20MD%20SHIP%20Cert%207.11.23%20Combined.pdf see page 5 and 35-36
Washington College: https://www.studentinsurance.com/Docs/Resources/8060_FINAL%2023-24%20Washington%20College%20SHIP%20Cert%20Combined%20w%20Notices%2010.9.23%20JR.pdf
see pages 5-6 and 33- 34 St
John's College
https://www.studentinsurance.com/Docs/Resources/8264_FINAL%2023-24%20St%20John's%20College%20Cert%20combined%20w%20notices%2012.21.23.pdf see page 5 -6 and 37 - 38

The table below shows the method for calculating the Usual and Customary Charge for specific services or supplies:

Service or Supply	Usual and Customary Charge
Professional services and other services or supplies not mentioned below	The Reasonable amount rate
Services of hospitals and other facilities	The Reasonable amount rate

Geographic area is normally based on the first 3 digits of the U.S. Postal Service zip codes.
For IN-Network, for Hospitals regulated by the Health Services Cost Review Commission (HSCRC), benefits may not exceed the rate set by the HSCRC as noted throughout our plan documents on pages listed below.
Wellfleet reimburses Out-Of-Network providers & facilities through Reasonable and Customary (R&C) methodology. IF revenue code on claim, it is paid only at benefit level on the plan.

Plan Documents:
McDaniel College: https://www.studentinsurance.com/Docs/Resources/8032_Final%2023-24%20Mc%20Daniel%20College%20MD%20SHIP%20Cert%207.11.23%20Combined.pdf see page 5 and 35-36
Washington College: https://www.studentinsurance.com/Docs/Resources/8060_FINAL%2023-24%20Washington%20College%20SHIP%20Cert%20Combined%20w%20Notices%2010.9.23%20JR.pdf
see pages 5 -6 and 33- 34 St
John's College
https://www.studentinsurance.com/Docs/Resources/8264_FINAL%2023-24%20St%20John's%20College%20Cert%20combined%20w%20notices%2012.21.23.pdf see page 5-6 and 37 - 38

(b) For each NQTL listed in Step 1 (a), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub- classification in the table below. Indicate whether the NQTL applies to all services within the classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies (e.g., "Yes for the following services:"). Similarly, response should be explicit whether the "Yes" applies to both M/S and MH/SUD.

Classifications and Sub-Classifications							
Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **Out of Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient-Office** sub-classification?	Is NQTL applied to **Out of Network Outpatient- Office** sub-classification?	Is NQTL applied to **In Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Out of Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?
Always Yes for Facility	Always Yes for Facility	Always Yes for Practitioner	Always Yes for Practitioner	Always Yes for Facility and Practitioner	Always Yes for Practitioner and Facility	Always Yes for Facility	Always No

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub- classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Benefit Classification/Sub- classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
In Network Inpatient (Facility)	1. State and Federal Law Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 3. Medicare Baseline Rates 4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty; i.e. Network Adequacy) 5. Geographic Market 6. Scope and Type of services 7. Medical Cost Budget 8. Utilization 9. Competitive insights, when available **Factors Considered but rejected:** There are no rejected factors. **Weight of Factors:** Each factor holds the same weight.	1. HSCRC: State of Maryland Where State/Federal law is not applicable, the following factors are also considered: For the following more details are available from Cigna upon request titled In-Network Reimbursement Methodology 2. M/S and MH/SUD facilities are based upon CMS methodology. 3. Medicare Geographical Practice Cost Index ("GPCI") 4. Internal analysis of market dynamics/network adequacy, including review of supply of facilities from state licensing sites and competitor directory review and demand-based utilization trends. 5. Medicare Geographical Practice Cost Index ("GPCI"), i.e. market rate and payment type for provider type and/or specialty 6. Type of Service are identified by CPT, HCPC and Revenue codes and Internal Cigna Data 7. External data sources include Payer self-reported rates as reported and required by Transparency laws and payment information from claims adjudicated with coordination of benefits (COB). Internal data sources: Affordability goals based on competitive client pricing. 8. Internal Cigna Claims Data 9. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code

Benefit Classification/Sub- classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
		Chapter 100 Subchapter B Section 9819); where available
In Network Inpatient (Practitioner)	Not Applicable	Not Applicable
Out of Network Inpatient - Facility	1. Provider Type(i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 2. Services and/or Procedures Performed 3. Geographical location 4. Industry Benchmark Rates/Methodology **Factors Considered but rejected:** There are no rejected factors. **Weight of Factors:** Each factor holds the same weight.	1. Claims data (i.e., taxonomy, provider specialty and type codes) 2. Percentage of Medicare fee schedule; Revenue Codes will have claim paid without reasonable and customary cutback based upon the out of network level of benefit in the plan. 3. Pricing solutions which include FAIR Health database for reasonable & customary where a CPT/HCPCS is noted, continuous discount agreements, provider negotiations, supplemental networks and ERS (Established Reimbursement Rates). Revenue Codes will have claim paid without reasonable and customary cutback based upon the out of network level of benefit in the plan 4. Pricing solutions which include reasonable & customary where a CPT/HCPS s noted, continuous discount agreements, provider negotiations, supplemental networks and ERS (Established Reimbursement Rates). Revenue Codes will have claim paid without reasonable and customary cutback based upon the out of network level of benefit in the plan
Out-of-Network Inpatient – Provider	Not applicable	Not applicable

Benefit Classification/Sub- classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
In Network Outpatient-Office (Practitioner)	Where State/Federal law is not applicable, the following factors are also considered: 1. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 2. Medicare Baseline Rates 3. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty; i.e. Network Adequacy) 4. Geographic Market 5. Scope and Type of services 6. Medical Cost Budget 7. Utilization 8. Competitive insights, when available **Factors Considered but rejected:** There are no rejected factors. **Weight of Factors:** Each factor holds the same weight	Where State/Federal law is not applicable, the following factors are also considered: For the following more details are available in the attachment titled In-Network Reimbursement Methodology 1. M/S and MH/SUD providers are classified based on provider type/level of training based upon CMS methodology (i.e., hospital, clinic and practitioner) and/or specialty (e.g. physician practitioners v. non-physician practitioner v. facility. 2. CMS Medicare Resources Based Relative Value" scale ("RBRVS") system. 3. Internal analysis of market dynamics and network need/network adequacy including review of supply of providers from state licensing sites and competitor directory review and demand-based utilization trends. 4. Medicare Geographical Practice Cost Index ("GPCI"), i.e. market rate and payment type for provider type and/or specialty 5. Type of Service are identified by CPT and HCPC codes 6. Internal determination 7. Internal Cigna Data 8. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available

Benefit Classification/Sub- classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
Out of Network Outpatient- Office (Practitioner)	1. Provider Type(i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 2.Services and/or Procedures Performed 3.Geographical location 4.Industry Benchmark Rates/Methodology **Factors Considered but rejected:** There are no rejected factors. **Weight of Factors:** Each factor holds the same weight.	1. Claims data (i.e., taxonomy, provider specialty and type codes) 2. CPT/HCPCS coding set by Centers for Medicare and Medicaid Services, National Correct Coding Initiative & American Medical Associations 3. Pricing solutions which include FAIR Health database for reasonable & customary, continuous discount agreements, provider negotiations, supplemental networks and ERS (Established Reimbursement Rates) 4. Pricing solutions which include FAIR Health database for reasonable & customary, continuous discount agreements, provider negotiations, supplemental networks and ERS (Established Reimbursement Rates)
In Network Outpatient-All Other (Facility and Practitioner)	1. State and Federal Law Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 3. Medicare Baseline Rates 4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty; i.e. Network Adequacy) 5. Geographic Market 6. Scope and Type of services	1. HSCRC: State of Maryland Where State/Federal law is not applicable, the following factors are also considered: For the following more details are available in the attachment titled In-Network Reimbursement Methodology 2. M/S and MH/SUD providers are classified based on provider type/level of training based upon CMS methodology (i.e., hospital, clinic and practitioner) and/or specialty (e.g. physician practitioners v. non-physician practitioner v. facility. 3. CMS Medicare Resources Based Relative Value" scale ("RBRVS") system. 4. Internal analysis of market dynamics and network need/network adequacy including review of supply of providers from state licensing sites and competitor directory

Benefit Classification/Sub- classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
	7. Medical Cost Budget 8. Utilization 9. Competitive insights, when available **Factors Considered but rejected:** There are no rejected factors. **Weight of Factors:** Each factor holds the same weight	review and demand-based utilization trends. 5. Medicare Geographical Practice Cost Index ("GPCI"), i.e. market rate and payment type for provider type and/or specialty 6. Type of Service are identified by CPT and HCPC codes 7. Internal determination 8. Internal Cigna Data 9. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available

Out of Network Outpatient- All Other (Facility and Practitioner)	1. Provider Type(i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 2. Services and/or Procedures Performed 3. Geographical location 4. Industry Benchmark Rates/Methodology **Factors Considered but rejected:** There are no rejected factors. **Weight of Factors:** Each factor holds the same weight.	1. Claims data (i.e., taxonomy, provider specialty and type codes). Zelis utilizes a percentage of Medicare fee schedule, negotiated amount or % of charges made by providers of such service or supply in the geographical area where received as compiled in FAIR health database. 2. CPT/HCPCS coding set by Centers for Medicare and Medicaid Services, National Correct Coding Initiative & American Medical Associations for providers. Facility reimbursement for R&C is only applied if CPT/HCPCS is billed. If Rev Code is applied, the reimbursement is paid at the out of network level of benefit on the plan. Zelis utilizes a percentage of Medicare fee schedule, negotiated amount or % of charges made by providers of such service or supply in the geographical area where received as compiled in FAIR health database. 3. Pricing solutions which include FAIR Health database for reasonable & customary, continuous discount agreements,

Benefit Classification/Sub- classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
		provider negotiations, supplemental networks and ERS (Established Reimbursement Rates). Zelis utilizes a percentage of Medicare fee schedule, negotiated amount or % of charges made by providers of such service or supply in the geographical area where received as compiled in FAIR health database. 4. Pricing solutions which include FAIR Health database for reasonable & customary, continuous discount agreements, provider negotiations, supplemental networks and ERS (Established Reimbursement Rates). Zelis utilizes a percentage of Medicare fee schedule, negotiated amount or % of charges made by providers of such service or supply in the geographical area where received as compiled in FAIR health database.

Emergency – In Network (Facility and Practitioner)	1. State and Federal Law Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 3. Medicare Baseline Rates 4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty; i.e. Network Adequacy) 5. Geographic Market 6. Scope and Type of services 7. Medical Cost Budget	1. HSCRC: State of Maryland Where State/Federal law is not applicable, the following factors are also considered: For the following more details are available in the attachment titled In-Network Reimbursement Methodology 2. M/S and MH/SUD providers are classified based on provider type/level of training based upon CMS methodology. 3. Medicare Geographical Practice Cost Index ("GPCI") 4. Internal analysis of market dynamics/network adequacy, including review of supply of facilities from state licensing sites and competitor directory review and demand-based utilization trends. 5. Medicare Geographical Practice Cost Index ("GPCI"), i.e. market rate and payment type for provider type and/or specialty 6. Type of Service are identified by CPT, HCPC and Revenue

Benefit Classification/Sub- classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
	8. Utilization 9. Competitive insights, when available **Factors Considered but rejected:** There are no rejected factors. **Weight of Factors:** Each factor holds the same weight.	codes and Internal Cigna Data 7. External data sources include Payer self-reported rates as reported and required by Transparency laws and payment information from claims adjudicated with coordination of benefits (COB). Internal data sources: Affordability goals based on competitive client pricing. 8. Internal Cigna Claims Data 9. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available
Emergency – Out of Network	NA	NA
Prescription	NA	NA

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)

In Network Inpatient – facility	1. State and Federal Law Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 3. Medicare Baseline Rates 4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty; i.e. Network Adequacy) 5. Geographic Market 6. Scope and Type of services 7. Medical Cost Budget 8. Utilization 9. Competitive insights, when available	1. Maryland HSCRC (Md. Ins. Code §§ §27-303): as defined in the current year Annual Rate Report as issued by Maryland Health Services Cost Review Commission (HSCRC). There is no threshold for this Factor, Plan applies exact rates as dictated by HSCRC. Where State/Federal law is not applicable, the following factors are also considered: 2. Provider types are dependent upon state licensing and credentialing requirements as outlined by the applicable state or NCQA. Providers with higher degree levels, may merit higher reimbursement, for example, in BH Psychiatrists are MD/DO while a therapist is a Master's Level degree. Cigna does not weight provider types or designate any additional provider and/or specialty designations (e.g., physician practitioner v. non-physician practitioner). Threshold is provider/license degree type (e.g. MD/DO, mid-level, master level, bachelors level) a. Diagnosis Related Group ("DRG"): Patient classification scheme which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital. (citation: CMS.gov). Applicable to Facility Inpatient and Facility Outpatient benefit classifications. For DRG reimbursement, weighting is not calculated within the contract or at the time of contract rate negotiation, but instead occurs at the time of payment as DRG reimbursement is dependent on a variety of variable factors as indicated on the claim form, such as patient age and diagnosis. Cigna utilizes CMS grouping software (Optum) that takes the information from the claim and "groups it" into the correct DRG. That DRG information is then used to calculate the reimbursement, based on the factor in the contract.	1. HSCRC: State of Maryland Where State/Federal law is not applicable, the following factors are also considered: 2. M/S and MH/SUD providers are classified based on provider type/level of training based upon CMS methodology. a. Optum Software for DRG grouping b. RBRV by Medicare pricing tool. 3. Medicare Geographical Practice Cost Index ("GPCI") 4. Internal analysis of market dynamics/network adequacy, including review of supply of providers from state licensing sites and competitor directory review and demand based utilization trends. 5. Medicare Geographical Practice Cost Index ("GPCI"), i.e. market rate and payment type for provider type and/or specialty 6. Type of Service are identified by CPT and HCPC codes 7. Medical Cost Budget is developed using self-reported payer reimbursement data, coordination of benefit claims, and internal affordability target to set competitive rates 8. Internal Cigna historical claims data 9. Coordination Of Benefit (COB) information

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		Cigna's DRG base rates are calculated using the factors defined in Step 1. The base rates for DRG are listed in the contract. The base rate is then multiplied by the CMS DRG weighting to determine reimbursement. State of Maryland sets a fee schedule that must be followed by all payers; by way of example: DRG 203 has a factor 17; CMS DRG weight x contracted factor = reimbursement b. Resource-Based Relative Value Scale ("RBRVS"): Cigna utilizes the Medicare Pricing Tool to determine if the provider's (current) rates are above the defined Medicare Baselines. The minimum standards are designated as a percentage of Medicare reimbursement, according to licensure and Medicare locality. Cigna uses standard Medicare Resource Based Relative Value Scale ("RBRVS"), a CMS created reimbursement methodology to reimburse providers for members covered under the Medicare program and as a baseline for commercial reimbursement rates. Cigna's RBRVS methodology calculates the allowable fee for a covered service. Cigna RBRVS is set annually: i.[(Work RVU x Work GPCI) + (Practice Expense RVU x Practice Expense GPCI) + ii. (Malpractice RVU x Malpractice GPCI)] = Geographically Adjusted RVU Total x Conversion Factor (CF) = Cigna RBRVS geographically adjusted fee Reimbursement c. Percent of Charge – percent of covered billed charges d. Per Diem – a per day, all-inclusive reimbursement rate for all covered services provided on that day 3. Reimbursement Rates. For codes with assigned Medicare	from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		Relative Value Unit ("RVU"): Unit values are assigned to each service (CPT code) by area of specialty and for some codes different RVUs for site of service: facility and non-facility. No specific threshold; RVU is utilized when available. 4. Market Dynamics: Supply of providers is determined using state licensing sites to verify licensure and existence of provider. Competitor directories (i.e. Aetna, Blue Cross) are used to identify available providers. These external sources, along with Plan's internal sources (i.e. existing network, utilization history, network adequacy) establishes the availability of providers. Demand can be determined by Plan's internal review of utilization/claims data. Threshold: pass/fail status of network adequacy standards. (e.g.. fail status may be result of supply/demand in balance and create the need for additional reimbursement considerations). 5. Geographic market (i.e. market rate and payment type for provider type and/or specialty): The geographic market may be adjusted based upon "Geographic Practice Cost Index ("GPCI'). GPCI reflects the relative cost of practicing in a locality against a national average. Each relative value is multiplied by the corresponding GPCI. The three component factors are then accumulated to arrive at an adjusted amount. This amount is then multiplied by the conversion factor to establish the Medicare full fee schedule amount in the Medicare Physician Fee Schedule Data Base (MPFSDB). CMS performs calculations on the fee schedule, with the exception of carrier-priced procedure codes, and provides fee schedule calculations to the Medicare Administrative Contractors (MACs); No specific threshold is applied. 6. Supply of provider type and/or specialty: Provider specific	

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)

		fee schedules are used for multi-specialty groups or unique specialty groups where reimbursement terms must be customized to meet the needs of that group or specialty. Provider specific or specialty fee schedules are used to retain providers if the providers are needed to meet network access requirements and/or increased membership. Threshold: pass/fail status of network adequacy standards. (e.g.. fail status may be result of supply/demand in balance and create the need for additional reimbursement considerations). 7. Medical cost budgets - MH/SUD and M/S medical cost budgets are established annually, using the same methodology including budgetary considerations for known contractual commitments as well as renegotiation of existing contracts. Additionally new negotiations are reviewed to set budget metrics. Budget metrics determine how much flexibility there is to negotiate non-standard rates, but do not create specific limits or exclusions applicable to providers. Threshold: meets/does not meet budgetary requirements. 8. Utilization: Utilization/claims history is used to determine need of provider related to meeting network access/patient preferences. For example, no prior utilization may indicate no need for the provider in-network, while evidence of prior enrollee utilization may indicate need for provider to meet network access standards and/or enrollee preferences. No specific threshold, utilization may be considered at any volume. 9. Competitive insights: When available through Coordination of Benefits or Transparency data, is used to determine fair market reimbursement rates. No specific threshold, this data is only available in some instances, but will be used when	

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		available.	
In Network Inpatient (Practitioner)	Not Applicable	Not Applicable	Not Applicable

Out of Network Inpatient – Facility	1. Provider Type 2. Services and/or Procedures Performed 3. Geographical location 4. Industry Benchmark Rates/Methodology	1. Provider Type: The provider type; facility 2. Revenue code Type: Utilize the most current version of industry standard CPT or HCPCS code set or Revenue codes. 3. Geographic Location: Zip code of the facility sending the claim 4. Industry Benchmark Rates/Methodology: Utilize Reasonable and Customary (R&C) data when CPT/HCPCS are billed. If Revenue codes are only billed, no R&C will be applied. (a) Wellfleet uses Fair Health for R&C Data. Wellfleet downloads Fair Health data bi-annually and uses that coding data to reimburse out of network services according to the specific plans out of network benefit level. Fair Health's rich data repository and independence make it a valued resource for reliable, objective data. FH® Charge Benchmarks provide up- to-date, actionable data based on recent claims from 493 distinct geographic regions nationwide. Fair Health has been consulted by numerous federal officials including those from the White House, the Department of Health and Human Services, the Department of Labor, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Department of Commerce, the Department of Agriculture and the Congressional Budget Office. Fair Health data has been used to address a broad range of issues including:	1. Taxonomy 2. Revenue Codes will have claim paid without reasonable and customary cutback based upon the out of network level of benefit in the plan. If a claim has a CPT/HCPCS, then R&C will be applied. Zelis utilizes a percentage of Medicare fee schedule, negotiated amount or % of charges made by providers of such service or supply in the geographical area where received as compiled in FAIR health database. 3. Revenue Codes will have claim paid without reasonable and customary cutback based upon the out of network level of benefit in the plan. If a claim has a CPT/HCPCS, then R&C will be applied. Zelis pricing solutions - Zelis utilizes a percentage of Medicare fee schedule, negotiated amount or % of charges made by providers of such service or supply in the geographical area where received as compiled in FAIR health database. 4. FAIR Health & CMS-

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		· Bureau of Labor Statistics in developing its medical pricing indices. ·Government Accountability Office to support studies of air ambulance and dental service ·Office of National Drug Control Policy under President Obama · The President's Commission on Combating Drug Addiction and the Opioid Crisis under President Trump (b) Zelis is a pricing solution that utilizes many data points, including but not limited to CMS data for savings opportunities.	

In Network Outpatient-Office (Practitioner)	1. State and Federal Law Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type 3. Medicare Baseline Rates 4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty, i.e. Network Adequacy) 5. Geographic Market 6. Scope and Type of services	Where State/Federal law is not applicable, the following factors are also considered: 2. Provider types are dependent upon state licensing and credentialing requirements as outlined by the applicable state or NCQA. Providers with higher degree levels, may merit higher reimbursement, for example, in BH Psychiatrists are MD/DO while a therapist is a Master's Level degree. Cigna does not weight provider types or designate any additional provider and/or specialty designations (e.g., physician practitioner v. non-physician practitioner). M/S rate reduction may be negotiated upon plan request. 3. Resource-Based Relative Value Scale ("RBRVS"): Cigna utilizes the Medicare Pricing Tool to determine if the provider's (current) rates are above the defined Medicare Baselines. The minimum standards are designated as a percentage of Medicare reimbursement, according to licensure and Medicare locality. Cigna uses standard Medicare Resource Based Relative Value Scale ("RBRVS"), a CMS created reimbursement methodology to reimburse providers for	Where State/Federal law is not applicable, the following factors are also considered: 2. M/S and MH/SUD providers are classified based on provider type/level of training based upon CMS methodology. 3. CMS Medicare Resources Based Relative Value" scale ("RBRVS") system. 4. Internal analysis of market dynamics/network adequacy, including review of supply of providers from state licensing sites and competitor directory review and demand-based utilization trends. 5. Medicare Geographical Practice Cost Index ("GPCI"), i.e. market rate and payment type for provider type and/or specialty

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
	7. Medical Cost Budget 8. Utilization 9. Competitive insights, when available	members covered under the Medicare program and as a baseline for commercial reimbursement rates. Cigna's RBRVS methodology calculates the allowable fee for a covered service. Cigna RBRVS is set annually: [(Work RVU x Work GPCI) + (Practice Expense RVU x Practice Expense GPCI) + (Malpractice RVU x Malpractice GPCI)] = Geographically Adjusted RVU Total x Conversion Factor (CF) = Cigna RBRVS geographically adjusted fee Reimbursement 4. Supply of provider type and/or specialty (network adequacy): Provider specific fee schedules are used for multi-specialty specialty groups or unique specialty groups where reimbursement terms must be customized to meet the needs of that group or specialty. Provider specific or specialty fee schedules are used to retain providers if the providers are needed to meet network access requirements and/or increase membership 5. Geographic market (i.e. market rate and payment type for provider type and/or specialty): The geographic market may be adjusted based upon "Geographic Practice Cost Index ("CPCI'). GPCI reflects the relative cost of practicing in a locality against a national average. Each relative value is multiplied by the corresponding GPCI. The three component factors are then accumulated to arrive at an adjusted amount. This amount is then multiplied by the conversion factor to establish the Medicare full fee schedule amount in the Medicare Physician Fee Schedule Data Base (MPFSDB). CMS performs calculations on the fee schedule, with the exception of carrier-priced procedure codes, and provides fee schedule calculations to the Medicare Administrative Contractors (MACs) 6. Type of Service are identified by CPT, HCPC and Revenue	6. Type of Service are identified by CPT and HCPC codes 7. Medical Cost Budget is developed using self-reported payer reimbursement data, coordination of benefit claims, and internal affordability target to set competitive rates 8. Internal Cigna historical claims data 9. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		codes and Internal Cigna Data 7. Medical cost budgets - MH/SUD and M/S medical cost budgets are established annually, using the same methodology including budgetary considerations for known contractual commitments as well as renegotiation of existing contracts. Additionally new negotiations are reviewed to set budget metrics. Budget metrics determine how much flexibility there is to negotiate non-standard rates, but do not create specific limits or exclusions applicable to providers. 8. Utilization: Utilization/claims history is used to determine need of provider related to meeting network access/patient preferences. For example, no prior utilization may indicate no need for the provider in-network, while evidence of prior enrollee utilization may indicate need for provider to meet network access standards and/or enrollee preferences. 9. Competitive insights: When available through Coordination of Benefits or Transparency data, is used to determine fair market reimbursement rates.	
Out of Network Outpatient- Office (Facility and Provider)	1. Provider Type(i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 2.Services and/or Procedures Performed 3.Geographical location 4.Industry Benchmark	1. Provider Type: The provider type; (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 2. Services and/or Procedure Type: Utilize the most current version of industry standard CPT or HCPCS code set 3. Geographic Location: Zip code of the facility sending the claim 4. Industry Benchmark Rates/Methodology: Utilize Reasonable and Customary (R&C) data. (a) Wellfleet uses Fair Health for R&C Data for CPT/HCPCS on claims. Wellfleet downloads Fair Health data biannually and uses that data to reimburse out of network services according to the specific plans out of network benefit level. When Revenue code is only applied on	1. Taxonomy 2. Codify with claims data Zelis reviews all claims submitted by providers that billed with a CPT or a Healthcare Common Procedure Coding System (HCPCS) code to confirm such claims are coded and billed accurately in accordance with nationally recognized coding guidelines, primarily set by the Centers for Medicare and Medicaid Services, National Correct Coding Initiative, and American Medical Association. Zelis will discuss the recommended edits with the clients for their approval.

	Rates/Methodology	claims, no R&C cutback is applicable and the claim is paid at the out of network benefit level.	3. Zelis pricing solutions – Zelis will recommend an out of network repriced amount based on a

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		Fair Health's rich data repository and independence make it a valued resource for reliable, objective data. FH® Charge Benchmarks provide up- to-date, actionable data based on recent claims from 493 distinct geographic regions nationwide. Fair Health has been consulted by numerous federal officials including those from the White House, the Department of Health and Human Services, the Department of Labor, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Department of Commerce, the Department of Agriculture and the Congressional Budget Office. Fair Health data has been used to address a broad range of issues including: · Bureau of Labor Statistics in developing its medical pricing indices. ·Government Accountability Office to support studies of air ambulance and dental service ·Office of National Drug Control Policy under President Obama · The President's Commission on Combating Drug Addiction and the Opioid Crisis under President Trump (b) Zelis is a pricing solution that utilizes many data points, including but not limited to CMS data for savings opportunities.	secured savings agreement, Zelis' Established Reimbursement Solution (ERS), a percentage of Medicare fee schedule, negotiated amount, or a percentage of charges made by providers of such service or supply in the geographic area where received as complied in FAIR Health database. 4. Fair Health & CMS

In Network Outpatient-All Other (Facility and Practitioner)	1. State and Federal Law Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type 3. Medicare Baselines Rates 4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand	1. Maryland HSCRC: as defined in the current year Annual Rate Report as issued by Maryland Health Services Cost Review Commission (HSCRC) Where State/Federal law is not applicable, the following factors are also considered: 2. Provider types are dependent upon state licensing and credentialing requirements as outlined by the applicable state or NCQA. Providers with higher degree levels, may merit higher reimbursement, for example, in BH Psychiatrists are MD/DO while a therapist is a Master's Level degree. Cigna does not weight provider types or designate any additional	1. HSCRC: State of Maryland Where State/Federal law is not applicable, the following factors are also considered: 2. M/S and MH/SUD providers are classified based on provider type/level of training based upon CMS methodology. 3. CMS Medicare Resources Based Relative Value" scale ("RBRVS") system. 4. Internal analysis of market

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)

	for provider type and/or specialty, i.e. Network Adequacy) 5. Geographic Market 6. Scope and Type of services 7. Medical Cost Budget 8. Utilization 9. Competitive insights, when available	provider and/or specialty designations (e.g., physician practitioner v. non-physician practitioner). 3. Resource-Based Relative Value Scale ("RBRVS"): Cigna utilizes the Medicare Pricing Tool to determine if the provider's(current) rates are above the defined Medicare Baselines. The minimum standards are designated as a percentage of Medicare reimbursement, according to licensure and Medicare locality. Cigna uses standard Medicare Resource Based Relative Value Scale ("RBRVS"), a CMS created reimbursement methodology to reimburse providers for members covered under the Medicare program and as a baseline for commercial reimbursement rates. Cigna's RBRVS methodology calculates the allowable fee for a covered service. Cigna RBRVS is set annually: [(Work RVU x Work GPCI) + (Practice Expense RVU x Practice Expense GPCI) + (Malpractice RVU x Malpractice GPCI)] = Geographically Adjusted RVU Total x Conversion Factor (CF) = Cigna RBRVS geographically adjusted fee Reimbursement 4. Supply of provider type and/or specialty: (network adequacy): Provider specific fee schedules are used for multi-specialty specialty groups or unique specialty groups where reimbursement terms must be customized to meet the needs of that group or specialty. Provider specific or specialty fee schedules are used to retain providers if the providers are needed to meet network access requirements and/or increase membership. 5. Geographic market (i.e. market rate and payment type for provider type and/or specialty): The geographic market may	dynamics/network adequacy, including review of supply of providers from state licensing sites and competitor directory review and demand-based utilization trends. 5. Medicare Geographical Practice Cost Index ("GPCI"), i.e. market rate and payment type for provider type and/or specialty 6. Type of Service are identified by CPT and HCPC codes 7. Medical Cost Budget is developed using self-reported payer reimbursement data, coordination of benefit claims, and internal affordability target to set competitive rates 8. Internal Cigna historical claims data 9. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)

		be adjusted based upon "Geographic Practice Cost Index ("CPCI'). GPCI reflects the relative cost of practicing in a locality against a national average. Each relative value is multiplied by the corresponding GPCI. The three component factors are then accumulated to arrive at an adjusted amount. This amount is then multiplied by the conversion factor to establish the Medicare full fee schedule amount in the Medicare Physician Fee Schedule Data Base (MPFSDB). CMS performs calculations on the fee schedule, with the exception of carrier-priced procedure codes, and provides fee schedule calculations to the Medicare Administrative Contractors (MACs); 6. Type of Service are identified by CPT, HCPC and Revenue codes and Internal Cigna Data 7. Medical cost budgets - MH/SUD and M/S medical cost budgets are established annually, using the same methodology including budgetary considerations for known contractual commitments as well as renegotiation of existing contracts. Additionally new negotiations are reviewed to set budget metrics. Budget metrics determine how much flexibility there is to negotiate non-standard rates, but do not create specific limits or exclusions applicable to providers. 8. Utilization: Utilization/claims history is used to determine need of provider related to meeting network access/patient preferences. For example, no prior utilization may indicate no need for the provider in-network, while evidence of prior enrollee utilization may indicate need for provider to meet network access standards and/or enrollee preferences 9. Competitive insights: When available through Coordination of Benefits or Transparency data, is used to determine fair	

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		market reimbursement rates.	
Out of Network Outpatient- All Other (Facility and Provider)	1. Provider Type(i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 2. Services and/or Procedures Performed 3. Geographical location 4. Industry Benchmark Rates/Methodology	1. Provider Type: The provider type; (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 2. Services and/or Procedure Type: Utilize the most current version of industry standard CPT or HCPCS code set 3. Geographic Location: Zip code of the facility sending the claim 4. Industry Benchmark Rates/Methodology: Utilize Reasonable and Customary (R&C) data. (a) Wellfleet uses Fair Health for R&C Data. Wellfleet downloads Fair Health data several times a year and uses that data to reimburse out of network services according to the specific plans out of network benefit level. If only revenue code on claim, it is paid only at benefit level on the plan. Fair Health's rich data repository and independence make it a valued resource for reliable, objective data. FH® Charge Benchmarks provide up- to-date, actionable data based on recent claims from 493 distinct geographic regions nationwide. Fair Health has been consulted by numerous federal officials including those from the White House, the Department of Health and Human Services, the Department of Labor, the Food and Drug Administration, the Centers for Disease Control and Prevention, the Department of Commerce, the Department of Agriculture and the Congressional Budget Office. Fair Health data has been used to address a broad range of issues including: · Bureau of Labor Statistics in developing its medical pricing indices. ·Government Accountability Office to support studies of air ambulance and dental service	1. Taxonomy 2. Codify with claims data 3. Zelis pricing solutions – see Attachment "Methodologies for Mental Health Parity (MHPAEA) 4. Fair Health & CMS

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		·Office of National Drug Control Policy under President Obama ·The President's Commission on Combating Drug Addiction and the Opioid Crisis under President Trump (b) Zelis is a pricing solution that utilizes many data points, including but not limited to CMS data for savings opportunities.	
Emergency – In Network	1. State and Federal Law Where State/Federal law is not applicable, the following factors are also considered: 2. Provider Type (i.e., hospital, clinic and practitioner) and/or specialty which determines the applicable type of reimbursement. 3. Medicare Baseline Rates 4. Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty; i.e. Network Adequacy) 5. Geographic Market 6. Scope and Type of services 7. Medical Cost Budget 8. Utilization	1. Maryland HSCRC (Md. Ins. Code §§ §27-303): as defined in the current year Annual Rate Report as issued by Maryland Health Services Cost Review Commission (HSCRC). There is no threshold for this Factor, Plan applies exact rates as dictated by HSCRC. Where State/Federal law is not applicable, the following factors are also considered: 2. Provider types are dependent upon state licensing and credentialing requirements as outlined by the applicable state or NCQA. Providers with higher degree levels, may merit higher reimbursement, for example, in BH Psychiatrists are MD/DO while a therapist is a Master's Level degree. Cigna does not weight provider types or designate any additional provider and/or specialty designations (e.g., physician practitioner v. non-physician practitioner). Threshold is provider/license degree type (e.g. MD/DO, mid-level, master level, bachelors level) a. Diagnosis Related Group ("DRG"): Patient classification scheme which provides a means of relating the type of patients a hospital treats to the costs incurred by the hospital. (citation: CMS.gov). Applicable to Facility Inpatient and Facility Outpatient benefit classifications. For DRG reimbursement, weighting is not calculated within the contract or at the time of contract rate negotiation, but instead occurs at the time of payment as DRG reimbursement is dependent on a variety of variable factors	1. HSCRC: State of Maryland Where State/Federal law is not applicable, the following factors are also considered: 2. M/S and MH/SUD providers are classified based on provider type/level of training based upon CMS methodology. 3. Medicare Geographical Practice Cost Index ("GPCI") 4. Internal analysis of market dynamics/network adequacy, including review of supply of providers from state licensing sites and competitor directory review and demand based utilization trends. 5. Medicare Geographical Practice Cost Index ("GPCI"), i.e. market rate and payment type for provider type and/or specialty 6. Type of Service are identified by CPT and HCPC codes 7. Medical Cost Budget is developed using self-reported payer reimbursement data, coordination of benefit claims, and internal

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
	9. Competitive insights, when available	as indicated on the claim form, such as patient age and diagnosis. Cigna utilizes CMS grouping software (Optum) that takes the information from the claim and "groups it" into the correct DRG. That DRG information is then used to calculate the reimbursement, based on the factor in the contract. Cigna's DRG base rates are calculated using the factors defined in Step 1. The base rates for DRG are listed in the contract. The base rate is then multiplied by the CMS DRG weighting to determine reimbursement. State of Maryland sets a fee schedule that must be followed by all payers; by way of example: DRG 203 has a factor 17; CMS DRG weight x contracted factor = reimbursement b. Resource-Based Relative Value Scale ("RBRVS"): Cigna utilizes the Medicare Pricing Tool to determine if the provider's (current) rates are above the defined Medicare Baselines. The minimum standards are designated as a percentage of Medicare reimbursement, according to licensure and Medicare locality. Cigna uses standard Medicare Resource Based Relative Value Scale ("RBRVS"), a CMS created reimbursement methodology to reimburse providers for members covered under the Medicare program and as a baseline for commercial reimbursement rates. Cigna's RBRVS methodology calculates the allowable fee for a covered service. Cigna RBRVS is set annually: i.[(Work RVU x Work GPCI) + (Practice Expense RVU x Practice Expense GPCI) + ii. (Malpractice RVU x Malpractice GPCI)] = Geographically Adjusted RVU Total x Conversion Factor (CF) = Cigna RBRVS geographically adjusted fee Reimbursement c. Percent of Charge – percent of covered billed charges d. Per Diem – a per day, all-inclusive reimbursement rate for	affordability target to set competitive rates 8. Internal Cigna historical claims data 9. Coordination Of Benefit (COB) information from other carriers, Transparency Data (No Surprises Act Section 114: 42 USC 300gg et seq. (PHSA Title XXVII Part D; 2799A-4); 29 USC 1185 et seq. (ERISA Section 719); Internal Revenue Code Chapter 100 Subchapter B Section 9819); where available

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		all covered services provided on that day 3. Reimbursement Rates. For codes with assigned Medicare Relative Value Unit ("RVU"): Unit values are assigned to each service (CPT code) by area of specialty and for some codes different RVUs for site of service: facility and non-facility. No specific threshold; RVU is utilized when available. 4. Market Dynamics: Supply of providers is determined using state licensing sites to verify licensure and existence of provider. Competitor directories (i.e. Aetna, Blue Cross) are used to identify available providers. These external sources, along with Plan's internal sources (i.e. existing network, utilization history, network adequacy) establishes the availability of providers. Demand can be determined by Plan's internal review of utilization/claims data. Threshold: pass/fail status of network adequacy standards. (e.g.. fail status may be result of supply/demand in balance and create the need for additional reimbursement considerations). 5. Geographic market (i.e. market rate and payment type for provider type and/or specialty): The geographic market may be adjusted based upon "Geographic Practice Cost Index ("GPCI'). GPCI reflects the relative cost of practicing in a locality against a national average. Each relative value is multiplied by the corresponding GPCI. The three component factors are then accumulated to arrive at an adjusted amount. This amount is then multiplied by the conversion factor to establish the Medicare full fee schedule amount in the Medicare Physician Fee Schedule Data Base (MPFSDB). CMS performs calculations on the fee schedule, with the exception of carrier-priced procedure codes, and provides fee schedule calculations to the Medicare Administrative	

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		Contractors (MACs); No specific threshold is applied. 6. Supply of provider type and/or specialty: Provider specific fee schedules are used for multi-specialty groups or unique specialty groups where reimbursement terms must be customized to meet the needs of that group or specialty. Provider specific or specialty fee schedules are used to retain providers if the providers are needed to meet network access requirements and/or increased membership. Threshold: pass/fail status of network adequacy standards. (e.g.. fail status may be result of supply/demand in balance and create the need for additional reimbursement considerations). 7. Medical cost budgets - MH/SUD and M/S medical cost budgets are established annually, using the same methodology including budgetary considerations for known contractual commitments as well as renegotiation of existing contracts. Additionally new negotiations are reviewed to set budget metrics. Budget metrics determine how much flexibility there is to negotiate non-standard rates, but do not create specific limits or exclusions applicable to providers. Threshold: meets/does not meet budgetary requirements. 8. Utilization: Utilization/claims history is used to determine need of provider related to meeting network access/patient preferences. For example, no prior utilization may indicate no need for the provider in-network, while evidence of prior enrollee utilization may indicate need for provider to meet network access standards and/or enrollee preferences. No specific threshold, utilization may be considered at any volume. 9. Competitive insights: When available through Coordination	

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		of Benefits or Transparency data, is used to determine fair market reimbursement rates. No specific threshold, this data is only available in some instances, but will be used when available.	
Emergency – Out of Network	Not applicable	Not applicable	Not applicable
Prescription	Not Applicable	Not applicable	Not Applicable

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

In Network Reimbursement

Whether for initial negotiation or renegotiation, Cigna uses its standard in-network provider reimbursement methodology as demonstrated in the In-Network Reimbursement Methodology Standard Operating Procedure(available upon request from Cigna) for MH/SUD and M/S providers. As previously noted, the factors considered in every negotiation include state/federal law, geographic market, provider type and supply, Medicare baseline rates, scope and type of service, cost budget, and utilization.

Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules. The schedules are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region. MH/SUD HM NET 011Provider Fee schedules policy shows the guidelines for consistent provider alignment based on their licensure and educational background.

Both MH/SUD and M/S negotiations are based upon provider and information availability at a single point in-time. Negotiations depend on several factors of which cannot simply be reduced to supply and demand including the provider's size (e.g., a large statewide or national hospital system vs. an individual solo practitioner);the scarcity or the "supply" of that provider type or specialty; and the reputation, name recognition, and/or quality of the provider. – many of these additional factors can be evidenced by the review of Competitive insights, when available, to ensure a fair market reimbursement rate is offered. It is important to note that different providers and facilities may have vastly different negotiating or so-called bargaining power. Both MH/SUD and M/S provider's bargaining power depends on the same factors which cannot simply be reduced to supply and demand including the provider's size (e.g., a large statewide or national hospital system vs. an individual solo practitioner); the scarcity or the "supply" of that provider type or specialty (i.e. network adequacy); and the reputation, name recognition, and/or quality of the provider. When referencing "vastly different negotiating or so-

called bargaining power" Cigna acknowledges the fact that large provider groups whether MH/SUD or MED/SURG have the ability to serve a larger customer base, hence giving them bargaining power to negotiate. Both Standard and Non-Standard (negotiated) fee schedules are developed based upon the same factors, including provider or facility's negotiation request. For both MH/SUD and M/S standard and non-standard reimbursement the following factors are considered in all negotiations, where applicable:

1. State & Federal Law (Maryland HSCRC)
Where State/Federal law is not applicable, the following factors are also considered:
o Type of provider (i.e., hospital, clinic and practitioner) and/or specialty
o Medicare baseline rates
o Geographic market (i.e., market rate and payment type for provider type and/or specialty)
o Market Dynamics (Supply of provider type and/or specialty Network need and/or demand for provider type and/or specialty, i.e. Network Adequacy)
o Scope and Type of Services
o Medical cost budgets
o Utilization
o Competitive Insights, where available
For both MH/SUD and M/S providers any revisions to the standard reimbursement rates for both in network facility-based services and in-network outpatient services are analyzed and negotiated by either a Recruiter or Contract Negotiator, with oversight from a Contracting Manager or Director. The same standard methodologies are used for both M/S and MH/SUD rate negotiation and any substantial deviations from standard reimbursement rates must be justified and approved by more senior representatives in the respective contracting areas. All staff participating in contract negotiation are trained on internal Cigna policies and procedures and have access to necessary tools to negotiate and develop appropriate reimbursement rates based on standard methodologies, provider-specific reimbursement requests and escalate for justification and approval any deviations. Per the MH/SUD Fee Exceptions HM-NET-010 policy, behavioral health has established clear guidelines/criteria for negotiating fee exceptions such as provider specialty, language/cultural skills, populations served etc. The aim of the exception process is to allow the contract negotiators to engage or retain practitioners who are essential to the integrity of the network.

Whether for initial negotiation or renegotiation, Cigna uses its standard in-network provider reimbursement methodology for MH/SUD and M/S providers. Network adequacy deficiencies (Network Need) is always considered when negotiating reimbursement rates. Standard reimbursement rates for inpatient and outpatient services for both M/S and MH/SUD providers are set based upon standard fee schedules, which are developed for facilities, physicians and non-physicians by state or region and reflect geographic variations within that state or region. Per the factors listed above, Provider-specific fee schedules are developed based upon the professional or facility's negotiation request or business need, including the satisfaction of network adequacy requirements. Cigna's preferred standard is to reimburse
the same rates across all plans/products. M/S contracts have the option to pay plans differently, while BH pays the same for all plans. This approach provides more favorable rates for MH/SUD providers. It is more favorable because MH/SUD providers are reimbursed at the same rate for all plan/product types. M/S providers
typically have a rate decrement from the standard, dependent upon the product type. There is no such decrement for MH/SUD; thus, making the reimbursement
to MH/SUD providers more favorable. For example, MHSUD pays the same rate for a Medicare provider as it does for a commercial provider. MS rate reduction may be negotiated upon plan request.

In determining any rate in both the M/S and MH/SUD facility agreements, Cigna assesses supply and demand of provider types and/or specialties based upon the same indicators including, but not limited to NCQA network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction surveys; and customer complaint data. That is, Cigna's reimbursement

rate development and negotiation processes are ultimately designed to ensure achievement of its adequacy standards for MH/SUD and M/S providers, and any departure from the standard fee schedules is informed by market demand, which may include, for example, the need to maintain, or achieve, network adequacy for a provider type in a particular geographic area.

Out of Network (Facility and Practitioner)

To determine Out of Network(OON) Rates, Wellfleet utilizes Zelis to apply R&C reimbursement rates to all OON outpatient facility M/S & MHSUD benefits that are billed with CPT/HCPCS codes(typically provider claims). If billed with Revenue codes only(typically with facility claims), no R&C will be applied and it is paid at the benefit level in the plan.

OON outpatient facility and provider claims as well as all original OON inpatient benefit claims are sent to Zelis. Zelis applies their pricing solutions, which include continuous discount agreements, supplemental networks, out of network negotiations and ERS savings. Zelis reviews all claims submitted by providers that billed with a CPT or a Healthcare Common Procedure Coding System (HCPCS) code to confirm such claims are coded and billed accurately in accordance with nationally recognized coding guidelines, primarily set by the Centers for Medicare and Medicaid Services, National Correct Coding Initiative, and American Medical Association. Zelis will discuss the recommended edits with Wellfleet for their approval. Wellfleet's policy for payment of out-of-network claims is a percent of the Fair Health allowable charge, for both M/S and MH/SUD providers. Zelis will recommend an out of network repriced amount based on a secured savings agreement, Zelis' Established Reimbursement Solution (ERS), a percentage of Medicare fee schedule, negotiated amount, or a percentage of charges made by providers of such service or supply in the geographic area where received as complied in FAIR Health database. Zelis performs the service for OON claims and upon completion of review , the claim is sent to Wellfleet with the discount applied for processing.

For both MH/SUD and M/S OON services, when no CPT/HCPCS is identified, no R&C will be applied to the revenue code, and Wellfleet will pay the claim based solely on the benefit level of the plan.

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Wellfleet performed a comparison of average in network **Maryland** claims payments during calendar year 2023 as a percentage of Medicare rates for the Wellfleet – Cigna book of business for CPT codes 99213 and 99214 for M/S Primary Care Physicians(PCPs) and Specialists against MHSUD Psychiatrists. The data is inconclusive due to the volume of claims noted for combined M/S totals 35 claims vs MHSUD with 4 claims. Therefore, Wellfleet performed the same comparison for the entire book of business for In Network as shown in DS 3 Reimbursement. The data comparison of M/S vs MH/SUD shows percentage of Medicare reimbursement is much greater for MHSUD. Parity is shown in operation.

Wellfleet was not able to provide in operation analysis for the state of Maryland exclusively as claims data was minimal. (20claims total for CPT code 90837 and 3 claims for 99213), therefore Wellfleet performed a comparison of average out of network claims payments during calendar year 2023 as a percentage of Medicare rates for the Wellfleet – Cigna book of business for **all states** utilizing the same strategy as In Network. In operation results show percentage of Medicare reimbursement is much greater for MHSUD.

Table A - Medical/Surgical Physicians compared to Psychiatrists - Data for January 1, 2023 through December 31, 2023

	Description	Column A	Column B
	In-Network Office Visits Only (non-facility based)	**CPT Code 99213**	**CPT Code 99214**
1	Weighted average allowed amount for primary care physicians (PCPs) -general practice, family practice, internal medicine, and pediatric medicine physicians	$ 128.89	$ 203.98
2	Weighted average allowed amount for non-PCP, non-psychiatrist medical/surgical specialist physicians	$ 183.36	$ 206.66
3	Weighted average allowed amount for PCPs and non-psychiatrist medical/surgical specialist physicians (combined)	$ 156.13	$ 205.32
4	Weighted average allowed amount for psychiatrists, including child psychiatrists	$ 198.72	$ 263.82
5	Percentage by which allowed amounts for PCPs and nonpsychiatrist medical/surgical specialist physicians (combined) were higher compared to psychiatrists, i.e. ((Row 3 / Row 4) – 1) x 100 = ____%	-21.43%	-22.17%

Table B (1) - Medical/Surgical Physicians compared to Psychologists and Clinical Social Workers for CPT Codes 99213 & 90834, Indexed to National Medicare Fee Schedule - Data for January 1, 2023 through December 31, 2023

		Column A	Column B	Column C
Provider Type	**CPT Codes**	**Plan Weighted Average Allowed Amount**	**National Medicare Fee Schedule Amount**	**Plan Weighted Average Allowed Amount as a Percentage of Medicare**
PCPs and non-psychiatrist M/S specialist physicians (combined)	99213	$ 156.13	$ 90.82	172%
Psychologists	90834	$ 219.18	$ 99.97	219%
Clinical Social Workers	90834	$ 221.26	$ 74.98	295%

Table B (2) - Medical/Surgical Physicians compared to Psychologists and Clinical Social Workers for CPT Codes 99214 & 90837, Indexed to National Medicare Fee Schedule - Data for January 1, 2023 through December 31, 2023

		Column A	Column B	Column C
Provider Type	**CPT Codes**	**Plan Weighted Average Allowed Amount**	**National Medicare Fee Schedule Amount**	**Plan Weighted Average Allowed Amount as a Percentage of Medicare**
PCPs and non-psychiatrist M/S specialist physicians (combined)	99214	$ 205.32	$ 128.43	160%
Psychologists	90837	$ 248.00	$ 147.07	169%
Clinical Social Workers	90837	$ 236.16	$ 110.30	214%

Step 6

Identify the measures used to ensure comparable design, development and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

Wellfleet's Mental Health and Substance Use Disorder Parity Compliance Program sets the processes and procedures for parity compliance, identifies discrepancies in coverage of services for the treatment of MH/SUD, and ensures appropriate identification and remediation of improper practices internally and with its delegates. Wellfleet assigned each benefit classification and has defined M/S and MH/SUD conditions as required by MHPAEA. Wellfleet's *Identification and Classification of Benefit Policy* is used for all NQTLs comparative analysis documentation. Wellfleet has established methodologies for the identification and testing, including a comparative analysis, of all NQTLs that are imposed on MH/SUD benefits. Wellfleet monitors for and detects improper practices by conducting ongoing and periodic reviews of Wellfleet's policies and procedures as well as the activities of any of Wellfleet's agents or representatives providing benefit management services or performing utilization reviews. Wellfleet has not identified any discrepancies in operational policies between MH/SUD and M/S benefits where the discrepancies present a comparability or stringency problem within the context of the NQTL requirement.

Bi-Annually, Wellfleet will request a report from its applicable vendors that indicates the average length of time to negotiate provider agreements and reimbursement rates. Reimbursement rates will also be reviewed for usual, customary, and reasonably charges between MH/SUD benefits and M/S benefits on an in- network basis, to ensure that the reimbursement rates standards for MH/SUD benefits are applied no more stringently than the standards used for M/S benefits.

Wellfleet has the same policy and procedure for R&C payment of out-of-network claims for inpatient M/S and MH/SUD providers. There is no difference as written for R&C payment. In addition, Wellfleet applies a process to obtain discounted rates for M/S and MH/SUD services through Zelis. When R&C is not applied (with Revenue codes only), then claim is paid at the benefit level of the plan. Therefore, *in writing*, the processes, standards, factors, and sources used to apply OON reimbursement to MH/SUD services is comparable and not more stringent than the processes, standards, factors, and sources used to apply OON reimbursement to M/S services.

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15- 144(e)(6)).

Over the past several years, Cigna has implemented new rate negotiations with MH/SUD practitioners, which has correlated to reimbursement increases, as evidenced by the upward trend in MH/SUD reimbursement rates as compared to Medicare over those years. This trend is reflective of the steps Cigna has taken because of an internal review of its MH/SUD network demonstrating comparability and representative of comparable network access outcomes between M/S and MH/SUD benefits. While operational outcomes are not determinative of NQTL compliance, and a plan may comply with the NQTL requirement notwithstanding a disparate outcome for an NQTL applied to MH/SUD benefits as compared to M/S benefits, comparable outcomes can help evidence compliance with the in-operation component of the NQTL requirement.

Wellfleet has assessed the methodology for calculating out-of-network reimbursement amounts and has concluded that it is designed and applied comparably, and no more stringently, as-written and in-operation across MH/SUD and M/S benefits. Wellfleet's methodology for determining out-of-network M/S provider reimbursement rates and out-of-network MH/SUD provider reimbursement rates are comparable and applied no more stringently to MH/SUD providers than to M/S providers as-written. As described in the foregoing, the plans establish in their terms one methodology, including the percentile or percentage, if any, applied to the MRC for the service that uniformly applies to MH/SUD and M/S benefits. There are not different methodologies for identifying the charge, or, as applicable, the percentile applied to the charge, used to calculate the amount the plan agrees to reimburse for the service rendered by an out-of-network provider. The

charges used to calculate MH/SUD benefits are subject to the same percentile or percentage as applies to M/S benefits (e.g., 80% of the MRC for the service).

Likewise, enrollees enjoy the protection from balance-billing afforded by any indirect rate arrangement accessed by the plan, whether the provider with which the plan has an indirect rate arrangement renders MH/SUD services or M/S services to the enrollees. Wellfleet does not limit application of these out-of-network rate arrangements to M/S services, and the indirect rate arrangements with MH/SUD providers leverage, just like M/S providers and where available, rates obtained by third party vendors and derived from third party databases that compile charges for the same or similar providers in the geographic area. Specifically, across MH/SUD and M/S providers the charges for services differ as-between inpatient and outpatient facilities and among different licensure/training levels, including physician and non-physician practitioners (e.g. MD/PhD v. psychologists), and across geographic areas.

1. Strategies for Addressing Provider Shortages

Wellfleet Insurance Company ("Wellfleet") utilizes the Cigna Health and Life Insurance Company ("Cigna") provider network for plans issued and delivered in Maryland.

Evernorth Behavioral Health ("Evernorth" or "EBH," formerly Cigna Behavioral Health), an affiliate of Cigna Health and Life Insurance Company ("CHLIC"), performs all aspects of addressing provider shortages for the MH/SUD Network, while Cigna performs all aspects of addressing provider shortages for the Med/Surg Network. References to "Cigna" contained herein include Evernorth Behavioral Health unless otherwise noted separately.

Cigna's MH/SUD network is open and not subject to closure or limitation. As such, Cigna maintains that Network Adequacy is an essential component that informs the Network Admissions NQTL comparative analysis. The strategies (including how provider shortages are addressed), methodologies and evidentiary standards for which Cigna evaluates its Network Admissions are in fact comparable and where there may be instances where the behavioral health network does not meet adequacy, such results are not demonstrative of a parity violation.

Cigna does not determine admission to the network based upon adequacy alone, nor does Cigna deny access to its MH/SUD network by considering the network "full" or "closed." Cigna's Network Admissions NQTL comparative analysis includes credentialing, provider standards contracting, and reimbursement. Network adequacy informs the Network Admissions NQTL. Where there are network deficiencies, Cigna may need to scrutinize the factors and evidentiary standards of its Network Admissions NQTL to ensure such standards are comparable. When a provider meets credentialing standards and agrees to contractual terms including reimbursement, they are admitted to the network. Moreover, Cigna complies with Section 15-112 (Provider Panels) of the Maryland Code requiring a provider network directory be available to prospective enrollees online or in print by request.

Step 1

(a) Provide a description of the plan's applicable NQTLs as applied to medical/surgical and MH/SUD benefits in the table below.

NQTL's Applicable to Med/Surg Benefits	NQTL's Applicable to MH/SUD Benefits
Process Overview: Cigna network is open to all interested providers who: 1. Sign and agree to contract terms (including rates) 2. Meet all credentialing requirements (which may vary based on provider type) Cigna's Network Adequacy assessment relies on the following factors: 1. Provider Availability (Definition: Time and/or Distance a customer must travel to a provider/facility. Additionally, a ratio comparison of number of customer to number of providers.) 2. Provider Accessibility (Definition: Time a customer must wait to receive an appointment. "Time to care".)	Process Overview: Cigna network is open to all interested providers who: 1. Sign and agree to contract terms (including rates) 2. Meet all credentialing requirements (which may vary based on provider type) Cigna's Network Adequacy assessment relies on the following factors: 1. Provider Availability (Definition: Time and/or Distance a customer must travel to a provider/facility. Additionally, a ratio comparison of number of customer to number of providers.) 2. Provider Accessibility (Definition: Time a customer must wait to receive an appointment. "Time to care".)

• Urban • Suburban • Rural Network Adequacy is measured according to accreditation standards along with internal and state specific requirements, as applicable. In instances where state specific standards are more stringent than the internal standard measurements for adequacy, the state specific standard is followed. When the Cigna internal standard is more stringent that Maryland's standard measurements the Cigna standard is applied. Cigna reviews participating providers to ensure that all TINs (Tax Identification Number or Taxpayer Identification Number) / NPIs(National Provider Identifier – a unique identification number for health care providers) have been loaded correctly in the applicable sources systems, especially for our large/pivotal provider relationships. Cigna and Evernorth maintain separate, but aligned, policies related to this process: • Measuring Availability of Providers for Insured Products policy (PS-8) As Cigna maintains an open network, Network Adequacy is leveraged to inform the Network Admissions NQTL. Where there are network deficiencies, Cigna may scrutinize the factors and evidentiary standards of its Network Admissions NQTL to ensure such standards are comparable. When a provider meets credentialing standards and agrees to contractual terms including reimbursement, they are admitted to the network. Where there are network shortages, Cigna utilizes the following strategies to identify potential providers for network recruitment purposes: 1. Review out-of-network utilization 2. Review of competitor provider directories 3. If competitor provider directories show no other option available (i.e., Cigna has contracted with all available providers in the market), an internet search is conducted to see if there are any other non-participating providers that can be added for recruitment In addition, Wellfleet applies MD Out of Network Provider paid at in network level guideline to address provider shortages for our members. Cigna does not audit to assess reimbursement rates to inform incentives as both do not offer incentives to join the network. Nor does Cigna offer performance/quality bonuses. Cigna do not negotiate fees or differentiate fee schedules based on provider group size. Every	• Urban • Suburban • Rural Network Adequacy is measured according to accreditation standards along with internal and state specific requirements, as applicable. In instances where state specific standards are more stringent than the internal standard measurements for adequacy, the state specific standard is followed. When the Cigna internal standard is more stringent that Maryland's standard measurements the Cigna standard is applied. Cigna reviews participating providers to ensure that all TINs (Tax Identification Number or Taxpayer Identification Number) / NPIs(National Provider Identifier – a unique identification number for health care providers) have been loaded correctly in the applicable sources systems, especially for our large/pivotal provider relationships. Cigna and Evernorth maintain separate, but aligned, policies related to this process: Measuring Availability of Behavioral Practitioners and Providers policy (HM-NET-032) As Cigna maintains an open network, Network adequacy is leveraged to inform the Network Admissions NQTL. Where there are network deficiencies, Cigna may scrutinize the factors and evidentiary standards of its Network Admissions NQTL to ensure such standards are comparable. When a provider meets credentialing standards and agrees to contractual terms including reimbursement, they are admitted to the network. Where there are network shortages, Cigna utilizes the following strategies when a provider shortage is noted to identify potential providers for network recruitment purposes: 1. Review out-of-network utilization 2. Review of competitor provider directories 3. If competitor provider directories show no other option available (i.e., Cigna has contracted with all available providers in the market), an internet search is conducted to see if there are any other non-participating providers that can be added for recruitment In addition, Wellfleet applies MD Out of Network Provider paid at in network level guideline to address provider shortages for our members. Cigna does not audit to assess reimbursement rates to inform incentives as both do not offer incentives to join the network. Nor does Cigna offer performance/quality bonuses. Cigna do not negotiate fees or differentiate fee schedules based on provider group size. Every

contract/reimbursement rate is managed on a case by case basis and may be subject to negotiation. See attachments for the Addressing Provider Shortages references: • PS_6_Measuring _Accessibility_of_Practioners_and_Providers_Policy • PS_8_Measuring _Availability_of_Practioners_and_Providers_Policy • um20-network-adequacy-provision • WIC MD Out of Network Provider paid at in network level guideline • 1 WIC MD Executive Summary 2024 Template Cigna OAP 6 25 2024 • 1 WIC MD Executive Summary 2024 Template Cigna PPO 6 25 2024 Plan documents: McDaniel College: https://www.studentinsurance.com/Docs/Resources/8032_Final%2023-24%20Mc%20Daniel%20College%20MD%20SHIP%20Cert%207.11.23%20Combined.pdf pages 40-41 Washington College: https://www.studentinsurance.com/Docs/Resources/8060_FINAL%2023-24%20Washington%20College%20SHIP%20Cert%20Combined%20w%20Notices%2010.9.23%20JR.pdf pages 37-38 St John's College https://www.studentinsurance.com/Docs/Resources/8264_FINAL%2023-24%20St%20John's%20College%20Cert%20combined%20w%20notices%2012.21.23.pdf pages 42-43 <u>Pharmacy</u> Wellfleet Insurance Company utilizes Express Scripts INC(ESI) for management of the pharmacy provider shortages, as agreed upon in the vendor contract	contract/reimbursement rate is managed on a case by case basis and may be subject to negotiation. See attachments for the Addressing Provider Shortages references: • um20-network-adequacy-provision • WIC MD Out of Network Provider paid at in network level guideline • HM_NET_031_Measuring_accesibility_of_Behavioral_Services_Policy • HM_NET_032 Measuring AvailofBH Pract&provs 6 27 24 • 1 WIC MD Executive Summary 2024 Template Cigna OAP 6 25 2024 • 1 WIC MD Executive Summary 2024 Template Cigna PPO 6 25 2024 Plan documents: McDaniel College: https://www.studentinsurance.com/Docs/Resources/8032_Final%2023-24%20Mc%20Daniel%20College%20MD%20SHIP%20Cert%207.11.23%20Combined.pdf pages 40-41 Washington College: https://www.studentinsurance.com/Docs/Resources/8060_FINAL%2023-24%20Washington%20College%20SHIP%20Cert%20Combined%20w%20Notices%2010.9.23%20JR.pdf pages 37-38 St John's College https://www.studentinsurance.com/Docs/Resources/8264_FINAL%2023-24%20St%20John's%20College%20Cert%20combined%20w%20notices%2012.21.23.pdf pages 42-43 <u>Pharmacy</u> Wellfleet Insurance Company utilizes Express Scripts INC(ESI) for management of the pharmacy provider shortages, as agreed upon in the vendor contract

(b) For each NQTL listed in Step 1 (a) (e.g., contract incentives, network sufficiency standards, etc.), identify whether the NQTL is applicable to medical/surgical or MH/SUD benefits for each applicable benefit classification and sub-classification in the table below. Indicate whether the NQTL applies to all services within the classification and sub-classification by entering "Yes" or "No" in the appropriate box. If the NQTL applies only to certain services within such classification and/or sub-classification, list each covered service to which the NQTL applies (e.g., "Yes for the following services:"). Similarly, response should be explicit whether the "Yes" applies to both M/S and MH/SUD.

Classifications and Sub-Classifications				
Is NQTL applied to **In Network Inpatient** classification?	Is NQTL applied to **In Network Outpatient- Office** sub-classification?	Is NQTL applied to **In Network Outpatient-All Other** sub-classification?	Is NQTL applied to **Emergency** classification?	Is NQTL applied to **Prescription** classification?
Yes applies to both MS and MHSUD providers	Yes applies to both MS and MHSUD providers	Yes applies to both MS and MHSUD providers	Yes applies to both MS and MHSUD providers	Yes both M/S and MHSUD.

Step 2

For each NQTL listed in Step 1, identify the factors and the source for each factor used to determine that it is appropriate to apply each NQTL to each classification, sub-classification or certain services within such classification or sub-classification for both MH/SUD and M/S benefits. Also, identify factors that were considered, but rejected. If any factor was given more weight than another, what is the reason for the difference in weighting? (§15-144(e)(1)).

Benefit Classification/Sub-classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
In Network Inpatient	1. State and Federal Law, as applicable 2. Lack of Provider Availability 3. Lack of Provider Accessibility to meet Appointment Wait Time Standards	1. Applicable Maryland state requirements pursuant to the Network Adequacy Access Plan.19

Benefit Classification/Sub-classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
	4. Out of Network Provider Member request • No additional factors were considered and subsequently rejected. • None of the factors are weighted.	• Maryland provider availability and accessibility standards as applicable by Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty monitoring 2. Provider to Enrollee Ratio Standards by Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty monitoring • Travel Distance Found Standards by Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty monitoring • Customer and/or Client Requests • Customer Complaints • Quality Concerns • Out-of-Network Provider Utilization • MD Executive Summary 2024 Template PPO & OAP 3. M/S and MH/SUD specific requirements: A. M/S: NCQA Network Management Standard 2 Accessibility of services **Element A:** Access to Primary Care Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: • Regular and Routine Care Appointment • Urgent Care Appointments • After Hours Care B.MH/SUD: NCQA Network Management Standard 2 Accessibility of Services Element B: Access to Behavioral Healthcare

Benefit Classification/Sub-classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
		Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: • Care for a non-life-threatening emergency within 6 hours. • Urgent care within 48 hours. • Initial visit for routine care within 10 business days. • Follow-up routine care. 4.MD Out of Network Provider paid at In Network Guideline
In Network Outpatient-Office	1. State and Federal Law, as applicable 2. Lack of Provider Availability 3. Lack of Provider Accessibility to meet Appointment Wait Time Standards 4. Out of Network Provider Member request • No additional factors were considered and subsequently rejected. • None of the factors are weighted.	1. Applicable Maryland state requirements pursuant to the Network Adequacy Access Plan. https://insurance.maryland.gov/Documents/newscenter/legislativeinformation/31.10.44-PropPub.pdf Maryland provider availability and accessibility standards as applicable by Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty monitoring 2. Provider to Enrollee Ratio Standards by Provider Type (i.e., hospital, clinic and practitioner) and/or specialty monitoring • Travel Distance Standards by Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty monitoring • Customer and/or Client Requests • Customer Complaints • Quality Concerns • Out-of-Network Provider Utilization • MD Executive Summary 2024 Template PPO & OAP 3. M/S and MH/SUD specific requirements: A. M/S: NCQA Network Management Standard Accessibility of services

Benefit Classification/Sub-classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
		Element A: Access to Primary Care Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: • Regular and routine care appointments. • Urgent care appointments. • After-hours care. B. MH/SUD: NCQA Network Management Standard Accessibility of Services Element B: Access to Behavioral Healthcare Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: • Care for a non-life-threatening emergency within 6 hours. • Urgent care within 48 hours 4 MD Out of Network Provider paid at In Network Guideline
In Network Outpatient-All Other	1. State and Federal Law, as applicable 2. Lack of Provider Availability 3. Lack of Provider Accessibility to meet Appointment Wait Time Standards 4. Out of Network Provider Member request No additional factors were considered and subsequently rejected. None of the factors are weighted.	1. Applicable Maryland state requirements pursuant to the Network Adequacy Access Plan.19 2. Maryland provider availability and accessibility standards as applicable by Provider Type (i.e., hospital, clinic and practitioner) and/or specialty monitoring • Provider to Enrollee Ratio Standards by Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty monitoring • Travel Distance Standards by Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty monitoring • Customer and/or Client Requests • Customer Complaints • Quality Concerns • Out-of-Network Provider Utilization • MD Executive Summary 2024 Template PPO & OAP

Benefit Classification/Sub-classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
		3. M/S and MH/SUD specific requirements: A. M/S: NCQA Network Management Standard 2 Accessibility of services **Element A**: Access to Primary Care Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: • Regular and routine care appointments. • Urgent care appointments. • After-hours care. C. MH/SUD: NCQA Network Management Standard 2 Accessibility of Services Element B: Access to Behavioral Healthcare Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: • Care for a non-life-threatening emergency within 6 hours. • Urgent care within 48 hours. • Initial visit for routine care within 10 business days. • Follow-up routine care. 4.MD Out of Network Provider paid at In Network Guideline
Emergency	1. State and Federal Law, as applicable 2. Lack of Provider Availability 3. Lack of Provider Accessibility to meet Appointment Wait Time Standards 4. Out of Network Provider Member request No additional factors were considered and subsequently rejected. None of the factors are weighted.	1. Applicable Maryland state requirements pursuant to the Network Adequacy Access Plan.19 2. Maryland provider availability and accessibility standards as applicable by Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty monitoring • Provider to Enrollee Ratio Standards by Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty monitoring • Travel Distance Standards by Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty monitoring • Customer and/or Client Requests • Customer Complaints

Benefit Classification/Sub-classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
		• Quality Concerns • Out-of-Network Provider Utilization • MD Executive Summary 2024 Template PPO & OAP 3. M/S and MH/SUD specific requirements: A. M/S: NCQA Network Management Standard 2 Accessibility of services Element A: Access to Primary Care Using valid methodology, the organization collects and performs an annual analysis of data to measure its performance against its standards for access to: • Regular and routine care appointments. • Urgent care appointments. • After-hours care. B. MH/SUD: NCQA Network Management Standard 2 Accessibility of Services Element B: Access to Behavioral Healthcare Using valid methodology, the organization annually collects and analyzes data to evaluate access to appointments for behavioral healthcare for: • Care for a non-life-threatening emergency within 6 hours. • Urgent care within 48 hours. • Initial visit for routine care within 10 business days. • Follow-up routine care. 4.MD Out of Network Provider paid at In Network Guideline
Prescription	1. State and Federal Law, as applicable 2. Lack of Pharmacy Availability 3. Lack of Pharmacy Accessibility	1. Enacted Maryland state & Federal requirements applicable to the Plan. 2. Client or Member notification, Performance guarantee with Express Scripts 3. Client or Member Notification, Performance Guarantee with Express Scripts

Benefit Classification/Sub-classification	**Factors** (a circumstance, condition, fact, standard, criterion, influence, or any other consideration that contributes to the development, design, or implementation of a NQTL)	**Sources for Each Factor** (the data, analyses, recommendation, requirement, meeting, or other information upon which a factor is based or from which a factor is derived or arises)
	• No additional factors were considered and subsequently rejected. • None of the factors are weighted.	

Step 3

Each factor must be defined. Identify and define the specific evidentiary standard(s) for each of the factors identified in Step 2 and any other evidence relied upon to design and apply each NQTL. Also, identify the source for each evidentiary standard. (§15-144(e)(2)).

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
In Network Inpatient MS	1. State and Federal Law, as applicable 2. Lack of Provider Availability 3. Lack of Provider Accessibility to meet Appointment Wait Time Standards 4. Out of Network Provider Member request	1. State and Federal Law, as applicable 2. Provider Availability • Travel Distance Standards – Calculation of the distance between a customer and provider, in miles. Cigna uses Quest Analytics to conduct this reporting/analysis. o Maryland specific standards: • "Urban" means a zip code that has a human population equal to or greater than 3,000 per square mile. • "Suburban" means a zip code that has a human population equal to or greater than 1,000 per square miles by less than 3,000 per square mile.	1. State and Federal Law, as applicable Maryland access standards, implemented through Cigna Policies • PS-8 Measuring Availability of Providers for Insured Products • PS-6 Measuring Accessibility of • Medical Services 2. Provider Availability is measured quarterly using Quest Analytics software to conduct distance analysis. • Appointment Wait Time Standards by Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty monitoring

<table>
<tr><th><u>Benefit Classification/Sub-classification</u></th><th><u>Factors</u> (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)</th><th><u>Evidentiary Standards and Applicable Thresholds</u> (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)</th><th><u>Source(s) for Each Evidentiary Standard</u> (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)</th></tr>
<tr><td></td><td></td><td>
"Rural" means a zip code that has a human population of less than 1,000 per square mile.
<table>
<tr><th rowspan="2">SPECIALTY</th><th colspan="3">MAXIMUM DISTANCE (MILES)</th></tr>
<tr><th>URBAN [1]</th><th>SUB-URBAN [2]</th><th>RURAL AREA [3]</th></tr>
<tr><td>Acute Inpatient Hospitals</td><td>10</td><td>30</td><td>60</td></tr>
<tr><td>Critical Care Services—Intensive Care Unit</td><td>10</td><td>30</td><td>100</td></tr>
<tr><td>Skilled Nursing Facilities</td><td>10</td><td>30</td><td>60</td></tr>
</table>
3. Provider Accessibility
Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined through provider surveys conducted twice per year.
Maryland specific standards
Waiting Time Standards
</td><td>
Customer and/or Client Requests
Customer Complaints
Quality Concerns
Out-of-Network Provider Utilization
MD Executive Summary 2024 Template
PPO & OAP

3. Provider Accessibility is measured through a provider survey conducted twice per year.

Lack of access is determined during Network Adequacy review; in the event any internal and/or state-specific metric is not met.
Inability to remediate that deficiency is caused by the unavailability of a provider/facility in the appropriate location with the appropriate degree/specialty. A variety of resources including internet searches, out-of-network utilization, and review of competitor provider directories are used to identify potential providers for network adequacy recruitment purposes.

4. Out of Network Provider paid at In Network level guideline
For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable, Wellfleet Group, LLC will treat the services received by the specialist or Non-
</td></tr>
</table>

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		<table><tr><td>Urgent care for medical services</td><td>72 hours</td></tr><tr><td>Routine primary care</td><td>15 calendar days</td></tr><tr><td>Preventive visit/well visit</td><td>30 calendar days</td></tr><tr><td>Non-urgent specialty care</td><td>30 calendar days</td></tr></table> 4. Out of Network Provider Member Request • Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and a. There are no specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease; or b. There is no reasonable access to specialist or Non- physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel. • If a request for a referral is accepted, for purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by the Member, Wellfleet Group, LLC will treat the services received by the specialist or Non-	physician specialist who is a Non- Preferred Provider as if the service was provided by a Preferred Provider. • Out of Network paid at In Network claims data

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		physician specialist who is an Out-of-Network Provider as if the service was provided by an In-Network Provider.	
In Network Inpatient MHSUD	1. State and Federal Law, as applicable 2. Lack of Provider Availability 3. Lack of Provider Accessibility to meet Appointment Wait Time Standards 4. Out of Network Provider Member request	1. State and Federal Law, as applicable 2. Provider Availability • Travel Distance Standards – Calculation of the distance between a customer and provider, in miles. Quest Analytics is used to conduct this reporting/analysis. • Maryland specific standards: o "Urban" means a zip code that has a human population equal to or greater than 3,000 per square mile. o "Suburban" means a zip code that has a human population equal to or greater than 1,000 per square miles by less than 3,000 per square mile. o "Rural" means a zip code that has a human population of less than 1,000 per square mile. o Inpatient Psychiatric Facility: 15/45/75 miles 3. Provider Accessibility • Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined through provider surveys conducted twice per year. **Maryland specific standards: Waiting Time Standards**	1.State and Federal Law, as applicable Maryland access standards, implemented through Evernorth Policies HM-NET-032 Measuring Availability of Behavioral Practitioners and Providers HM-NET-031 Measuring Accessibility of Behavioral Services. 2. Provider Availability is measured quarterly using Quest Analytics software to conduct distance analysis. • Appointment Wait Time Standards by Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty monitoring • Customer and/or Client Requests • Customer Complaints • Quality Concerns • Out-of-Network Provider Utilization • MD Executive Summary 2024 Template PPO & OAP 3.Provider Accessibility is measured through a provider survey conducted twice per year. Lack of access is determined during Network Adequacy review, in the event any internal and/or state-specific metric is not met.

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		Inpatient urgent care for mental health services: 72 hours Inpatient urgent care for substance use disorder services: 72 hours Outpatient urgent care for mental health services: 72 hours Outpatient urgent care for substance use disorder services: 72 hours Non-urgent mental health care: 10 calendar days Non-urgent substance use disorder care.: 10 calendar days 4. • Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and a. There are no specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease; or b. There is no reasonable access to specialist or Non- physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for	Inability to remediate that deficiency is caused by the unavailability of a provider/facility in the appropriate location with the appropriate degree/specialty. A variety of resources including internet searches, out-of-network utilization, and review of competitor provider directories are used to identify potential providers for network adequacy recruitment purposes. 4. Out of Network Provider paid at In Network level guideline • For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable, Wellfleet Group, LLC will treat the services received by the specialist or Non- physician specialist who is a Non- Preferred Provider as if the service was provided by a Preferred Provider. • Out of Network paid at In Network claims data

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		the condition or disease without unreasonable delay or travel. • If a request for a referral is accepted, for purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by the Member, Wellfleet Group, LLC will treat the services received by the specialist or Non-physician specialist who is an Out-of-Network Provider as if the service was provided by an In-Network Provider. • For a Mental Health Disorder or Substance Misuse Disorder, services received in accordance with this provision will be provided at no greater cost to the Member than if the Covered Medical Expenses were received by an In-Network Provider.	
In Network Outpatient-Office MS	1. State and Federal Law, as applicable 2. Lack of Provider Availability 3. Lack of Provider Accessibility to meet Appointment Wait Time Standards 4. Out of Network Provider Member request	1. State and Federal Law, as applicable 2. Provider Availability • Travel Distance Standards – Calculation of the distance between a customer and provider, in miles. Quest Analytics is used to conduct this reporting/analysis. • Maryland specific standards: • "Urban" means a zip code that has a human population equal to or greater than 3,000 per square mile. • "Suburban" means a zip code that has a human population equal to or greater than 1,000 per square miles by less than 3,000 per square mile. • "Rural" means a zip code that has a	1. State and Federal Law, as applicable Maryland access standards, implemented through Cigna Policies • PS-8 Measuring Availability of Providers for Insured Products • PS-6 Measuring Accessibility of • Medical Services 2. Provider Availability is measured quarterly using Quest Analytics software to conduct distance analysis. • Appointment Wait Time Standards by Provider Type (i.e., hospital, clinic and practitioner) and/or specialty monitoring

<table>
<tr><th><u>Benefit Classification/Sub-classification</u></th><th><u>Factors</u> (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)</th><th><u>Evidentiary Standards and Applicable Thresholds</u> (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)</th><th><u>Source(s) for Each Evidentiary Standard</u> (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)</th></tr>
<tr><td></td><td></td><td>human population of less than 1,000 per square mile.

<table>
<tr><th rowspan="2">SPECIALTY</th><th colspan="3">MAXIMUM DISTANCE (MILES)</th></tr>
<tr><th>URBAN [1]</th><th>SUB-URBAN [2]</th><th>RURAL AREA [3]</th></tr>
<tr><td>Acute Inpatient Hospitals</td><td>10</td><td>30</td><td>60</td></tr>
<tr><td>Critical Care Services—Intensive Care Unit</td><td>10</td><td>30</td><td>100</td></tr>
<tr><td>Skilled Nursing Facilities</td><td>10</td><td>30</td><td>60</td></tr>
</table>
3. Provider Accessibility
• Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined through provider surveys conducted twice per year.
o Maryland specific standards:
Waiting Time Standards</td><td>• Customer and/or Client Requests
• Customer Complaints
• Quality Concerns
• Out-of-Network Provider Utilization
• MD Executive Summary 2024 Template
PPO & OAP

3. Provider Accessibility is measured through a provider survey conducted twice per year.

Lack of access is determined during Network Adequacy review, in the event any internal and/or state-specific metric is not met.
Inability to remediate that deficiency is caused by the unavailability of a provider/facility in the appropriate location with the appropriate degree/specialty. A variety of resources including internet searches, out-of-network utilization, and review of competitor provider directories are used to identify potential providers for network adequacy recruitment purposes.

4. Out of Network Provider paid at In Network level guideline
• For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable, Wellfleet Group, LLC will treat the services</td></tr>
</table>

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		<table><tr><td>Urgent care for medical services</td><td>72 hours</td></tr><tr><td>Routine primary care</td><td>15 calendar days</td></tr><tr><td>Preventive visit/well visit</td><td>30 calendar days</td></tr><tr><td>Non-urgent specialty care</td><td>30 calendar days</td></tr></table> 4. Out of Network Provider Member Request • Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and a. There are no specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease; or b. There is no reasonable access to specialist or Non- physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel. • If a request for a referral is accepted, for purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by he Member, Wellfleet Group, LLC will treat the services received by the specialist or Non-physician specialist who is an Out-of- Network Provider as if the service was provided by an In-Network Provider.	received by the specialist or Non-physician specialist who is a Non- Preferred Provider as if the service was provided by a Preferred Provider. • Out of Network paid at In Network claims data

<table>
<tr><th><u>Benefit Classification/Sub-classification</u></th><th><u>Factors</u> (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)</th><th><u>Evidentiary Standards and Applicable Thresholds</u> (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)</th><th><u>Source(s) for Each Evidentiary Standard</u> (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)</th></tr>
<tr><td>In Network Outpatient Office – MHSUD</td><td>1. State and Federal Law, as applicable
2. Lack of Provider Availability
3. Lack of Provider Accessibility to meet Appointment Wait Time Standards
4. Out of Network Provider Member request</td><td>1. State and Federal Law, as applicable
2. Provider Availability
a. Travel Distance Standards – Calculation of the distance between a customer and provider, in miles. Plan uses Quest Analytics to conduct this reporting/analysis.
b. Maryland specific standards:
i. "Urban" means a zip code that has a human population equal to or greater than 3,000 per square mile.
ii. "Suburban" means a zip code that has a human population equal to or greater than 1,000 per square miles by less than 3,000 per square mile.
iii. "Rural" means a zip code that has a human population of less than 1,000 per square mile.
c. Inpatient Psychiatric Facility: 15/45/75 miles
3. Provider Accessibility
a. Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined
b. through provider surveys conducted twice per year.
c. Maryland specific standards:
<table><tr><th colspan="2">Waiting Time Standards</th></tr><tr><td>Inpatient urgent care for mental health services</td><td>72 hours</td></tr><tr><td>Inpatient urgent care for substance use disorder services</td><td>72 hours</td></tr><tr><td>Outpatient urgent care for mental health services</td><td>72 hours</td></tr></table></td><td>1. State and Federal Law, as applicable Maryland access standards, implemented through Evernorth Policies
• HM-NET-032 Measuring Availability of Behavioral Practitioners and Providers
• HM-NET-031 Measuring Accessibility of Behavioral Services.
2. Provider Availability is measured quarterly using Quest Analytics software to conduct distance analysis.
a. Appointment Wait Time Standards by Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty monitoring
b. Customer and/or Client Requests
c. Customer Complaints
d. Quality Concerns
e. Out-of-Network Provider Utilization
f. MD Executive Summary 2024 Template PPO & OAP
3. Provider Accessibility is measured through a provider survey conducted twice per year.</td></tr>
</table>

<table>
<tr><th><u>Benefit Classification/Sub-classification</u></th><th><u>Factors</u> (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)</th><th><u>Evidentiary Standards and Applicable Thresholds</u> (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)</th><th><u>Source(s) for Each Evidentiary Standard</u> (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Outpatient urgent care for substance use disorder services</td><td>72 hours</td></tr>
<tr><td>Non-urgent mental health care</td><td>10 calendar days</td></tr>
<tr><td>Non-urgent substance use disorder care.</td><td>10 calendar days</td></tr>
</table>

4.
Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and
a. There are no specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or
disease; or
b. There is no reasonable access to specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel.
• If a request for a referral is accepted, for purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by the Member, Wellfleet Group, LLC will treat the services received by the specialist or Non- physician specialist who is an Out-of-Network Provider as if the service was provided by an In-Network Provider.</td><td>Lack of access is determined during Network Adequacy review, in the event any internal and/or state-specific metric is not met. Inability to remediate that deficiency is caused by the unavailability of a provider/facility in the appropriate location with the appropriate degree/specialty. A variety of resources including internet searches, out-of- network utilization, and review of competitor provider directories are used to identify potential providers for network adequacy recruitment purposes.

4. Out of Network Provider paid at In Network level guideline
• For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable, Wellfleet Group, LLC will treat the services received by the specialist or Non- physician specialist who is a Non- Preferred Provider as if the service was provided by a Preferred Provider.
• Out of Network paid at In Network claims data</td></tr>
</table>

<table>
<tr><th><u>Benefit Classification/Sub-classification</u></th><th><u>Factors</u> (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)</th><th><u>Evidentiary Standards and Applicable Thresholds</u> (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)</th><th><u>Source(s) for Each Evidentiary Standard</u> (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)</th></tr>
<tr><td></td><td></td><td>• For a Mental Health Disorder or Substance Misuse Disorder, services received in accordance with this provision will be provided at no greater cost to the Member than if the Covered Medical Expenses were received by an In-Network Provider.</td><td></td></tr>
<tr><td>In Network Outpatient-All Other MS</td><td>1. State and Federal Law, as applicable
2. Lack of Provider Availability
3. Lack of Provider Accessibility to meet Appointment Wait Time Standards
4. Out of Network Provider Member request</td><td>1 . State and Federal Law, as applicable
2. Provider Availability
• Travel Distance Standards – Calculation of the distance between a customer and provider, in miles. Plan uses Quest Analytics to conduct this reporting/analysis.
o Maryland specific standards:
• "Urban" means a zip code that has a human population equal to or greater than 3,000 per square mile.
• "Suburban" means a zip code that has a human population equal to or greater than 1,000 per square miles by less than 3,000 per square mile.
• "Rural" means a zip code that has a human population of less than 1,000 per square mile.

<table><tr><th rowspan="2">SPECIALTY</th><th colspan="3">MAXIMUM DISTANCE (MILES)</th></tr><tr><th>URBAN [1]</th><th>SUB- URBAN [2]</th><th>RURAL AREA [3]</th></tr></table></td><td>1.State and Federal Law, as applicable Maryland access standards, implemented through Cigna Policies
• PS-8 Measuring Availability of Providers for Insured Products
• PS-6 Measuring Accessibility of
• Medical Services
2. Provider Availability is measured quarterly using Quest Analytics software to conduct distance analysis.
• Appointment Wait Time Standards by Provider Type (i.e., hospital, clinic and practitioner) and/or specialty monitoring
• Customer and/or Client Requests
• Customer Complaints
• Quality Concerns
• Out-of-Network Provider Utilization
• MD Executive Summary 2024 Template PPO & OAP

3. Provider Accessibility is measured through a provider survey conducted twice per year.</td></tr>
</table>

<table>
<tr><th><u>Benefit Classification/Sub-classification</u></th><th><u>Factors</u> (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)</th><th><u>Evidentiary Standards and Applicable Thresholds</u> (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)</th><th><u>Source(s) for Each Evidentiary Standard</u> (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)</th></tr>
<tr><td></td><td></td><td>
<table>
<tr><td>Acute Inpatient Hospitals</td><td>10</td><td>30</td><td>60</td></tr>
<tr><td>Critical Care Services—Intensive Care Unit</td><td>10</td><td>30</td><td>100</td></tr>
<tr><td>Skilled Nursing Facilities</td><td>10</td><td>30</td><td>60</td></tr>
</table>

3. Provider Accessibility
• Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined through provider surveys conducted twice per year.
o Maryland specific standard
<table>
<tr><th colspan="2">Waiting Time Standards</th></tr>
<tr><td>Urgent care for medical services</td><td>72 hours</td></tr>
<tr><td>Routine primary care</td><td>15 calendar days</td></tr>
<tr><td>Preventive visit/well visit</td><td>30 calendar days</td></tr>
<tr><td>4Non-urgent specialty care</td><td>30 calendar days</td></tr>
</table>
</td><td>Lack of access is determined during Network Adequacy review, in the event any internal and/or state-specific metric is not met.
Inability to remediate that deficiency is caused by the unavailability of a provider/facility in the appropriate location with the appropriate degree/specialty. A variety of resources including internet searches, out-of-network utilization, and review of competitor provider directories are used to identify potential providers for network adequacy recruitment purposes.

4. Out of Network Provider paid at In Network level guideline
• For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable, Wellfleet Group, LLC will treat the services received by the specialist or Non- physician specialist who is a Non- Preferred Provider as if the service was provided by a Preferred Provider.
• Out of Network paid at In Network claims data</td></tr>
</table>

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and a. There are no specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease; or b. There is no reasonable access to specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel. • If a request for a referral is accepted, for purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by the Member, Wellfleet Group, LLC will treat the services received by the specialist or Non- physician specialist who is an Out-of-Network Provider as if the service was provided by an In-Network Provider. For a Mental Health Disorder or Substance Misuse Disorder, services received in accordance with this provision will be provided at no greater cost to the Member than if the Covered Medical Expenses were received by an In-Network Provider.	
In Network Outpatient All Other MHSUD	1. State and Federal Law, as applicable 2. Lack of Provider Availability	1. State and Federal Law, as applicable 2. Provider Availability • Travel Distance Standards – Calculation of the distance between a customer and provider, in miles. Quest Analytics is used to conduct this reporting/analysis. • Maryland specific standards:	1. Maryland access standards, implemented through Evernorth Policies • HM-NET-032 Measuring Availability of Behavioral Practitioners and Providers • HM-NET-031 Measuring Accessibility of Behavioral Services.

<table>
<tr><th><u>Benefit Classification/Sub-classification</u></th><th><u>Factors</u> (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)</th><th><u>Evidentiary Standards and Applicable Thresholds</u> (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)</th><th><u>Source(s) for Each Evidentiary Standard</u> (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)</th></tr>
<tr><td></td><td>3. Lack of Provider Accessibility to meet Appointment Wait Time Standards
4. Out of Network Provider Member request</td><td>▪ "Urban" means a zip code that has a human population equal to or greater than 3,000 per square mile.
▪ "Suburban" means a zip code that has a human population equal to or greater than 1,000 per square miles by less than 3,000 per square mile.
▪ "Rural" means a zip code that has a human population of less than 1,000 per square mile.
• Inpatient Psychiatric Facility: 15/45/75 miles
3. Provider Accessibility
• Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined
• through provider surveys conducted twice per year.
• Maryland specific standards:
<table><tr><th colspan="2">Waiting Time Standards</th></tr><tr><td>Inpatient urgent care for mental health services</td><td>72 hours</td></tr><tr><td>Inpatient urgent care for substance use disorder services</td><td>72 hours</td></tr><tr><td>Outpatient urgent care for mental health services</td><td>72 hours</td></tr><tr><td>Outpatient urgent care for substance use disorder services</td><td>72 hours</td></tr><tr><td>Non-urgent mental health care</td><td>10 calendar days</td></tr></table></td><td>2. Provider Availability is measured quarterly using Quest Analytics software to conduct distance analysis.
• Appointment Wait Time Standards by Provider Type (i.e., hospital, clinic, and practitioner) and/or specialty monitoring
• Customer and/or Client Requests
• Customer Complaints
• Quality Concerns
• Out-of-Network Provider Utilization
• MD Executive Summary 2024 Template PPO & OAP

3. Provider Accessibility is measured through a provider survey conducted twice per year.
Lack of access is determined during Network Adequacy review, in the event any internal and/or state-specific metric is not met.
Inability to remediate that deficiency is caused by the unavailability of a provider/facility in the appropriate location with the appropriate degree/specialty. A variety of resources including internet searches, out-of-network utilization, and review of competitor provider directories are used to identify potential providers for network adequacy recruitment purposes.</td></tr>
</table>

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		Non-urgent substance use disorder care. — 10 calendar days 4. Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and a. There are no specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease; or b. There is no reasonable access to specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel. • If a request for a referral is accepted, for purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by the Member, Wellfleet Group, LLC will treat the services received by the specialist or Non- physician specialist who is an Out-of-Network Provider as if the service was provided by an In-Network Provider. • For a Mental Health Disorder or Substance Misuse Disorder, services received in accordance with this provision will be provided at no greater cost to the Member than if the Covered Medical Expenses were received by an In-Network Provider.	4. Out of Network Provider paid at In Network level guideline • For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable, Wellfleet Group, LLC will treat the services received by the specialist or Non- physician specialist who is a Non- Preferred Provider as if the service was provided by a Preferred Provider. • Out of Network paid at In Network claims data

<table>
<tr><th><u>Benefit Classification/Sub-classification</u></th><th><u>Factors</u> (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)</th><th><u>Evidentiary Standards and Applicable Thresholds</u> (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)</th><th><u>Source(s) for Each Evidentiary Standard</u> (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)</th></tr>
<tr><td>Emergency</td><td>1. State and Federal Law, as applicable
2. Lack of Provider Availability
3. Lack of Provider Accessibility to meet Appointment Wait Time Standards
4. Out of Network Provider Member request</td><td>1 . State and Federal Law, as applicable
2. Provider Availability
• Travel Distance Standards – Calculation of the distance between a customer and provider, in miles. Plan uses Quest Analytics to conduct this reporting/analysis.
o Maryland specific standards:
• "Urban" means a zip code that has a human population equal to or greater than 3,000 per square mile.
• "Suburban" means a zip code that has a human population equal to or greater than 1,000 per square miles by less than 3,000 per square mile.
• "Rural" means a zip code that has a human population of less than 1,000 per square mile.

3. Provider Accessibility
• Appointment Wait Time Standards – Time from request of an appointment to appointment, as determined through provider surveys conducted twice per year.
o Maryland specific standard
<table><tr><th colspan="2">Waiting Time Standards</th></tr><tr><td>Emergency Care</td><td>Immediately</td></tr></table>
4.
Member is diagnosed with a condition or disease that requires specialized health care services or medical care; and</td><td>1.State and Federal Law, as applicable
Maryland access standards, implemented through Cigna Policies
• PS-8 Measuring Availability of Providers for Insured Products
• PS-6 Measuring Accessibility of
• Medical Services
2. Provider Availability is measured quarterly using Quest Analytics software to conduct distance analysis.
• Appointment Wait Time Standards by Provider Type (i.e., hospital, clinic and practitioner) and/or specialty monitoring
• Customer and/or Client Requests
• Customer Complaints
• Quality Concerns
• Out-of-Network Provider Utilization
• Prov MD Executive Summary 2024 Template PPO & OAP

Provider Accessibility is measured through a provider survey conducted twice per year.

Lack of access is determined during Network Adequacy review, in the event any internal and/or state-specific metric is not met.
Inability to remediate that deficiency is caused by the unavailability of a provider/facility in the appropriate location</td></tr>
</table>

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
		a. There are no specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease; or b. There is no reasonable access to specialist or Non-physician specialist in the Preferred Provider Organization network with the professional training and expertise to treat or provide health care services for the condition or disease without unreasonable delay or travel. • If a request for a referral is accepted, for purposes of calculating any Deductible, Copayment amount, or Coinsurance payable by the Member, Wellfleet Group, LLC will treat the services received by the specialist or Non-physician specialist who is an Out-of-Network Provider as if the service was provided by an In-Network Provider. For a Mental Health Disorder or Substance Misuse Disorder, services received in accordance with this provision will be provided at no greater cost to the Member than if the Covered Medical Expenses were received by an In-Network Provider.	with the appropriate degree/specialty. A variety of resources including internet searches, out-of-network utilization, and review of competitor provider directories are used to identify potential providers for network adequacy recruitment purposes. 4. Out of Network Provider paid at In Network level guideline • For purposes of calculating any Deductible, Copayment amount, or Coinsurance payable, Wellfleet Group, LLC will treat the services received by the specialist or Non- physician specialist who is a Non- Preferred Provider as if the service was provided by a Preferred Provider. • Out of Network paid at In Network claims data
Prescription	1. State and Federal Law, as applicable 2. Lack of Pharmacy Availability 3. Lack of Pharmacy Accessibility	1. Enacted Maryland state & Federal requirements applicable to the Plan. 2. A **single** Client or Member Notification expressing difficulty with finding an in-network pharmacy ; Performance Guarantee with Express Scripts - Network changes may not negatively impact more than **5%** of a single client's membership 3. A **single** Client or Member Notification expressing difficulty with accessing an in-network pharmacy ; Performance Guarantee with Express Scripts - Network changes may not negatively impact more than **5%** of a single client's membership	1. Internal RegEd Notification & External notification from the PBM 2. Notice from Student Health Administrative Office at each individual school or Notice from the member; Performance Guarantee within Wellfleet's Master Contract with Express Scripts, which states "The removal of a chain pharmacy from Sponsor's (Wellfleet's) network will not create disruption that impacts (i) more than 5% of all Sponsor's

Benefit Classification/Sub-classification	**Factors** (factors listed in Step 3 should be consistent with the verbiage and numbering system used in Step 2)	**Evidentiary Standards and Applicable Thresholds** (the carrier's defined level and type of evidence necessary to evaluate whether a given factor is established, present, or utilized, which results in the determination to apply or not apply a NQTL to which that factor relates)	**Source(s) for Each Evidentiary Standard** (sources in Step 3 are those used to establish the specific threshold/definition for the evidentiary standard; see complete instructions for distinctions between sources listed in Steps 2 and 3)
			Members and (ii) more than 5% of a single group's (schools) Members 3.Notice from Student Health Administrative Office at each individual school or Notice from the member; Performance Guarantee within Wellfleet's Master Contract with Express Scripts, which states "The removal of a chain pharmacy from Sponsor's (Wellfleet's) network will not create disruption that impacts (i) more than 5% of all Sponsor's Members and (ii) more than 5% of a single group's (schools) Members

Step 4

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, as written. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(3)).

Cigna maintains an open network for both M/S and MH/SUD Network Providers, such that new providers looking to contract with Cigna will be admitted if they meet Cigna's Network Provider admission criteria ("Credentialing Criteria").

1) To ensure network adequacy for both MH/SUD and M/S networks in the state of Maryland, Cigna drafts a single Network Adequacy Plan for both MH/SUD and M/S individual plan type networks for submission annually in July. Requirements for such Network Adequacy Plan submissions are reflected in the PS-8 Measuring Availability of Providers for Insured Products applicable to the medical network for M/S benefits and HM-NET-032 Measuring Availability of Behavioral Practitioners and Providers, applicable to the behavioral health network for MH/SUD benefits. The Network Adequacy Plan includes requirements for both Provider Availably and Provider Access.

   M/S and MH/SUD Network Adequacy monitoring uses separate but aligned policies (Measuring Availability of Providers for Insured Products policy (PS-8) Measuring Availability of Behavioral Practitioners and Providers policy (HM-NET-032)). M/S and MH/SUD utilize the same geo-access software (Quest Analytics) for measuring and assessing Network Adequacy standards. Use of the same system ensures comparability of the tools and methodologies used for assessment.

M/S and MH/SUD network adequacy and compliance teams regularly assess changes and additions to network adequacy requirements in conjunction with each other, prior to implementing policy changes.

2) In its review of Provider Availability, Cigna reviewed the above-mentioned policies (PS-8 and HM-NET-32) to ensure Maryland specific Provider to Enrollee Ratio Standards were reflected in writing and such standards were being applied. Additionally, Cigna reviewed provider availability ratios as between M/S and MH/SUD providers. In this instance the applicable ratio if 1:2,000 for a M/S non- PCP provider and 1:2,000 for a MH/SUD provider. compared between M/S and MH/SUD and concluded that the 1:2,000 ratio for MH/SUD was comparable to the M/S 1:2,000 ratio for non-PCP services. Cigna considers MH/SUD specialty services, rather than primary care, therefore it is compared to non-PCP specialties. CMS defines Specialty Care as "health services that focus on a specific area of medicine or group of patients with specific types of symptoms and conditions" and Primary Care as "health services that cover a range or prevention, wellness and treatment for common illnesses". Mental Health and Substance Use Disorder services focus on a specific area of medicine, as such MH/SUD represents a specialty service.

   In its review of Travel Distance Standards, Cigna reviewed the above-mentioned policies (PS-8 and HM-NET-32) to ensure Maryland specific standards distance standards are reflected in writing between M/S and MH/SUD facility types and concluded that the standards were comparable. Standards for Inpatient Psychiatric Facilities were 5-15 miles further than Acute Inpatient Hospitals.

   Though the standards are different, they are comparable given Inpatient Psychiatric Facilities are less available than Acute Inpatient Hospitals. Additionally, travel distance between M/S and MH/SUD provider types were compared, in many instances the 10/25/60 mile requirement for MH/SUD providers (i.e., LCSW, Psychiatry, Psychology) was a shorter distance than for medical specialists (i.e., Endocrinology, Allergy/Immunology).

3) In its review of Provider Accessibility, Cigna reviewed the above-mentioned policies (PS-8 and HM-NET-32) to ensure Maryland specific Appointment Wait Time Standards were reflected in writing for M/S and MH/SUD providers. Urgent care standards were the same between M/S and MH/SUD at 72 hours and non-urgent services for MH/SUD were 10 calendar days compared to 30 calendar days for M/S, meaning time to care for MH/SUD services is shorter for customers. Additionally, Cigna confirmed the implementation of UM-20 Network Adequacy Provision Policy, which is applicable for both MH/SUD and M/S. This policy establishes in writing “The Network Adequacy Provision” criteria for authorization of services by a non-participating (Out-of-Network) health care professional at the in-network level of benefits when an appropriate qualified, participating health care professional is not available to provide medically necessary services within a reasonable distance from the customer’s home or within reasonable appointment availability time frames (distance and availability time frames are dictated by state law). If at least one participating health care professional is not available within the established mileage specification the customer may receive authorization to visit a non-participating health care professional at the in-network benefit level.” In the event of a provider shortage, the time between the knowledge of such provider shortage the remediation of such shortage, members may receive out of network services at the in-network benefit level.

   Cigna conducts quality management activities for both medical and behavioral healthcare products. Evernorth maintains NCQA Managed Behavioral Healthcare Organization (“MBHO”) Accreditation and conducts an annual directory audit which includes a valid random sample to ensure the network and directory meet all NCQA

MBHO accreditation requirements. MBHO Accreditation includes standards for Behavioral Health Care, Credentialing/Re-credentialing, Provider Accessibility and Availability Monitoring, and Provider Contracting and Satisfaction. Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records). CHLIC also maintains NCQA accreditation, which requires a comprehensive and rigorous audit of the Quality Program documents, policies, and other materials regarding Quality Management, Utilization Management, Case Management, Care Coordination, Credentialing, and Members' Rights & Responsibilities (approximately 250 documents). This evidence spans a period of 2 years and much of the evidence must be reviewed and approved by our Medical Management Quality Committee ("MMQC"), Integrated Health Management Quality Committee ("IHMQC"), and Clinical Advisory Committee ("CAC").
Additionally, NCQA performs an audit of a random sample of denials, appeals, case management, and credentialing cases (approximately 350 records).

NCQA Requirements dictate that Cigna monitors MH/SUD and M/S provider availability and accessibility utilizing various elements including:

- The use of ratios such as the number of each type of practitioners to number of members or the number of primary care practices accepting new patients to number of members.
- The geographic distribution of practitioners that are within an acceptable distance to a practitioner's office or within an acceptable drive time.
- A Quantitative and qualitative analysis that includes initial measurements to analyze data, then subsequent remeasurements if quantitative analysis demonstrates that stated goals were not met.

4) Wellfleet Insurance Company evaluated its MD Out of Network paid at in network level guideline which Wellfleet will pay at the Preferred Allowance level for Treatment by a Non-Preferred Provider and will calculate the Insured Person's cost-sharing amount at the Preferred Provider level if there is no Preferred Provider in the service area available to treat the member for a specific Covered Injury or Covered Sickness; or Wellfleet cannot provide the member access to a Preferred Provider to treat a specific Covered Injury or Covered Sickness without unreasonable travel or delay; or cannot reasonably reach a Preferred Provider. Wellfleet will work the request within 2 working days after receipt of the information necessary to make the determination. This policy applies to both MS and MHSUD providers.

Cigna and Evernorth each maintain separate but aligned policies regarding measuring access and availability of providers and services to ensure that provider availability and accessibility is comparable to and no more stringently designed and applied to MH/SUD benefits, as written. The separate policies are maintained due to variations that may exist between MH/SUD and M/S standards from a federal, state, or internal standard perspective. Additionally, Cigna has separate contracting, compliance and monitoring teams that separate assess compliance with requirements for MH/SUD and M/S networks. However, both the MH/SUD and M/S teams work together to ensure parity compliance both in writing, by at least annually assessing and comparing their policies and in operation by at least annually assessing in operation compliance with travel distance and appointment standards. M/S and MH/SUD policy owners work together to assess policy changes and implement similar policies and processes, where appropriate, and the M/S and MH/SUD have representative on the policy committee to ensure awareness of and compliance with parity from a policy and standards perspective.

Policies PS_6 and HM_NET_031 demonstrate establishing national accessibility standards and a national methodology for assessing performance against those standards. The use of customer surveys and complaints and measuring results against metrics established by the state or the national accessibility standard. A continuous quality improvement process is used to identify opportunities for improvement. Each provider panel shall meet the wait time standards for at least 95% of the enrollees covered under the plan. When clinically appropriate, telehealth may be utilized. A semiannual Maryland specific Provider survey is conducted to measure the following performance measures.

Waiting Time Standards	
Urgent care (including medical, behavioral health, and substance use disorder services)	72 hours
Non-urgent specialty care	30 calendar days
Non-urgent behavioral health/substance use disorder services	10 calendar days

When access to care standards are not met, Cigna engages in active recruitment of the relevant provider type and/or specialty at issue. Wellfleet receives member requests to have an Out of Network provider be reimbursed at In Network level and approves when there are no specialist or non physician specialist in the provider organization network with the professional training and expertise to treat the condition. Wellfleet will treat the services received by the provider as if the service was provided by an In Network provider.

The Behavioral Network Compliance team, led by a Senior Manager with 10+ years of experience in Behavioral Health Network/Provider Contracting/Provider Relations/Compliance, intakes and assesses all new and changing regulations related to Network Adequacy. This team also maintains internal policies housing this information, in consultation with various business owners, such as the Behavioral Network Contracting Director and Behavioral Network Provider Relations & Strategy Director (15+ years industry experience).

After business assessment of the policy contents, all policies are formally governed by Cigna's policy committee. This committee is composed of representative from multiple business areas that provide oversight of and approval for Cigna's policies. Medical and BH policies are managed by the same committee.

Policies are reviewed at least annually but may be updated more frequently due to changes in regulations, requirements, or business processes. Time spent maintaining policies is highly variable depending on the volume of changes being required and whether implementation/corrective actions are needed.

Pharmacy

Express Scripts provides the management of the pharmacy network available to Wellfleet customers, as agreed upon in the Performance Guarantee of our vendor contract. There is no distinction within the Pharmacy contracting process, the Performance Guarantee, or the Pharmacy Network Listing, between M/S and MH/SUD related prescriptions, nor are pharmacies classified as M/S or MH/SUD. The Wellfleet pharmacy information is housed with the Prescription Drug formulary, Prior Authorization listings, and other pertinent Prescription Drug information and serves as a convenient single point of access for its members. In the instance of any of the factors listed above being triggered, Express Scripts will perform outreach to pharmacies local to our members to initiate contract negotiations. Again, these negotiations do not include whether the pharmacy dispenses MH/SUD or M/S drugs.

The factors, sources, and evidentiary standards utilized to support any potential pharmacy network shortages are applied in a comparable manner and no more stringently for MHSUD as compared to M/S, as written.

Step 5

Provide the comparative analyses performed and relied upon to determine whether each NQTL is comparable to and no more stringently designed and applied, in operation. The comparative analyses shall include the results of any audits and reviews, and an explanation of the methodology. (§15-144(e)(4)).

Cigna considers the composition of its current M/S network providers and MH/SUD network providers by provider type and/or specialty, in addition to census (membership) data, to ensure it maintains an adequate M/S provider network and an adequate MH/SUD provider network to meet the clinical needs of its customers, contracted requirements and identified client expectations as applicable "Access" is the extent to which Cigna has providers of an appropriate type and number distributed geographically to meet the needs of members and "availability" is defined as the timeliness within which a member can obtain services by appointment (i.e., urgent appointment within 72 hours). Cigna conducts oversight and monitoring of the adequacy of its M/S provider network(s) and MH/SUD provider network to assess whether they are meeting its internal and regulatory driven network access standards.

When access to care standards are not met, each engage in active recruitment of the relevant provider type and/or specialty at issue. Both Cigna and Evernorth monitor network adequacy on at least an annual basis and create recruitment and corrective action plans to address any deficiencies. Recruitment activity may include targeted specialties or geographies. Upon determination of a deficiency, Cigna utilizes a variety of resources, including but not limited to: state licensing boards, competitor provider directories, out-of-network claims/utilization reports and internet searches to identify provider/facility contracting leads. Applicable leads are routed to the appropriate contracting teams for recruitment, Network adequacy corrective actions determined during annual review as well as Quality Management analysis of provider surveys and customer complaints related to access and availability are also used to assess network adequacy and inform corrective action plans. Recruitment plans to address network adequacy are developed and modified as needed throughout the year.

Wellfleet reviewed its 2023 claims data which demonstrated zero (0) Out of Network providers paid at In Network levels. When a request for a referral is accepted, for purposes of calculating coinsurance payable by the member, Wellfleet will treat the services received by the Out of Network provider as if the service was provided by an In Network provider.

Both Cigna and Evernorth conduct at least annual analysis of network adequacy and availability requirements. Cigna acknowledges provider types are not identical and cannot be made identical due to the nature of the inherent differences between M/S and MH/SUD provider services, credentialing, and licensing requirements. Both Cigna and Evernorth use Quest Analytics software program to determine the travel distance between a participant and defined provider types and evaluate the availability of providers within the network. Availability standards are established by utilizing Federal and State standards and internal performance metrics for both the M/S and MH/SUD provider networks.

Cigna and Evernorth use the same tool (Quest Analytics) to conduct the time/distance network adequacy assessment. Similar information is input into the tool (list of providers, list of customers, time/distance standards). Results are produced and reviewed for accuracy prior to being formally presented to and accepted by the relevant Quality Committee. In addition to compliance with all applicable state and federal Network Adequacy requirements, Cigna and Evernorth also maintain and monitor against internal network adequacy standards, as defined in policy HM-NET-032 and PS-8). The standards are monitored on a quarterly basis to ensure compliance. Additionally, the policy and included standards are reviewed on at least an annual basis to ensure they remain adequate and relevant in address provider shortages.

Provider appointment availability requirements are monitored for both MH/SUD and M/S via a Plan initiated survey twice per year. Survey format is similar, but differs due to differences in the required appointment availability standards (i.e. M/S 30 calendar days, MH/SUD 10 calendar days). Results are compiled and analyzed at the end of each survey route. Recruitment and corrective action plans are created to address any deficiencies. Recruitment activity may include targeted specialties or geographies. Upon determination of a deficiency, Cigna utilizes a variety of resources, including but not limited to: state licensing boards, competitor provider directories, out-of-network claims/utilization reports and internet searches to identify provider/facility contracting leads. Applicable leads are routed to the appropriate contracting teams for recruitment, Network adequacy corrective actions determined during annual review as well as Quality Management analysis of provider surveys and customer complaints related to access and availability are also used to assess network adequacy and inform corrective action plans. Recruitment plans to address network adequacy are developed and modified as needed throughout the year.

For both its M/S and MH/SUD provider directories, Cigna has aligned policies to establish and monitor appropriate Provider Directory display, search and navigation, management, and appeals process. Policies are reviewed on at least an annual basis to ensure compliance with parity and all state/federal regulations. Additionally, annual review ensures appropriate oversight and alignment of Evernorth's policies and procedures to Cigna's.

Annually, Cigna and WIC submit Network Access Filing, which includes information on both the M/S and MH/SUD networks. Separate filings are submitted by plan type. The Network Access Filing includes:

.

- Executive Summary:
    - Percentage of enrollees for which the carrier met the required travel distance standard as prescribed by COMAR 31.10.44.05
    - Number of Local Health Departments and Essential Community Providers available in the Plan's network
    - Median appointment wait times, as derived from Plan conducted appointment availability surveys.
    - Provider to enrollee ratios, as prescribed by COMAR 31.10.44.07
- Assessment of Network Sufficiency:
    - Description of the network and the factors used to build and maintain the network.
    - Plan's current and prior year enrollment
    - Number of in-network providers and facilities within the travel distance standards as required by COMAR 31.10.44.04
    - Information on how Plan defines MH/SUD provider types.
    - Role of telehealth in meeting network sufficiency requirements.
    - Plan's monitoring processes and methods
- Internal Procedures & Processes
    - Customer Service Representatives
    - Assistance to Enrollees in obtaining services
    - Network directory(ies)
    - Enrollee portal
- Geo Access analysis – comparing enrollee locations to provider/facility locations to assess compliance with Maryland-specific time/distance adequacy requirements.

- Justification/waivers required for any areas of deficiency, using Maryland prescribed forms.

Per the provider survey administered by Cigna, the following appointment availability results were obtained. M/S urgent care and MH/SUD inpatient urgent care results were compared and found that MH/SUD services were typically available quicker than medical urgent care services. Additionally, standards for non-urgent care were able to be compared and found comparable results, that MH/SUD care was, on average, available faster than M/S non-urgent care services.

April 2024 Median Appointment Waiting Time All Cigna Networks			
	Medical	**Mental Health**	**Substance Use Disorder**
Urgent Care	21.1 hours		
Inpatient Urgent Care		10.9 hours	17.1 hours
Outpatient Urgent Care		52.1 hours	43.8 hours
Routine Primary Care	2.4 calendar days		
Preventative care/Well visit	6.5 calendar days		
Non- Urgent	5.8 calendar days (specialty care)	5.4 calendar days	3.0 calendar days

While some MH/SUD providers may be able to render services for both Mental Health and Substance Use diagnosis, oftentimes different providers are needed, which could result in appointment availability variability. Cigna asserts that the difference in appointment wait time between MH and SUD was not significant (~10 hours) and indicated that customers could receive any MH/SUD care within a reasonable amount of time.

Wellfleet assessed its MH/SUD provider network based upon claims submitted 2023. Due its small number of covered lives(537), the percent of providers listed with no claims in 6months was >99%. The number of covered lives per provider is <1. The provider network is adequate for the population for our plans.

Pharmacy

Express Scripts maintains the Pharmacy Network for Wellfleet. There are currently 1,064 pharmacies contracted with the PBM throughout the state. See chart below for location of pharmacies. None of these pharmacies dispense exclusively MH/SUD or M/S medications.

County	Count of Contracted Pharmacy
ALLEGANY	15
ANNE ARUNDEL	106

BALTIMORE	157
BALTIMORE CITY	130
CALVERT	14
CAROLINE	4
CARROLL	28
CECIL	16
CHARLES	25
DORCHESTER	4
FREDERICK	52
GARRETT	6
HARFORD	56
HOWARD	53
KENT	3
MONTGOMERY	174
PRINCE GEORGE'S	125
QUEEN ANNE'S	6
SOMERSET	3
ST. MARY'S	13
TALBOT	8
WASHINGTON	33
WICOMICO	19
WORCESTER	14

If Wellfleet is notified of Pharmacy availability or accessibility issues by either a Student Health Administrative Office at one of our Client Schools or by a single member. Wellfleet works with the member and school to ensure adequate coverage. This process is applied in the same manner to MH/SUD and M/S Pharmacy availability or accessibility issues. Express Scripts will analyze the network pharmacies within the member/school's location and identify pharmacies that would be most appropriate to fulfill the needs. If contracting with a new pharmacy is necessary, Express Scripts will perform outreach and negotiations to ensure that Wellfleet members are taken care of. If the pharmacy is unwilling to agree to standard terms with Express Scripts, Wellfleet can add the pharmacy to the network with various pricing methodologies that are more favorable for the pharmacy (Pass-through, NADAC, acquisition, etc.). In the state of Maryland, this path to network contracting has not been required since inception of the Wellfleet plan.

Step 6

Identify the measures used to ensure comparable design, development, and application of each NQTL that is implemented by the carrier and any entity delegated by the carrier to manage MH benefits, SUD benefits, or M/S benefits on behalf of the carrier. (§15-144(e)(5)).

For both its M/S provider network and its MH/SUD provider network, Cigna aligned policies to establish and monitor clinically appropriate access and availability. Alignment includes standard (1) provider to customer ratios by provider type and/or specialty in urban, suburban and rural geographic regions; (2) time/distance standards for accessing the various provider types and/or specialties located within urban, suburban and rural geographic regions; and (3) appointment wait times for emergency care, urgent care and routine outpatient care for the various provider types and/or specialties, as prescribed by NCQA. Policies are reviewed on at least an annual basis to ensure compliance with parity and all states/federal regulations. Additionally, results of the appointment availability surveys are reviewed at the end of each survey cycle. MH/SUD and M/S results are reviewed together.

Where appropriate, recruitment plans and corrective actions are aligned to ensure parity between MH/SUD and M/S results and action plans. For example, as part of a recent review of the MH/SUD network is was determined that there were deficiencies for Opioid Treatment Programs (OTPs). Plan used Maryland and SAMHSA OTP listings to identify programs that would remediate the deficiencies. These recruitment leads were passed along to Plans' MH/SUD contracting teams for outreach. That team will attempt to outreach the programs multiple times to make a good faith contract offer.

Assessing supply and demand of M/S and MH/SUD facilities are based upon the same indicators including, but not limited to, NCQA and NAIC network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction surveys; and customer complaint data. Providers to customer ratios are normally calculated with the Provider count constant at 1, where the Provider count is based on unique Provider and the Customer count is based on customer's home zip code. To convert to a ratio in this format, Cigna divides the customer count by the Provider count. For example, for an area with 3,000 customers and 30 Providers, – the ratio would be 1:100.

Geographic variation in availability of providers – for example, outpatient utilization patterns vary dramatically across national regions and plan designs. Regions with high density of providers may have higher than national norm utilization and our outlier/unusual case identification program consider geographic specific variations. In remote or rural areas, occasionally geographic availability guidelines are not able to be met due to lack of, or absence of, qualified Practitioners and/or Providers. The organization may need to alter the standard based on local availability. Supporting documentation that such situation exists must be supplied along with the proposed guideline changes to the appropriate Quality Committee for approval. Annually, the Quality Management team reviews and assesses the behavioral health care professional network to determine if goals are met and if the network is robust enough to meet the needs of its customers. NCQA requires certain measures to assess availability for urban/suburban, rural, and ratios (behavioral health care professional to customers) across its networks. Likewise, the Network team reviews and assesses the medical health care professional network to determine if goals are met in 90% of the zip codes within the service area for each provider specialty category for PCPs, High Volume Specialist, High Impact Specialists, and Hospitals.

Cigna defines its *supply of providers* as the number of available providers of a particular type/license in a particular geographic area. Factors in determining supply of providers include (1) the evaluation of Cigna's existing network, the evidentiary source of which is Cigna's internal provider contracting and credentialing data sources; and (2) the evaluation of other payers' networks the evidentiary source of which is third party data comprising of competitor intel, i.e., directories, licensing and NPI registry:

Cigna defines its *demand for provider type* as the number of members requiring a particular service/level of care in a particular geographic area. Factors applicable to *provider demand* include (1) internal claims experience, the evidentiary source of which is Cigna's historical claims data and (2) external GeoAccess reports the evidentiary source of which is network access assessments that measure the distance between members and providers. These assessments can be leveraged to determine how to adequately support its existing membership and the potential market if a strategic growth/network fortification plan is undertaken, as required to meet any applicable regulatory access standards.

Cigna defines a lack of access as determined during Network Adequacy review, in the event any internal and/or state-specific metric is not met. Inability to remediate that deficiency is caused by the unavailability of a provider/facility in the appropriate location with the appropriate degree/specialty. Plan uses a variety of resources including internet searches, out-of-network utilization, and review of competitor provider directories to identify potential providers for network adequacy recruitment purposes.

To ensure adequacy of its behavioral Health Network, Cigna maintains Provider Availability and Accessibility Monitoring Program (the "Program") implemented by the Behavioral Health Quality Committee. The Program includes the monitoring of provider availability and access on an ongoing basis and an analysis is performed annually to ensure that established accreditation, state, and federal standards for reasonable geographical location, number of providers, appointment availability, and provision for emergency care are measured. Monitoring activities may include evaluation of satisfaction surveys, evaluation of complaint and appeal reports, and evaluation of providers to customer ratios. An assessment of the provider network is also performed to ensure that the network meets the cultural, ethnic, racial, and linguistic needs and preferences of customers. Specific deficiencies are addressed with a corrective action plan and follow up activities are conducted to reassess compliance. Cigna uses access assessments to evaluate that its supply of M/S and MH/SUD providers adequately meets its membership demand.

Maryland Specific Standards

Wellfleet is aware of not meeting access requirements due to lack of providers available for the opioid treatment programs. Where there are available provider types not meeting access standards, Cigna is actively recruiting. Additionally, waiver submissions for network adequacy or appointment wait time deficiencies and corrective action plan are submitted per requirement set forth by Maryland. The research shows opioid treatment programs are not available inside the radius standards at this time.

Wellfleet is aware of the significant workforce shortages for MH/SUD providers. The supply (or lack thereof) of quality behavioral health providers is outside of Cigna's control. While Cigna maintains parity in process and Network admissions standards are applied in a manner that is comparable to and no more stringent for MH/SUD than for M/S, the Networks do not necessarily produce the same outcome, which is permissible under MHPAEA.

To address this issue, Cigna maintains an open network and supplements its network with access to over 250,000 virtual behavioral healthcare. The virtual care behavioral health network includes large provider groups including, but not limited to Alma, Headspace, Headway, Talkspace and many smaller groups/clinics and independent providers. Moreover, Cigna monitors and reviews its credentialing data and tracks approval and denial rates as well as timelines for approval. Wellfleet has telehealth programs available for MHSUD treatment including Teladoc and CareConnect for crisis that are available to our members.

Step 7

Disclose the specific findings and conclusions reached by the carrier that indicate compliance with the Parity Act. (§15-144(e)(6)).

Cigna maintains a robust behavioral health network of in person and virtual providers including child, adolescent, and adult psychiatrists; clinical psychologists; clinical social workers; psychiatric nurse practitioners (with and without prescription-writing privileges); mental health/substance abuse counselors; and marriage and family therapists as in alignment with regulatory requirements. Cigna measures behavioral health network adequacy based upon three categories of providers: prescribers, psychologists, and master's level clinicians. This encompasses all the MH/SUD provider types contracted in the network. Given MH/SUD provider shortages, Cigna considers every contracted MH/SUD provider specialty high-volume.

Provider availability and accessibility monitoring is conducted on an ongoing basis and an analysis is performed annually to ensure that established accreditation, state, and federal standards for reasonable geographical location, number of providers, appointment availability, and provision for emergency care are measured. Monitoring activities may include evaluation of satisfaction surveys, evaluation of complaint and appeal reports, and evaluation of provider to customer ratios. An assessment of the provider network is also performed to ensure that the network meets the cultural, ethnic, racial, and linguistic needs and preferences of customers. Specific deficiencies are addressed with a corrective action plan and follow up activities are conducted to reassess compliance.

Cigna assesses supply and demand of both M/S and MH/SUD provider types and/or specialties based upon the same indicators including NCQA and NAIC, and federal/state, network adequacy and access standards focused on distribution of provider types within geographic regions (i.e. zip codes); plan population density within geographic regions (i.e. zip codes); time and/or distance to access provider type within urban, suburban and rural areas; appointment wait times for emergent, urgent and routine visits; customer satisfaction surveys; customer complaint data. The conclusion of such assessments may result in an increase or decrease in the provider's reimbursement rate.

Cigna continues to invest in the breadth of the behavioral network, which has more than doubled since 2021 to approximately 13,000 MH/SUD providers and facilities in the state of Maryland. Additionally, the virtual care network (telehealth) has grown over 250% since 2021 to include over 5,000 providers. Over the past several years Cigna has conducted a comprehensive review of its MH/SUD network admission standards, including network access standards, contracting processes and reimbursement rates applicable to Network Providers. Cigna's behavioral health network remains open, and Cigna accepts all credentialed behavioral health providers who request to join the network. Any variances in contracting processes as well as a range of reimbursement rates based on percentages of Medicare RVUs as compared to M/S reimbursement rates were identified and analyzed for adherence to the NQTL requirement. Cigna may agree to non-standard contracts and increased reimbursement rates as necessary to meet access needs, particularly in specialty provider board certification shortage areas such as psychiatry and child and adolescent care.

In connection with its ongoing NQTL compliance efforts, Cigna has taken proactive, additional steps to continually ensure the comparability of standards for provider admissions into the MH/SUD provider network, including reimbursement rate methodology, to ensure the processes, strategies and evidentiary standards implemented are not more stringent for MH/SUD services than M/S services. Consistent with the NQTL requirement for comparability/stringency, Cigna has confirmed that standards for provider admission into the MH/SUD provider network, including credentialing, adequacy, and provider reimbursement rates for inpatient and outpatient services are comparable to,

and applied no more stringently than, that of the M/S provider network as written and in operation. Put differently, Cigna's network has the ability to meet the MH/SUD services needs of our enrollees by providing reasonable access to a sufficient number of in-network providers for both inpatient and outpatient services.

MHPAEA DATA REPORT FOR CALENDAR YEAR ENDING: 12/31/2023						
HEALTH PLAN		McDaniel College Washington College St Johns College				
BENEFIT	CLASSIFICATION	# OF AUTHORIZATION REQUESTS RECEIVED	# OF AUTHORIZATION REQUESTS APPROVED	# OF AUTHORIZATION REQUESTS DENIED	% APPROVED	% DENIED
MENTAL HEALTH BENEFITS	INN-INPATIENT	132	132	0	100%	0%
	OON-INPATIENT	8	8	0	100%	0%
	EMERGENCY SERVICES	4	4	0	100%	0%
	RX	0	0	0	0%	0%
	INN-OUTPATIENT OFFICE	0	0	0	0%	0%
	OON-OUTPATIENT OFFICE	0	0	0	0%	0%
	INN-OUTPATIENT ALL OTHER	3	2	1	67%	33%
	OON-OUTPATIENT ALL OTHER	0	0	0	0%	0%
SUBSTANCE USE	INN-INPATIENT	14	12	2	86%	14%

DISORDER BENEFITS	**OON-INPATIENT**	3	3	0	100%	0%
	EMERGENCY SERVICES	0	0	0	0%	0%
	RX	0	0	0	0%	0%
	INN-OUTPATIENT OFFICE	0	0	0	0%	0%
	OON-OUTPATIENT OFFICE	0	0	0	0%	0%
	INN-OUTPATIENT ALL OTHER	0	0	0	0%	0%
	OON-OUTPATIENT ALL OTHER	0	0	0	0%	0%
MEDICAL/ SURGICAL BENEFITS	**INN-INPATIENT**	127	100	27	79%	21%
	OON-INPATIENT	1	0	1	0%	100%
	EMERGENCY SERVICES	4	4	0	100%	0%
	RX	2	2	0	100%	0%
	INN-OUTPATIENT OFFICE	0	0	0	0%	0%
	OON-OUTPATIENT OFFICE	0	0	0	0%	0%
	INN-OUTPATIENT ALL OTHER	127	96	31	76%	24%

	OON-OUTPATIENT ALL OTHER	5	3	2	60%	40%
BENEFIT	**CLASSIFICATION**	**# OF CLAIMS SUBMITTED**	**# OF CLAIMS APPROVED**	**# OF CLAIMS DENIED**	**% APPROVED**	**% DENIED**
MENTAL HEALTH BENEFITS	**INN-INPATIENT**	114	61	53	54%	54%
	OON-INPATIENT	0	0	0	0%	0%
	EMERGENCY SERVICES	36	34	2	94%	6%
	RX	726	453	273	62%	38%
	INN-OUTPATIENT OFFICE	370	349	21	94%	6%
	OON-OUTPATIENT OFFICE	56	56	0	100%	0%
	INN-OUTPATIENT ALL OTHER	69	61	8	88%	1%
	OON-OUTPATIENT ALL OTHER	9	4	5	44%	56%
SUBSTANCE USE DISORDER BENEFITS	**INN-INPATIENT**	0	0	0	0%	0%
	OON-INPATIENT	0	0	0	0%	0%
	EMERGENCY SERVICES	12	11	1	92%	8%
	RX	0	0	0	0%	0%

	INN-OUTPATIENT OFFICE	0	0	0	0%	0%
	OON-OUTPATIENT OFFICE	0	0	0	0%	0%
	INN-OUTPATIENT ALL OTHER	0	0	0	0%	0%
	OON-OUTPATIENT ALL OTHER	0	0	0	0%	0%
MEDICAL/ SURGICAL BENEFITS	**INN-INPATIENT**	0	0	0	0%	0%
	OON-INPATIENT	0	0	0	0%	0%
	EMERGENCY SERVICES	0	0	0	0%	0%
	RX	937	575	362	61%	39%
	INN-OUTPATIENT OFFICE	196	196	0	100%	0%
	OON-OUTPATIENT OFFICE	6	6	0	100%	0%
	INN-OUTPATIENT ALL OTHER	16	16	0	100%	0%
	OON-OUTPATIENT ALL OTHER	0	0	0	0%	0%