MHPAEA Summary Form

Under a federal law called the Mental Health Parity and Addiction Equity Act (MHPAEA), Aetna 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).

Aetna 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 Aetna at **MHPGeneralInquiries@aetna.com**..

If you have questions on your specific health plan, please call the phone number on your ID card.

Overview:

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

Please refer to your plan documents for specific benefit coverage and limitations. Or contact us at the toll-free number on your member ID card.

1. Prior Authorization Review Process

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

Please see Aetna's **precertification lists** for identification of the medical/surgical and mental health and/or substance use disorder benefits to which a prior authorization requirement applies.

For PPO, POS, and Indemnity plans:

Precertification

You need pre-approval from us for some **covered services**. Pre-approval is also called **precertification**.

In-network
Your network **physician** or **PCP** is responsible for obtaining any necessary **precertification** before you get the care. **Network providers** cannot bill you if they fail to ask us for **precertification**. But if your **physician** or **PCP** requests **precertification** and we deny it, and you still choose to get the care, you will have to pay for it yourself.

Out-of-network
When you go to an **out-of-network provider**, you are responsible to get any required **precertification** from us. If you don't **precertify**:

- Your benefits may be reduced, or the plan may not pay. See your schedule of benefits for details.
- You will be responsible for the unpaid bills.
- Your additional out-of-pocket expenses will not count toward your **deductible** or **maximum out-of-pocket limit**, if you have any.

Timeframes for **precertification** are listed below. For **emergency services**, **precertification** is not required, but you should notify us as shown. In addition, **precertification** will not be denied on the basis of late notification from a **hospital**, if your condition prevented the **hospital** from knowing your state or our emergency notice process.

To obtain **precertification**, contact us. A representative is available 24 hours a day, 7 days a week. You, your **physician** or the facility must call us within these timelines:

Type of care	Timeframe
Non-emergency admission	Call at least 14 days before the date you are scheduled to be admitted
Emergency admission	Call within 48 hours or as soon as reasonably possible after you have been admitted
Urgent admission	Call before you are scheduled to be admitted
Outpatient non-emergency medical services	Call at least 14 days before the care is provided, or the treatment or procedure is scheduled

An urgent admission is a **hospital** admission by a **physician** due to the onset of or change in an illness, the diagnosis of an illness, or injury.

We will tell you and your **physician** in writing of the **precertification** decision, where required by state law. An approval is valid for 180 days as long as you remain enrolled in the plan.

For an inpatient **stay** in a facility, we will tell you, your **physician** and the facility about your **precertified** length of **stay**. If your **physician** recommends that you stay longer, the extra days will need to be **precertified**. You, your **physician**, or the facility will need to call us as soon as reasonably possible, but no later than the final authorized day. We will tell you and your **physician** in writing of an approval or denial of the extra days.

If you or your **provider** request **precertification** and we don't approve coverage, we will tell you why and explain how you or your **provider** may request review of our decision. See the *Complaints, claim decisions and appeal procedures* section.

Types of services that require precertification
Precertification is required for inpatient **stays** and certain outpatient services and supplies.

The following types of out-of-network services and supplies require **precertification**:

Inpatient

- Gender affirming treatment
- Gene-based, cellular and other innovative therapies (GCIT)
- Obesity (bariatric) **surgery**
- **Stays** in a hospice facility
- **Stays** in a **hospital**
- **Stays** in a **rehabilitation facility**
- **Stays** in a **residential treatment facility** for treatment of **mental health disorders** and **substance related disorders**

- **Stays** in a **skilled nursing facility**

Outpatient

- Complex imaging
- Comprehensive **infertility** services
- Cosmetic and reconstructive **surgery**
- Non-emergency transportation by airplane
- Gene-based, cellular and other innovative therapies (GCIT)
- Injectables, (immunoglobulins, growth hormones, multiple sclerosis medications, osteoporosis medications, Botox, hepatitis C medications)
- Kidney dialysis
- Knee **surgery**
- Outpatient back **surgery** not performed in a **physician's** office
- Sleep studies
- Wrist **surgery**

Certain **prescription** drugs are covered under the medical plan when they are given to you by your doctor or health care facility. The following **precertification** information applies to these **prescription** drugs:

For certain drugs, your **provider** needs to get approval from us before we will cover the drug. The requirement for getting approval in advance guides appropriate use of certain drugs and makes sure they are **medically necessary**.

For HMO and EPO plans:

Precertification

You need pre-approval from us for some **covered services**. Pre-approval is also called **precertification**.

Your network **physician** or **PCP** is responsible for obtaining any necessary **precertification** before you get the care. **Network providers** cannot bill you if they fail to ask us for **precertification**. But if your **physician** or **PCP** requests **precertification** and we deny it, and you still choose to get the care, you will have to pay for it yourself.

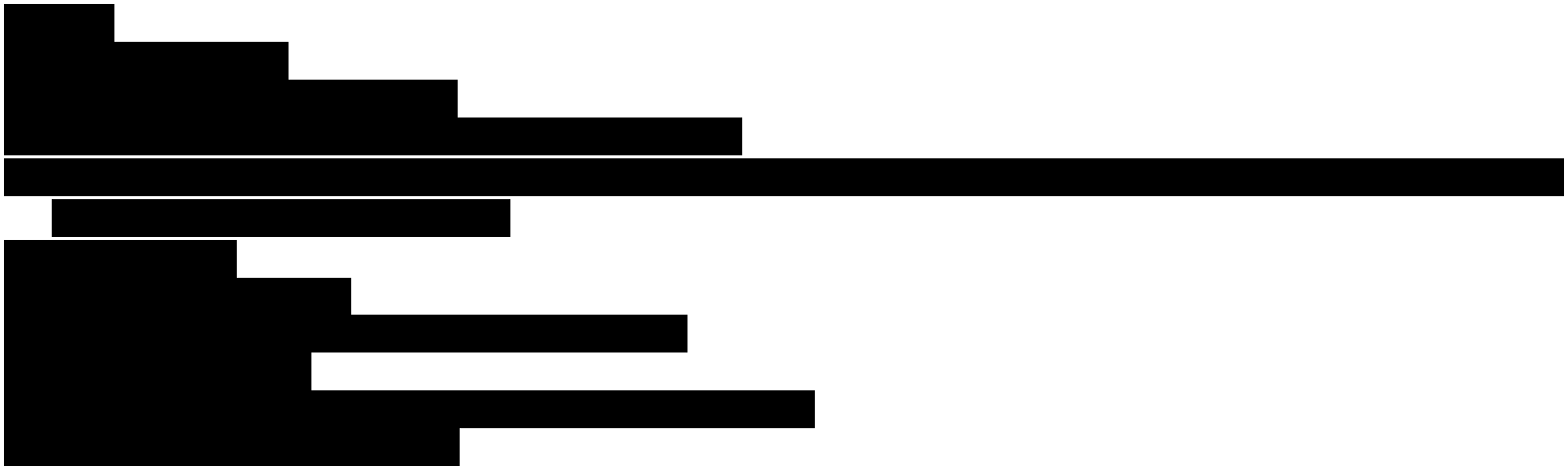
B. Identify the factors used in the development of the limitation(s);

Factors for determining the list of services subject to a prior authorization requirement:

Inpatient (in- and out-of-network)

- Place of service
- Federal law

Outpatient All Other (in-network)



Prescription

- Evidence-based drug uses
- Cost-effectiveness

Factors for the administration processes, including timelines:

- NCQA utilization management standards for Health Plan Accreditation and Managed Behavioral Health Organization accreditation
- State and Federal law

Factors for criteria used to determine whether to approve or deny prior authorization requests:

- In accordance with “generally accepted standards of medical practice”
- Clinically appropriate, in terms of type, frequency, extent, site, place of service, and duration, and considered effective for your illness, injury or disease
- State law

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

Sources and evidentiary standards for determining the list of services subject to a prior authorization requirement:

Inpatient (in- and out-of-network)

- Place of service: established upon admission to the facility and is identified on the claim submission.
- Federal Law: The Federal Newborns' and Mothers' Health Protection Act (NMHPA) of 1996.

Outpatient All Other (in-network)

[redacted]

Prescription

- Evidence-based drug uses – The accepted safe and efficacious use of a drug for a particular illness, disease, or condition within the intended treatment population; the accepted sequential drug use (e.g., initial [first line] therapy, second line therapy), or concurrent drug use. Safer and more efficacious and drugs and/or first line therapies are placed in lower tiers. It may include the physician practice of prescribing a drug for a purpose other than one of the indications for which the product is approved by the US Food and Drug Administration. It includes consideration for patient safety and whether there is evidence of harm or unknown long-term safety, and/or evidence that long-term and/or unsupervised use of a drug may compromise the patient's safety. Evidence-based drug uses may require a laboratory value or test, or may indicate a restriction to a population with certain specific characteristics or attributes (e.g., age, sex, diagnoses, comorbidities, site of care, treatment-naïve/experienced). Evidence-based drug uses may signal the potential for waste or unnecessary use when a drug needs frequent dose adjustments, when it is available in multiple strengths, or when it may need a dose titration. During treatment, evidence-based drug use may warrant the confirmation that a patient is responding to therapy via patient monitoring. Additionally, evidence-based drug use may require additional treatment-supportive therapies (e.g., behavioral counseling, diet therapy, case management, and other standard non-drug supportive therapies). Sources include US Food and Drug Administration labeling, published peer-reviewed clinical literature and standards of care, accepted clinical practice guidelines, governments health agencies (US Preventive Services Task Force, Centers for Disease Control and Prevention, US Food and Drug Administration), external clinical experts, and similar drugs.
- Cost-effectiveness – When multiple drugs exist to treat a given condition, the drugs that are equally efficacious and are less costly are place in lower tiers to provide more cost-effective therapy, impacting positively on members. These existing multiple drugs are a generic equivalent, biosimilar or a therapeutic alternative. A generic equivalent or biosimilar drug means as defined by US Food and Drug Administration; a therapeutic alternative means it is a different chemical agent in the same pharmacological or therapeutic class and has a similar therapeutic effect. These existing multiple drugs can mean a drug with multiple dosage forms available. A dosage form is the physical form in which a drug is manufactured or administered. Examples of dosage forms include tablets, capsules, powders, oral disintegrating tablets and oral and injectable solutions. A drug may be available in multiple dosage forms, with vastly different costs which may or may not offer a clinical advantage. More cost-effective treatment options may be available and covered on a preferred tier, may not require a prior authorization or step therapy and would be a generic equivalent, biosimilar or a therapeutic alternative. The plan sponsor cost is the lowest net cost

option for a generic equivalent, biosimilar, or brand-name drug being considered. Sources include similar drugs, utilization trend reports, and applicable manufacturer agreements.

Sources and evidentiary standards for the administration processes, including timelines:

- Aetna sets timeliness standards to meet NCQA guidelines and standards. NCQA considers all inpatient MH/SUD admissions urgent. Aetna applies the urgent precertification timeline to MH/SUD admissions.
- Federal and State law. Aetna follows Federal DOL/ERISA claims regulation definition of urgent care for commercial plans, including these plans. Maryland law prohibits carriers from refusing to pay a claim for arbitrary or capricious reasons based on all available information. Aetna does not deny inpatient or observation ancillary charges for lack of timely notification.
- Maryland law requires non-urgent precertification coverage requests to be completed within 2 working days after the receipt of the information needed for review.

Factors and evidentiary standards for criteria used to determine whether to approve or deny prior authorization requests:

- Generally accepted standards of medical practice and clinical appropriateness evidentiary standards are well-conducted clinical trials or cohort studies published in peer-reviewed, evidence-based scientific literature to be safe and effective for treating or diagnosing the condition or illness for which it's meant. Aetna's clinicians use the following guidelines in making medical necessity determinations for M/S and MH/SUD precertification requests. The medical necessity guidelines include reference to clinical trials and studies.
  - Aetna® Clinical Policy Bulletins (**aetna.com/health-care-professionals/clinical-policy-bulletins.html**)
  - MCG Health care guidelines® (**mcg.com/care-guidelines/care-guidelines/**)
  - National Comprehensive Cancer Network treatment guidelines (**www.nccn.org/guidelines/category_1**)
  - American Society of Addiction Medicine (ASAM) Criteria; Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions, Third Edition (**aetna.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html**)
  - Aetna's Applied Behavioral Analysis (ABA) Medical Necessity Guide (**aetna.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html**)
  - Level of Care Utilization System for Psychiatric and Addictive Services (LOCUS) (**aetna.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html**)

- Child Adolescent Level of Care Utilization System for Psychiatric and Addictive Services/ Child and Adolescent Service Intensity Instrument (CALOCUS-CASII) (**aetna.com/health-care-professionals/patient-care-programs/locat-aba-guidelines.html**)
- State law. As to substance use disorder prior authorization requests, Maryland Insurance Code Ann. § 15-802(5) requires carriers to use ASAM criteria for all utilization management determinations for substance use disorder benefits.

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

Determining the list of services subject to a prior authorization requirement:

For in-network benefits, precertification applies to:

- Services on the Aetna Participating Provider Precertification List
- Services on the Aetna Behavioral Health Precertification List

The Aetna Participating Provider Precertification List and Aetna Behavioral Health Precertification List are referred to collectively as the National Precertification List (NPL). It is the participating provider's responsibility to seek precertification, and there is no penalty to the member if precertification is not obtained.

For out-of-network benefits, The Member Precertification List (MPL) is part of the certificate of coverage which is filed with each State department of insurance. It describes which services are subject to precertification and what the consequences are of failing to obtain it. Members are responsible for seeking precertification of services on the MPL. *Note: all out-of-network outpatient MH/SUD services do not require precertification as of 01/01/2023 for members covered under Maryland-sitused policies*

Inpatient Services (applicable to in-network and out-of-network services): Aetna uses the factors of place of service and applicable law, which are applied comparably to establish the written policies which establish that all inpatient services, except for the exceptions noted, are subject to pre-authorization. These factors are applied equally to M/S and MH/SUD. The place of service for a particular service is determined based on guidance of the National Uniform Billing Committee, which is the governing body for forms and codes used in facility bills. This criteria is used for both M/S and MH/SUD to establish inpatient status such that prior-authorization is required. Aetna applies any applicable law in determining which services are/are not subject to prior authorization, which in this instance includes the Newborns' and Mothers Health Protection Act.

Outpatient Services (applicable to in-network services only): Inclusion of M/S and MH/SUD services on the NPL is determined by the NPL Committee, which is comprised of clinicians and other subject matter experts representing both MH/SUD and M/S expertise. Proposed additions or changes to the NPL are submitted to the NPL Committee and can come from various sources. The Committee considers the factors listed above and decides whether to add or remove the service from the NPL. The factors are the same for both M/S and MH/SUD, and the factors are applied equally to M/S and MH/SUD services.

Administration processes, including timelines:

The administrative processes, including applicable timelines for Aetna to notify providers and/or members of its determination in response to a precertification request, are the same across the three (3) applicable benefit classifications. The administrative processes and the timelines are the same for M/S and MH/SUD services.

Criteria used to determine whether to approve or deny prior authorization requests:

For both M/S and MH/SUD services, Aetna employs the same written policies to select and apply criteria used to determine whether to approve or deny prior authorization requests. Aetna clinicians use the following guidelines:

LOCUS and CALOCUS/CASII (MH/SUD)
For patients with commercial plans, Aetna® will use the Level of Care Utilization System (LOCUS) and the Child and Adolescent Level of Care Utilization System/Child and Adolescent Service Intensity Instrument (CALOCUS/CASII) for its medical necessity reviews. This person-centered approach aims to find the best fit between individual needs and behavioral health services.

ASAM (MH/SUD)
Aetna uses the most current criteria published by the American Society of Addiction Medicine (ASAM) Criteria to guide clinicians in evaluating the medical necessity of levels and types of care for substance use disorders. ASAM criteria are generally accepted, national standards for SUD treatment decisions and are recognized as such by many courts and regulators, including Maryland. Use of ASAM is required by Md. Insurance Code Ann. § 15-802(5) for SUD clinical reviews.

MCG Health Care Guidelines® (M/S)
Aetna uses the most current evidence-based care guidelines published by MCG Health to guide clinicians in making medically necessary level of care determinations for M/S services.

Aetna® Clinical Policy Bulletins (CPBs) (MH/SUD and M/S)

Clinical Policy Bulletins (CPBs) detail the services and procedures Aetna considers medically necessary, cosmetic, or experimental and unproven. CPBs are based on:

- Peer-reviewed, published medical journals
- A review of available studies on a particular topic
- Evidence-based consensus statements
- Expert opinions of health care professionals
- Guidelines from nationally recognized health care organizations

NCCN Clinical Practice Guidelines in Oncology (M/S)

Aetna uses the most current criteria published by the National Comprehensive Cancer Network (NCCN) to make medical necessity determinations in oncology clinical reviews. The NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) are comprised of recommendations for the prevention, diagnosis, and management of malignancies across the continuum of care. The NCCN Guidelines currently apply to more than 97% of cancers affecting patients in the United States. The NCCN Guidelines incorporate real-time updates in keeping with the rapid advancements in the field of cancer research and management.

ABA Medical Necessity Guide (MH/SUD)

This guide is used by clinicians to decide appropriate levels and types of services that are medically necessary for a patient. It can also help with the coverage determination process. Aetna performs ABA medical necessity reviews pursuant to Maryland insurance regulation COMAR 31.10.39, and we only request the clinical information permitted by law, as outlined on the Uniform Treatment Form.

Aetna applies the same strategy, Certificate of Coverage definition of “medical necessity”, and factors/sources/process to determine medical necessity for both MH/SUD and M/S services. The factors, sources, and evidentiary standards are the same for M/S and MH/SUD. Both M/S and MH/SUD medical necessity reviews utilize appropriately applicable and generally accepted standards of practice to guide clinician with coverage determinations.

Every individual Med/Surg and MH/SUD medical necessity determination is afforded independent clinical consideration based on the member’s presentation. Aetna staff considers the individual needs of the member when utilizing guidelines, including, but not limited to:

- Age
- Co-morbidities

- Complications
- Progress of treatment
- Need for skilled care
- Psychosocial situation
- Risk related to ethnicity or genetic factors
- Home environment, when applicable.

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

Determining the list of services subject to a precertification/prior authorization requirement:

As set forth above, a prior authorization requirement only applies to MH/SUD services in the following benefit classifications: In Network Inpatient, In Network Outpatient-All Other, and Prescription. Discussion of the Prescription benefit classification follows.

Precertification is required for all inpatient admissions for both MH/SUD and M/S services except for inpatient maternity and hospice, which are equally applicable.

As for In-Network Outpatient-All Other benefits, Aetna applies the same factors and sources, and the same National Precertification List Policy and Procedure, to MH/SUD and M/S benefits in deciding which services to add to, retain or remove from the National Precertification list. The same factors and sources, and the same National Clinical Services Policies and Procedures, apply to handling precertification requests for MH/SUD and M/S benefits. The NPL Policy and Procedure requires documentation of each factor a service meets before the NPL Committee will review the recommendation. Aetna conducts the same annual process to review both MH/SUD and M/S services on the NPL list and determine whether to retain or remove the services from the list. Specifically, [redacted]

Aetna's review shows that there are only 5 MH/SUD services in the classification subject to precertification compared to approximately 34 *categories* of M/S services. No new MH/SUD services have been added to the NPL in the past 6 years. An in-operation review of the services added to the NPL during the review period shows that no new MH/SUD services were added to the NPL. During the annual review, two M/S and one MH/SUD service was retained on the NPL using the same factors and evidentiary standards described above and detailed in the NPL Policy and Procedure.

From this information it is clear that the factors and sources used to determine which MH/SUD services are subject to a prior authorization requirement are comparable to, and not more stringent than those used for M/S services.

Administrative processes, including timelines:

The timelines for urgent and non-urgent precertification requests are the same for both MH/SUD and M/S, both In Network and Out of Network, and Inpatient and Outpatient. All MH/SUD inpatient admissions are considered urgent and follow the precertification determination timelines for urgent care. The timelines for urgent care require a quicker turnaround time than the timeline for non-urgent care. In operation, Aetna monitors the turnaround time to make determinations on M/S and MH/SUD prior authorization requests. Aetna's review of internal data shows that the average turnaround time to issue a determination on precertification requests was lower than the standard for both M/S and MH/SUD requests. Further, Aetna's review of internal data shows that, on average, the MH/SUD requests were determined more quickly or the same as M/S requests. Aetna is therefore able to conclude that the timelines and administrative process for precertification are applied comparably, and not more stringently, to MH/SUD services compared to M/S services.

Criteria used to determine whether to approve or deny prior authorization requests:

Aetna applies the same strategy, Certificate of Coverage definition of medical necessity, and factors/sources/process to determine medical necessity for both MH/SUD and M/S services. The Aetna Clinical Policy Bulletins and third-party clinical guidelines used by clinicians to make MH/SUD and M/S medical necessity determinations are developed and adopted by the same Clinical Policy Council pursuant to its written charter. Consequently, as written, the medical necessity NQTL is applied comparably and no more stringently to MH/SUD benefits than M/S benefits.

Aetna's medical necessity coverage policy development and application process is consistent between MH/SUD and M/S. Aetna applies the same factors, processes, strategies and evidentiary standards to determine whether a new technology is considered experimental and investigational for both MH/SUD and M/S. The Aetna Clinical Policy Bulletins and third-party clinical guidelines used by clinicians to make MH/SUD and M/S medical necessity determinations are developed and adopted by the same Clinical Policy Council pursuant to its written charter.

An in-operation review of Aetna's prior authorization approval and denial rates shows fewer denials for MH/SUD than for M/S overall. Additionally, Aetna's Internal Quality Reviews and Inter-Rater Reliability Assessments provide a way to evaluate whether utilization of MH/SUD and M/S services is performed comparably and not more stringently for MH/SUD, in operation, by auditing the accuracy of the results of precertification determinations. The IQR and IRR results

for M/S and MH/SUD for 2023 show that the audits were performed as required. These IQR/IRR reports show that both Medical and Behavioral Health Medical Directors and clinicians are performing medical necessity reviews accurately and consistently; the overall score for MH/SUD services was slightly higher than for M/S services.

Consequently, Aetna concludes that the prior authorization NQTL was applied comparably and no more stringently to MH/SUD benefits than to M/S benefits.

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

Prescription benefit classification

The UM Clinical Development team drafts UM NQTL requirements that include coverage for use supported by evidence-based medicine and standard of care sources.

- The Formulary Review Committee (FRC) meets regularly to discuss and review drug information and makes recommendations for prior authorization for the P&T Committee's review and approval.
- Standard UM NQTLs are reviewed internally by a CVS Caremark Medical Director, and externally by an external clinical specialist prescriber as part of the Clinical Program Oversight (CPO).
- The P&T Committee reviews and approves the UM NQTLs for clinical appropriateness.

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

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

The sources and evidentiary standards used are different for each drug and each drug class and are disease or condition specific; however, their level of evidence is the same and consistent with the policies. The sources are cited in the monographs and therapeutic class review references, and their use is consistent with the policies and procedures. Age restrictions are applied to MH/SUD or MED/SURG drugs if clinical evidence indicates a drug is potentially harmful or

not effective in a population that can be defined by age, and these restrictions were found in the sample prior authorization criteria reviewed. The P&T committee members use these monographs, therapeutic class reviews and presentations to make informed decisions and vote on recommendations using the same process and equally weighing applicable factors and sources for formulary UM NQTLs considerations.

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

The processed drug coverage extract file was analyzed by Pharmacy Benefit Management (PBM) Pharmacists via a review of:

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

Testing of the formulary prior authorization NQTL shows that overall, it is applied to a lower percentage of MH drugs and zero percentage of SUD drugs compared to MED/SURG. Further analysis at the drug level reveals that the factors and the sources are not used differently or applied more stringently for MH/SUD drugs, and justify the application of prior authorization to maintain cost-effectiveness and align with the evidence-based drug use.

In conclusion, this analysis has demonstrated that the application of prior authorization as an NQTL, the factors, evidentiary standards, sources, processes, identified above, both as written and in operation, are not applied more stringently to drugs used for MH/SUD conditions than to drugs used for MED/SURG conditions.

2. Prescription Drug Formulary Design

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

Advanced Control Plan Formulary

What you can expect to pay

With your pharmacy plan, the amount you pay depends on the drug your doctor prescribes. It's either a flat fee or a percentage of the drug's/medicine's price.

Each drug is grouped as a generic, a brand or a specialty drug. The preferred drugs within these groups will generally save you money compared to a non-preferred drug. Typically, generic drugs are less expensive than brands.

Specialty prescription drugs typically include higher-cost drugs that require special handling, special storage or monitoring. These types of drugs may include, but are not limited to, drugs that are injected, infused, inhaled or taken by mouth.

You're covered for all types of medicine — some more expensive, and some less.

- Preferred generic: the lowest cost
- Preferred brand: a slightly higher cost
- Non-preferred brand and generic: a higher cost
- Preferred Specialty: lower cost for specialty drugs
- Non-preferred Specialty: higher cost for non-preferred specialty drugs

Your pharmacy plan may not have all the coverage levels listed above so check your plan documents to see how much you will pay.

Standard Opt Out Plan Formulary

What you can expect to pay

With your pharmacy plan, the amount you pay depends on the drug your doctor prescribes. It's either a flat fee or a percentage of the drug's/medicine's price.

Each drug is grouped as a generic, a brand or a specialty drug. The preferred drugs within these groups will generally save you money compared to a non-preferred drug. Typically, generic drugs are less expensive than brands.

Specialty prescription drugs typically include higher-cost drugs that require special handling, special storage or monitoring. These types of drugs may include, but are not limited to, drugs that are injected, infused, inhaled or taken by mouth.

You're covered for all types of medicine — some more expensive, and some less.

- Generic: the lowest cost
- Preferred brand: a slightly higher cost
- Non-preferred brand and generic: a higher cost
- Preferred Specialty: lower cost for specialty drugs
- Non-preferred Specialty: higher cost for non-preferred specialty drugs

Your pharmacy plan may not have all the coverage levels listed above so check your plan documents to see how much you will pay.

Aetna Health Exchange Plan Formulary (Small Group)

What you can expect to pay

With your pharmacy plan, the amount you pay depends on the drug your doctor prescribes. It's either a flat fee or a percentage of the drug's/medicine's price.

Each drug is grouped as a generic, a brand or a specialty drug. The preferred drugs within these groups will generally save you money compared to a non-preferred drug. Typically, generic drugs are less expensive than brands.

Specialty prescription drugs typically include higher-cost drugs that require special handling, special storage or monitoring. These types of drugs may include, but are not limited to, drugs that are injected, infused, inhaled or taken by mouth.

Covered services are based on the drugs listed in the drug guide. We exclude prescription drugs not in the drug guide unless we approve a medical exception. If it is medically necessary for you to use a prescription drug that is not in this drug guide, you or your provider must request a medical exception.

You're covered for all types of medicine — some more expensive, and some less.

- Preferred generic: the lowest cost
- Preferred brand: a slightly higher cost
- Non-preferred brand and generic: a higher cost
- Preferred Specialty: lower cost for specialty drugs
- Non-preferred Specialty: higher cost for non-preferred specialty drugs

Your pharmacy plan may not have all the coverage levels listed above so check your plan documents to see how much you will pay.

For all formularies:

What if I need a drug that requires an exception to the precertification, step therapy or quantity limits requirements? Or what if I need a drug that's not covered under my plan?

In certain cases, you or your prescriber can request a medical exception to the precertification, step therapy or quantity limits requirements or for a drug that's not covered on your plan. You can ask for your request to be expedited. Expedited coverage decisions are made within 24 hours.

We'll then contact you or your prescriber with our decision. All medically necessary outpatient prescription drugs will be covered. If a medical exception is approved, you only need to pay the copay after the deductible. This amount is based on your pharmacy plan design.

How can your provider request a medical exception?

- Submit their request through our secure provider website on **www.availity.com**.
- Call the Aetna Pharmacy Precertification Unit: Non-Specialty **1-800-294-5979 (TTY: 711)** or Specialty **1-866-814-5506 (TTY: 711)**.
- Fax the completed request form to: Non-Specialty 1-888-836-0730 or Specialty 1-866-249-6155.
- Mail the completed request form to: Medical Exception to Pharmacy Prior Authorization Unit 1300 East Campbell Road Richardson, TX 75081

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

- Evidence-based drug uses
- Drug pipeline
- Cost-effectiveness
- Specialty drug status
- Regulatory requirements

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

- Evidence-based drug uses: The accepted safe and efficacious use of a drug for a particular illness, disease, or condition within the intended treatment population; the accepted sequential drug use (e.g., initial [first line] therapy, second line therapy), or concurrent drug use. Safer and more efficacious and drugs and/or first line therapies are placed in lower tiers. It may include the physician practice of prescribing a drug for a purpose other than one of the

indications for which the product is approved by the US Food and Drug Administration. It includes consideration for patient safety and whether there is evidence of harm or unknown long-term safety, and/or evidence that long-term and/or unsupervised use of a drug may compromise the patient's safety. Evidence-based drug uses may require a laboratory value or test or may indicate a restriction to a population with certain specific characteristics or attributes (e.g., age, sex, diagnoses, comorbidities, site of care, treatment-naïve/experienced). Evidence-based drug uses may signal the potential for waste or unnecessary use when a drug needs frequent dose adjustments, when it is available in multiple strengths, or when it may need a dose titration. During treatment, evidence-based drug use may warrant the confirmation that a patient is responding to therapy via patient monitoring. Additionally, evidence-based drug use may require additional treatment-supportive therapies (e.g., behavioral counseling, diet therapy, case management, and other standard non-drug supportive therapies). Sources include: US Food and Drug Administration labeling, Centers for Medicare & Medicaid Services accepted drug compendia, Published peer-reviewed clinical literature, accepted clinical practice guidelines, standards of care, and government health agencies, External clinical experts Similar drugs.

- Drug pipeline: In the pharmaceutical industry, drugs in development are referred to as being in the pipeline. Monitoring late-stage development of new brands, generics, biosimilars, supplemental indications, or over the counter switches, informs the potential future availability of new therapies.
- Cost-effectiveness: When multiple drugs exist to treat a given condition, the drugs that are equally efficacious and are less costly are place in lower tiers to provide more cost-effective therapy, impacting positively on members. These existing multiple drugs are a generic equivalent, biosimilar or a therapeutic alternative. A generic equivalent or biosimilar drug means as defined by US Food and Drug Administration; a therapeutic alternative means it is a different chemical agent in the same pharmacological or therapeutic class and has a similar therapeutic effect. These existing multiple drugs can mean a drug with multiple dosage forms available. A dosage form is the physical form in which a drug is manufactured or administered. Examples of dosage forms include tablets, capsules, powders, oral disintegrating tablets and oral and injectable solutions. A drug may be available in multiple dosage forms, with vastly different costs which may or may not offer a clinical advantage. More cost-effective treatment options may be available and covered on a preferred tier, may not require a prior authorization or step therapy and would be a generic equivalent, biosimilar or a therapeutic alternative. The plan sponsor cost is the lowest net cost option for a generic equivalent, biosimilar, or brand-name drug being considered.
- Specialty drug status: Specialty drugs are used for difficult to treat chronic conditions, requiring close monitoring and education of the patient. These high-cost drugs may require patient-specific dosing, medical devices, special handling and delivery, and/or limited distribution by a manufacturer; these drugs may need to be dispensed from a

specialty pharmacy. Sources include: US Food and Drug Administration labeling, Centers for Medicare & Medicaid Services accepted drug compendia, Published peer-reviewed clinical literature, accepted clinical practice guidelines standards of care and government health agencies, External clinical experts, Similar drugs

- Regulatory requirements: Federal/state regulations dictate how certain drugs should be covered on the formulary. Internal Revenue Service. Internal Revenue Bulletin: 2004-15. Notice 2004-23. Health Savings Accounts—Preventive Care. Published April 12, 2004. **http://www.irs.gov/irb/2004-15_IRB/ar10.html** Accessed October 6, 2023.

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

Methodology

Comparative analysis of the application of factors as written was performed by Pharmacy Benefit Management (PBM) Pharmacists via a review of:

- formulary management policies and procedures
- samples of drug monographs and therapeutic class reviews
- committees' policies and procedures and meeting minutes

Process Findings

- The CVS Caremark Medical Affairs, Formulary Administration team monitors new drug databases, reviews the sources to consider the drug for inclusion in the formulary and tier assignment, and conducts the drug evaluation using the applicable sources and evidentiary standards.
- The Formulary Review Committee (FRC) meets a minimum of 10 times per year and on an ad hoc basis as needed, to discuss and review the information provided by the Formulary Administration teams. The FRC votes and makes final recommendations for drug inclusions and tier placements for the P&T Committee review and approval.
- The CVS Caremark Clinical Formulary team develops drug monographs and therapeutic class reviews using the sources.
- The P&T Committee meets at least quarterly to review drug monographs and therapeutic class reviews and approve the presented formularies.

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

The policies and procedures show that personnel and committee members follow the same processes when considering MH/SUD and MED/SURG drugs. The minutes show that these experts evaluate and consider the factors for tier assignments in the same manner, regardless of whether a drug is used to treat a MH/SUD or MED/SURG condition or disease.

The sources and evidentiary standards vary depending on the drug and each drug class and are disease or condition specific; however, their level of evidence is the same and consistent with the policies. The sources are cited in the monographs and therapeutic class review references, and their use is consistent with the policies and procedures. The P&T committee members use these monographs, therapeutic class reviews and formulary presentations to make informed decisions and vote on recommendations using the same process and considering the same factors and sources for formulary and tiering considerations.

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

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

1. Advanced Control Plan Formulary

Findings and Conclusion of Formulary Design:

As written, a review of the policies and procedures, minutes, and drug monographs and therapeutic class reviews revealed that the same factors are used, in the same manner, relying on the same sources that are specific to each drug or drug class, and have the same level of evidence. The personnel involved and their credentials do not differ based on whether a drug considered is MH/SUD or MED/SURG.

In operation, analysis and testing of the tiers revealed that the factors and the sources are not used differently or more stringently with respect to MH/SUD compared to MED/SURG drugs, and the justification for placement of these drugs in the preferred or non-preferred tiers was consistent across both categories of drugs. Number of brands in the tested non-preferred tiers 3 and 5 are not more stringent for MH/SUD drugs than for MED/SURG drugs placed in those same tiers, and therapeutic alternatives are abundant in lower preferred tiers.

In conclusion, this analysis has demonstrated that in the determination of formulary design as an NQTL, the factors, evidentiary standards, sources, processes, identified above, both as written and in operation, are not applied more stringently to drugs used for MH/SUD conditions than to drugs used for MED/SURG conditions. Moreover, as stated in the MHPAEA regulations, a plan complies with the mental health parity provisions if it establishes the different levels of financial requirements based on reasonable factors determined in accordance with the rules for NQTLs and without regard to whether a drug is generally prescribed for MED/SURG or MH/SUD benefits.

Findings and Conclusion for non-formulary coverage requests:

Plan pharmacists looking at the data for coverage requests for drugs not covered on the formulary found that for the Advanced Control Plan formulary, the number of MH/SUD totaled 130 requests.

The 363 total requests for non-formulary drugs include 130 MH/SUD drug requests that were non-formulary. Of the 130 non-formulary MH/SUD requests there was a 34% approval rate. In comparison, for Med Surg drugs on the Advanced Control formulary, there was a 27% approval rate.

2. Standard Opt Out Formulary

Findings and Conclusion of Formulary Design:

As written, a review of the policies and procedures, minutes, and drug monographs and therapeutic class reviews revealed that the same factors are used, in the same manner, relying on the same sources that are specific to each drug or drug class, and have the same level of evidence. The personnel involved and their credentials do not differ based on whether a drug considered is MH/SUD or MED/SURG.

In operation, analysis and testing of the tiers revealed that the factors and the sources are not used differently or more stringently with respect to MH/SUD compared to MED/SURG drugs, and the justification for placement of these drugs in the preferred or non-preferred tiers was consistent across both categories of drugs. Number of brands in the tested

non-preferred tiers 3 and 5 are not more stringent for MH/SUD drugs than for MED/SURG drugs placed in those same tiers, and therapeutic alternatives are abundant in lower preferred tiers.

In conclusion, this analysis has demonstrated that in the determination of formulary design as an NQTL, the factors, evidentiary standards, sources, processes, identified above, both as written and in operation, are not applied more stringently to drugs used for MH/SUD conditions than to drugs used for MED/SURG conditions. Moreover, as stated in the MHPAEA regulations, a plan complies with the mental health parity provisions if it establishes the different levels of financial requirements based on reasonable factors determined in accordance with the rules for NQTLs and without regard to whether a drug is generally prescribed for MED/SURG or MH/SUD benefits.

Findings and Conclusion for non-formulary coverage requests:

Plan pharmacists looking at the data for coverage requests for drugs not covered on the formulary found that for the Standard Opt Out formulary, the number of MH/SUD totaled 1 request.

The 6 total requests for non-formulary drugs, there was only 1 MH/SUD drug that was non formulary. Of the 1 non-formulary MH/SUD request there was a 0% approval rate. In comparison, for Med Surg drugs on the Standard Opt Out formulary, there was a 60% approval rate (3 out of 5 requests).

3. Aetna Health Exchange Formulary (Small Group)

Findings and Conclusion of Formulary Design:

As written, a review of the policies and procedures, minutes, and drug monographs and therapeutic class reviews revealed that the same factors are used, in the same manner, relying on the same sources that are specific to each drug or drug class, and have the same level of evidence. The personnel involved and their credentials do not differ based on whether a drug considered is MH/SUD or MED/SURG.

In operation, analysis and testing of the tiers revealed that the factors and the sources are not used differently or more stringently with respect to MH/SUD compared to MED/SURG drugs, and the justification for placement of these drugs in the preferred or non-preferred tiers was consistent across both categories of drugs. Number of brands in the tested non-preferred tiers 3 and 5 are not more stringent for MH/SUD drugs than for MED/SURG drugs placed in those same tiers, and therapeutic alternatives are abundant in lower preferred tiers.

In conclusion, this analysis has demonstrated that in the determination of formulary design as an NQTL, the factors, evidentiary standards, sources, processes, identified above, both as written and in operation, are not applied more stringently to drugs used for MH/SUD conditions than to drugs used for MED/SURG conditions. Moreover, as stated in the MHPAEA regulations, a plan complies with the mental health parity provisions if it establishes the different levels of financial requirements based on reasonable factors determined in accordance with the rules for NQTLs and without regard to whether a drug is generally prescribed for MED/SURG or MH/SUD benefits.

Findings and Conclusion for non-formulary coverage requests:

Plan pharmacists looking at the data for coverage requests for drugs not covered on the formulary found that for the Exchange formulary the number of MH/SUD non-formulary requests totaled 183 requests.

Of the total 733 requests for non-formulary drugs, 183 were for MH/SUD drugs that were non-formulary. Of the 183 requests there was a 28% approval rate. In comparison, for Med Surg non-formulary drugs, there was a 19% approval rate.

3. Provider (Including Facility) Reimbursement

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

Applicable to all in-network all medical/surgical and mental health and/or substance use disorder benefits:

Negotiated charge

For health coverage:

This is the amount a **network provider** has agreed to accept or that we have agreed to pay them or a third party vendor (including any administrative fee in the amount paid).

For surprise billing, calculations will be made based on the median contracted rate.

We may enter into arrangements with **network providers** or others related to:

- The coordination of care for members
- Improving clinical outcomes and efficiencies

Some of these arrangements are called:

- Value-based contracting
- Risk sharing
- Accountable care arrangements

These arrangements will not change the **negotiated charge** under this plan.

Applicable to all out-of-network all medical/surgical and mental health and/or substance use disorder benefits:

Surprise bill

There may be times when you unknowingly receive services or do not consent to receive services from an **out-of-network provider**, even where you try to stay in the network for your **covered services**. You may then get a bill at the out-of-network rate that you didn't expect. This is called a surprise bill.

An **out-of-network provider** cannot balance bill or attempt to collect costs from you that exceed your in-network cost-sharing requirements, such as **deductibles**, **copayments** and **coinsurance** for the following services:

- **Emergency services** provided by an **out-of-network provider**
- Non-emergency surgical or ancillary services provided by an **out-of-network provider** at an in-network facility, except when the **out-of-network provider** has given you the following:
  - The out-of-network notice for your signature
  - The estimated charges for the items and services
  - Notice that the **provider** is an **out-of-network provider**
  - Obtaining consent from you to be treated and balance-billed by the **out-of-network provider**
- Out-of-network air ambulance services

Surgical or ancillary services mean any professional services including:

- **Surgery**
- Anesthesiology
- Pathology
- Radiology
- Hospitalist services
- Laboratory services

A facility in this instance means an institution providing health care related services, or a health care setting. This includes the following:

- **Hospitals** and other licensed inpatient centers
- Ambulatory surgical or treatment centers
- **Skilled nursing facilities**
- **Residential treatment facilities**
- Diagnostic, laboratory, and imaging centers
- Rehabilitation
- Other therapeutic health settings

A surprise bill claim is paid based on the median contracted rate for all plans offered by us in the same insurance market for the same or similar item or service that is:

- Provided by a **provider** in the same or similar specialty or facility of the same or similar facility type; and
- Provided in the geographic region in which the item or service is furnished

The median contracted rate is subject to additional adjustments specified in federal regulations.

Any cost share paid with respect to the items and services will apply toward your in-network **deductible** and out-of-pocket maximum, if you have one.

It is not a surprise bill when you knowingly choose to go out-of-network and have signed a consent for these services. In this case, you are responsible for all charges.

You may request external review if you are seeking to determine if the federal surprise bill law applies to your situation.

If you receive a surprise bill or have any questions about what a surprise bill is, contact us.

Allowable amount

This is the amount of an **out-of-network provider's** charge that is eligible for coverage. You are responsible for all charges above this amount. The **allowable amount** depends on the geographic area where you get the service or supply.

Contact us or check your plan documents for information on calculating the allowable amount for specific services or supplies.

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

- Maryland law
- Health Services Cost Review Commission (HSCRC) rates
- Federal law

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

- For hospitals regulated by the HSCRC, inpatient, outpatient, and emergency services are reimbursed based on the rates set by the HSCRC.
- For HMO claims, Aetna complies with MD Code, Health-General §§ 19-710(e) and 19-710.1), which requires payment of specified rates to non-participating hospitals, trauma physicians for trauma care rendered to a trauma patient in a trauma center, and any other health care provider for E&M and other services.
- For out-of-network emergency services, HB 959/Md. Insurance Code Ann. § 15-1A-14: Aetna does not impose any cost-sharing amount greater than the amount imposed for emergency services furnished by a health care provider with a contractual relationship with the carrier. Aetna will reimburse a nonparticipating physician for emergency services the greater of: median negotiated amount; general out of network payment determination; or, the Medicare amount.

- For claims other than HMO, Aetna complies with HB 959/Md. Insurance Code Ann. § 15-1A-14: Aetna does not impose any cost-sharing amount greater than the amount imposed for emergency services furnished by a health care provider with a contractual relationship with the carrier. Aetna will reimburse a nonparticipating physician for emergency services the greater of: median negotiated amount; general out of network payment determination; or, the Medicare amount.
- For surprise bills, the qualifying payment amount is calculated using the methodology described in 45 C.F.R. §149.140(c), which is based on the median contracted rate for all plans offered by the carrier in the same insurance market for the same or similar item or services that is: provided by a provider in the same or similar specialty or facility of the same or similar facility type; and provided in the geographic region in which the item or service is furnished.

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

Participating Provider and Facility Reimbursement

This NQTL is implemented by the plan's definition of Negotiated Charge, which is the amount a network provider has agreed to accept or that Aetna has agreed to pay them or a third-party vendor (including any administrative fee in the amount paid).

Non-Participating Provider and Facility Reimbursement

This NQTL is implemented by the Allowable Amount, which is the amount of an out-of-network provider's charge that is eligible for coverage according to the method defined in the Certificate (typically a specified percentile of prevailing charges or a percentage of Medicare rates). The method for determining the Allowable Amount for a given plan is always the same for MH/SUD and M/S providers.

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

The factors, strategy, processes and evidentiary standards and evidentiary standards used in establishing participating provider rates are the same for both M/S and MH/SUD providers.

The factors, strategy, processes and evidentiary standards for determining reimbursement for MH/SUD facility-based providers are comparable to M/S facility-based providers. First, for hospital services regulated by the Health Services Cost Review Commission (HSCRC), the allowable amount is the rate approved by the HSCRC. These rates are loaded into Aetna's system for claim processors to use in paying claims. For facilities and services not regulated by the HSCRC, the strategy, processes and evidentiary standards for determining reimbursement for MH/SUD facility-based providers are comparable to M/S facility-based providers.

Aetna compensates non-participating providers based on the terms of the member's plan, at the lesser of the billed charges or the allowable amount. The allowable amount is determined the same way both MH/SUD and M/S claims.

4. Strategies for Addressing Provider Shortages

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

Applicable to all in-network medical/surgical and mental health and/or substance use disorder benefits

Aetna maintains sufficient numbers and types of M/S providers in its network and monitors how effectively this network meets the needs and preferences of its membership. Aetna establishes mechanisms to ensure access to appointments for M/S services. Provider shortages are monitored and addressed through analysis of network availability and accessibility, referred to together as "network adequacy."

Definitions:

Network availability refers to the extent to which practitioners of the appropriate type and number are geographically distributed to meet the needs of members.

Network accessibility refers to members' ability to receive timely care from network providers (that is, to schedule an appointment).

Who provides the care

Network providers

We have contracted with **providers** in the **service area** to provide **covered services** to you. These **providers** make up the network for your plan.

To get network benefits, you must use **network providers**. There are some exceptions:

- **Emergency services** – see the description of **emergency services** in the *Coverage and exclusions* section.
- Urgent care – see the description of urgent care in the *Coverage and exclusions* section.
- **Network provider** not reasonably available – You can get services from an **out-of-network provider** if an appropriate **network provider** is not available without unreasonable delay, travel or doesn't have the training or expertise to treat your condition. You must request approval from us before you get the care. Contact us for assistance.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.

- Clinical trials (routine patient costs)-see the description of clinical trials (routine patient costs) in the *Coverage and exclusions* section.

You may select a **network provider** from the online directory through your member website.

You will not have to submit claims for services received from **network providers**. Your **network provider** will take care of that for you. And we will pay the **network provider** directly for what this plan owes.

Access standards

Maryland state regulations require that our contracted providers meet the following time frames for appointment access:

- **Urgent care appointments (including medical, behavioral health and substance use disorder):** within 72 hours
- **Routine primary care:** within 15 calendar days
- **Preventive visit/well visit:** within 30 calendar days
- **Nonurgent specialty care:** within 30 calendar days
- **Nonurgent behavioral health/substance use disorder services:** within 10 calendar days

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

- Maryland state availability standards, as defined in COMAR 31.10.44.04
- Maryland state accessibility standards, as defined in COMAR 31.10.44.05

The factors are the same for M/S and MH/SUD.

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

Geographic availability standards for inpatient M/S and MH/SUD facilities are detailed in Aetna policy, based on the requirements set forth in COMAR 31.10.44.04. Minimum availability standards apply for the following M/S and MH/SUD inpatient facilities/services: inpatient psychiatric facilities, residential crisis services, SUD residential treatment facilities, acute inpatient hospitals, critical care services/intensive care units, and skilled nursing facilities, outpatient MH clinics, outpatient SUD facilities, diagnostic radiology facilities, outpatient dialysis facilities, ambulatory infusion centers, and ambulatory or outpatient surgical centers, and residential crisis services.

Numeric availability standards for M/S and MH/SUD providers are detailed in Aetna policy Standards exist for primary care (general practice, family practice, and internal medicine), pediatricians, OB/Gyns, MH and providers.

Appointment accessibility standards for M/S and MH/SUD providers and facilities are detailed in Aetna policy. Standards are also summarized in the Provider Manual, quoted above.

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

Aetna's analysis of the "as written" strategies in place to address any provider shortages in our network shows that those strategies are applied comparably to M/S and MH/SUD services and are not more stringently designed or applied to MH/SUD services than to M/S services. Specifically, in addition to the written Maryland state accessibility and availability criteria noted above which contain the regulatorily prescribed standards, Aetna also applies internal written policies to assess network sufficiency that define the standards and goals for M/S and MH/SUD practitioner appointment accessibility and establishes a mechanism for monitoring, evaluating, and managing member access to practitioners.

In addition, Aetna has an established process by which practitioner and provider availability standards are set and periodically assessed. This process defines minimum requirements for network composition and ensures compliance with applicable state and federal regulatory standards as well as applicable accreditation standards. Finally, Aetna has an established process for assessing network adequacy, identifying opportunities to improve network adequacy, and evaluating implemented activities for effectiveness. Together, these are the "written" strategies and processes Aetna employs to ensure adequate networks that align with Maryland standards.

In operation, Aetna monitors the sufficiency of its network when it completes Maryland's required annual Network Adequacy filing and takes any action based on the results of that adequacy analysis. This analysis shows Aetna's network providers for both M/S and MH/SUD services exceeded the minimum standards. Indeed, the median appointment waiting time was below the standard for all MH/SUD and M/S care types, and MH/SUD non-urgent care was available sooner than non-urgent M/S care. Additionally, the interventions for M/S and MH/SUD show Aetna's commitment to increasing the network provider availability and accessibility beyond the state required minimums across all provider types. The actions taken for MH/SUD providers improved access from 2022 to 2023.

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

In conclusion, Aetna has demonstrated that both, as written and in operation, the processes, strategies and evidentiary standards used to address any provider shortages with respect to those providers who render MH/SUD services are comparable to and applied no more stringently than the processes, strategies, evidentiary standards, and factors used

to address provider shortages with respect to providers who render M/S services. As an initial starting point, the primary factor driving application of this NQTL to providers who render MH/SUD and M/S services is Maryland's regulated availability and accessibility standards, as defined in COMAR 31.10.44 et seq. Importantly, Aetna's plan year 2023 network adequacy filings demonstrate that Aetna did not have provider shortages in Maryland in 2023 that would directly implicate the need to apply this NQTL to address any MH/SUD network inadequacies. Specifically, the MH/SUD minimum travel distance standards were met more often than the M/S minimums. Additionally, the numeric provider-to-member ratios were not only met, but were exceeded. Finally, results showed that the actual appointment waiting times for MH/SUD providers were quicker than required by the standards.

In addition, Aetna uses the processes and strategies, as written, comparably for MH/SUD and M/S providers and no more stringently for MH/SUD providers than M/S providers. For the policies in writing, Aetna equally relies on the availability and accessibility standards and goals/thresholds set by law for MH/SUD and M/S providers. There is no difference in the process or strategy to set these written standards for MH/SUD and M/S providers. For monitoring network adequacy, the Accreditation Governance team manages the interventions to improve network adequacy with local market Network Management and Behavioral Health Network Management using the same measures for identifying barriers to provider availability and accessibility. In addition to the standards set in Aetna's availability and accessibility policies, Aetna reviews member complaints, member and provider survey results, and out of network requests for both M/S and MH/SUD. There is no difference in the written standards requiring evaluation of network adequacy, identification of interventions, and monitoring effectiveness of those interventions.

Finally, for both MH/SUD and M/S providers, Aetna maintains an open panel for providers to apply to join the network, even where the mandated minimums have been met. The strategies to find and recruit additional providers are similar for MH/SUD as M/S providers, including reviewing non-participating claim reports, coordinating with key provider partners and local health systems, and ensuring all active service locations are captured.

5. Provider Network Directories

A. Provide the specific plan language for each NQTL in the above defined category and identify the medical/surgical and mental health and/or substance use disorder benefits to which it applies[1];

Applicable to all in-network medical/surgical and mental health and/or substance use disorder benefits

Aetna maintains a paper provider directory, available in hard copy upon request. The paper directory is updated quarterly. The online directory is public and can be accessed without creating an account or entering a policy number. The online directory is updated 6 days a week, excluding holidays, Sundays, or interruptions due to system maintenance, upgrades, or unplanned outages. Updates are triggered by providers notifying Aetna of changes to their information, as well as Aetna conducting targeted reviews and directory audits. Providers may use a provider portalor submit an online form to notify Aetna of corrections to their provider data.

The provider information is maintained in the same database for both the print and online directories, for both M/S and MH/SUD providers and facilities. For both print and online directories, only contracted providers are listed.

Directory audits are conducted on a quarterly basis.

The directory includes information about referrals and special exceptions for providers not in the network. The full directory is also available in Spanish. Accessibility information for individuals with disabilities are provided, as well as language assistance for those with limited English proficiency. There is also a web link under each entry to "Report Incorrect Provider Info."

Providers

Our **provider** network is there to give you the care you need. The easiest way to find **network providers** and see important information about them is by logging in to your member website. There you'll find our online **provider** directory. See the *Contact us* section for help.

Who provides the care

[1] Respectfully, Aetna disagrees that provider network directories independently "function as an NQTL," as a provider directory does not "otherwise limit the scope or duration of benefits for treatment under a plan or coverage" as contemplated by MHPAEA or its implementing regulations. Md. Code Ann., Ins. § 15-144 (citing 45 C.F.R. § 146.136 and 29 C.F.R. § 2590.712). Subject to and without waiving this objection, Aetna is committed to maintaining accurate, useful provider network directories that meet all legal requirements, and provides the information requested by the Administration herein.

Network providers

We have contracted with **providers** in the **service area** to provide **covered services** to you. These **providers** make up the network for your plan.

To get network benefits, you must use **network providers**. There are some exceptions:

- **Emergency services** – see the description of **emergency services** in the *Coverage and exclusions* section.
- Urgent care – see the description of urgent care in the *Coverage and exclusions* section.
- **Network provider** not reasonably available – You can get services from an **out-of-network provider** if an appropriate **network provider** is not available without unreasonable delay, travel or doesn't have the training or expertise to treat your condition. You must request approval from us before you get the care. Contact us for assistance.
- Transplants – see the description of transplant services in the *Coverage and exclusions* section.
- Clinical trials (routine patient costs)-see the description of clinical trials (routine patient costs) in the *Coverage and exclusions* section.

You may select a **network provider** from the online directory through your member website.

You will not have to submit claims for services received from **network providers**. Your **network provider** will take care of that for you. And we will pay the **network provider** directly for what this plan owes.

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

Specificity and Accuracy of Provider Directory Information

- Applicable Federal law
- Applicable Maryland law
- Information provided by contracted providers and facilities
- Verification of information provided by contracted providers

Directory Display and Searchability, and Navigation Assistance

- Identification of the most common specialties, facility types, and services members search for and make appointments with.
- Identification of the most common conditions and procedures members search for.
- Member experience and usability testing
- Online Accessibility

- Language assistance

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

- Internal Aetna search analytics and claim activity
- NCQA guidelines
- Web Content Accessibility Guidelines and Principles of Inclusive Design

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

A member's perception of the provider network is a key driver of their satisfaction with the health plan and perception of the health plan's quality. Directory accuracy and usability are critical to ensuring members can locate participating providers and access care that meets their M/S and MH/SUD needs. Aetna maintains a single provider directory, which includes both M/S and MH/SUD providers. Current and prospective members can access the directory online or on paper, without a password or account. Searches can be conducted by name or provider type and can be filtered by various attributes such as gender, language, hospital affiliation, and whether the provider is accepting new patients. Aetna evaluates the online provider directory for understandability and usefulness to members and prospective members, including reading level, intuitive content organization, and ease of navigation.

For both M/S and MH/SUD practitioners, the directory includes all information required by state and federal law, as well as additional information that may be voluntarily provided by a provider. The directory includes provider specialties, which help members locate a provider that best meets their needs. For M/S providers, the specialty is generally a board certification (Cardiology, Endocrinology, Internal Medicine, Ob/Gyn, Pediatrics, etc.) and does not require further distinction. For MH/SUD, providers may attribute multiple specialties to themselves based on focus areas. Aetna maintains a detailed list to best meet the needs of our members. In addition to diagnoses, such as anxiety disorder, depression, attention deficit disorder, and addiction, the focus areas include the types of concerns providers may be able to address. Examples include domestic violence, parenting issues, grief, and gender identity. For MH/SUD providers, this is important, since the licensure (MD, LCSW, LPC) alone does not indicate what concerns a provider may treat. By including the additional focus areas for MH/SUD providers, a member can locate providers that will meet their needs at least just as easily as they can locate M/S providers.

For both M/S and MH/SUD facilities, the directory includes the facility type. For M/S, the facility type is specific to the type of care offered. For example, facility types include children's hospitals, laboratories, MRI centers, and physical therapy centers. For MH/SUD, there are fewer facility types, but this is supplemented with the types of services and levels of care offered by each facility. These attributes help a member distinguish, for example, residential treatment facilities for eating disorders from residential treatment facilities for substance abuse, or facilities that treat children from those that treat adults. By including additional service information, and by making this filterable in the online provider directory, Aetna helps members locate MH/SUD facilities that meet their needs at least just as easily as they can search for M/S facilities.

With so much information housed in the provider directory, a well-defined plan for ongoing maintenance is crucial to ensure the information is accurate. Participating providers are required to notify Aetna of changes to their practice. To help make this effortless for providers, both M/S and MH/SUD providers are prompted once per quarter to verify their information within an online provider portal. Additionally, Aetna conducts ongoing targeted proactive directory quality reviews, directed at reviewing providers without activity at a listed service location. This process applies equally to M/S and MH/SUD providers. Aetna makes outreach calls to verify these providers' information and make directory updates. The information verified includes whether the provider is accepting new patients at this location and how often the provider practices at this location. This is important for providers who may see patients at multiple offices and therefore have multiple listings in the directory. If they no longer see patients at a location or visit it infrequently, it should not be listed in the directory and will be removed. By removing inactive locations from the directory, members can better find providers accepting new patients in a convenient location. When members happen across inaccurate directory listings, they can report inaccurate information by clicking a link within each directory listing. These reports are reviewed by Aetna's provider data services team, which will make the required updates.

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

Aetna's analysis of the "as written" strategies in place to provide its members with an accurate directory that includes all information required by law, that is organized and searchable in a way to help members find the information they need, and to maintain the accuracy of that directory information, shows that those strategies are applied comparably to M/S and MH/SUD services and are not more stringently designed or applied to MH/SUD services than to M/S services. Aetna applies the same criteria for inclusion in its provider directories for both M/S and MH/SUD services, which is that all contracted providers are to be listed in the directory. Aetna includes all information required by law and applies internal

policies and procedures in developing and maintaining the provider directory, which apply equally to M/S and MH/SUD providers. Additionally, Aetna's policies and procedures for maintenance of the directory, updating provider information, and monitoring directory accuracy apply equally to M/S and MH/SUD providers. A

Aetna's analysis of the "in operation" strategies in place relating to the specificity of the directory and display and searchability of various specialty, subspecialty, facility types, and specific services shows that those strategies are applied comparably to M/S and MH/SUD services and are not more stringently designed or applied to MH/SUD services than to M/S services. In operation, the online directory includes a free text search box, making any specific provider (i.e. Dr. John Smith) or any specialty searchable by either the clinical name or common name. The online directory also allows members to navigate to services by category; the initial directory page provides thirteen (13) categories, which include: 1) Medical Doctors and Specialists; 2) Hospitals and Facilities; 3) Urgent Care; 4) Walk-In clinics; 5) Pharmacy; 6) Dental Care; 7) Vision; 8) Labs and Testing; 9) Alternative Medicine; 10) DME; 11) Common Procedures and Conditions; 12) Institutes of Quality/Excellence, and a specific, dedicated category for Mental Health. Each of these categories then serve as a central resource for members requiring information related to that category. The Mental Health Category serves as a central source for all directory information pertaining to MH/SUD services. Users may navigate based on categories such as mental health professionals, facilities, telehealth, and employee assistance programs. If, for example, a user selects mental health professionals, they may then search for in-network individual providers based on various areas of concern as referenced above. These include, for example, anxiety and stress management counseling, domestic violence, eating disorder specialist, gender identity, and drug, alcohol, and other addictions. Users can also search for facility types and telehealth options. By providing this dedicated central mental health resource, at minimum, Aetna provider directories offer members an ability that is equal to that for M/S services, to search for and identify specific MH/SUD providers and services based on a member's specific health concerns.

As required by Section 15-112 (p)(3)(i) of the Insurance Article, Aetna conducts regular directory audits to ensure accuracy, which include periodic review of at least a reasonable sample size of its network directory. Aetna's Network and Provider Data Services Unit includes a Data Validation and Quality (DVQ) Outreach Team. On a quarterly basis, the DVQ Outreach Team will select a sample of individual practitioners and non-individual practitioners subject to audit. The directory accuracy audits apply equally to MH/SUD and M/S individual providers and facilities, and results are monitored in aggregate. Through the directory accuracy audits, Aetna updates contact information and removes providers not practicing at service locations listed in the directory. Aetna is committed to removing providers who are no longer participating or practicing. In addition to updating the providers identified for audit, Aetna analyzes root causes to identify ways to keep provider information current.

In reviewing the recent audit results, we found that many of the providers not practicing at the directory locations were in fact practicing at other locations, as opposed to being included in the directory erroneously. In the 2023 directory audits, there were fewer MH/SUD directory inaccuracies identified than M/S, and among those inaccuracies, there was only one MH/SUD provider who is no longer participating compared to 11 M/S practitioners. Further, as demonstrated in Aetna's review, a higher percentage of MH/SUD providers are accepting new patients than M/S providers, and a greater or similar percentage of MH/SUD providers specialize in treating children as M/S providers.

Taken together, Aetna's conclusions are that members can search for and locate a participating MH/SUD provider, at minimum, just as easily as for a M/S provider. The most important conclusions are that the design of the directory demonstrates that members have a central place to locate information pertaining to mental health, which is organized by category and focus area in a way that maximizes the opportunity to meet a member's health search needs, and that the policies and strategies used to determine what information is included in the directory and to verify and maintain the accuracy of that information are the same for M/S and MH/SUD services. Altogether, Aetna's review demonstrates that in writing and in operation, the processes, strategies, evidentiary standards and factors used in the design and maintenance of its provider directories as they relate to MH/SUD benefits are comparable to, and not applied more stringently than the same as to M/S benefits.