Sentara Health Plans MHPAEA Comparative Analysis Reporting

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

10/1/2026 Version 1

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2026 Nonquantitative Treatment Limitation (NQTL) Submission

MEDICAL NECESSITY: ALL CLASSIFICATIONS

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See **45 CFR 146.137(c)(1).** Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also **FAQ 45** (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

Description of NQTL:

Medical necessity is the standard and criteria used to determine whether services and supplies are needed to diagnose or treat an illness, injury, condition, or disease.

Standard for Medical Necessity:

Medically necessary services and/or supplies means the use of services or supplies which are:

1. Required to identify, evaluate, or treat the Member's condition, disease, ailment, or injury, including pregnancy related conditions;
2. In accordance with recognized standards of care for the Member's condition, disease, ailment, or injury;
3. Appropriate with regard to standards of good medical practice;
4. Not solely for the convenience of the Member, or a participating Physician, Hospital, or other health care Provider; and
5. The most appropriate supply or level of service which can be safely provided to the Member as substantiated by the records and documentation maintained by the Provider of the services or supplies.

This standard for medical necessity does not vary between MH/SUD benefits and M/S benefits.

The Medical Policy Committee is responsible for defining and creating the standard for medical necessity. Medical necessity determinations are rendered in accordance with a utilization management program description that is updated annually. Any adverse determinations are rendered by medical directors or, where necessary, a specialty advisor.

Third-party vendors provide specified utilization management services for Sentara, as noted below:

- A vendor ("UM Vendor 1") conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents in accordance with a master services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease.

- A separate vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a master services agreement. UM Vendor 2 is URAC and NCQA accredited. Under the master services agreement and statements of work incorporate therein, UM Vendor 2 provides access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

- A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial

Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization. UM Vendor 3 uses Sentara's definition of medical necessity as defined above.

Standard for Emergency Services:

Sentara adopts the definition of Emergency Services in the Virginia Code § 38.2-3438.

Emergency is defined as the sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson who possesses an average knowledge of health and medicine to result in (a) serious jeopardy to the mental or physical health of the individual, or (b) danger of serious impairment of the individual's bodily functions, or (c) serious dysfunction of any of the individual's bodily organs or parts, or (d) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Emergency Medical Condition is defined as, regardless of the final diagnosis rendered to a Covered person, a medical or behavioral health condition manifesting itself by acute symptoms of sufficient severity, including severe pain, so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) serious jeopardy to the mental or physical health of the individual, (ii) danger of serious impairment to bodily functions, (iii) serious dysfunction of any bodily organ or part, or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus.

Blanket Exclusions:

For individual and small group plans, Sentara compiles its Exclusions & Limitations ("E&Ls") from the EHB Benchmark Plan and federal and state law mandates and regulations. For large group plans, identical considerations apply with the exception of the EHB Benchmark Plan, which does not apply to large group plans. As explained below, as a matter of practice, E&Ls with clinical components are not treated as blanket exclusions, and are reviewed for medical necessity.

In application, services identified as E&Ls with clinical components such as cosmetic services, wilderness/nature therapy, equine therapy, and massage therapy are reviewed for medical necessity upon a request for authorization regardless of whether the service is M/S or MH/SUD. Specifically, when a request for authorization is received with any service or procedure code that does not comport with an internal medical policy or MCG CareWeb ("MCG"), the utilization review nurse will forward the request to the Medical Policy Committee for review. The Medical Policy Committee will conduct a thorough review of peer reviewed literature. The completed review will be sent to the Medical Director for final review and determination. Medical Directors will utilize their professional judgment and individual considerations to select resources relating to the clinical circumstances of the member from the list below or as otherwise identified by the reviewer. In the absence of relevant peer reviewed literature, minimal available resources, and/or none of the

identified entities have published guidelines or recommendations, the information will be considered by the Medical Director in the context of the member's benefit plan and apparent lack of peer reviewed evidence related to the coverage for the requested service. After review, the Medical Director will document his or her determination and the references used and the result is sent to the utilization review nurse for processing.

The Medical Policy Committee has reviewed certain services, such as nature/wilderness therapy in its review of "new" technology. By way of example, the Medical Policy Committee specifically reviewed Wilderness Therapy in February 2023. At that time, the Medical Policy Committee generally deemed Wilderness Therapy to lack clinical utility but indicated that requests should be reviewed for medical necessity. Since that time, MCG has adopted clinical guidelines for Wilderness Therapy, which Sentara has adopted in lieu of using internally-developed criteria.

There are no HCPCS/CPT codes for identified E&Ls that are "always excluded." Those E&Ls with recognized HCPCS codes are reviewed, as a matter of practice, for medical necessity irrespective of diagnosis.

Separate from the services that have a clinical component, and thus trigger a medical necessity review, Sentara includes on its E&L list services that, by their nature, are non-medical services. For example, work hardening programs are on Sentara's E&L list because such programs are occupational services and, by their nature, are not medical services. Specifically, work hardening programs offer therapeutic services aim at allowing an individual to regain the functions needed for a specific job. While Sentara does not cover work hardening programs, Sentara does cover physical therapy and occupational therapy to allow members to regain physical function. In this way, physical therapy and occupational therapy are medical services aimed at improving member's health, as opposed to work hardening programs which are non-medical and are aimed only at specific job-related functions.

- Administrative Charges (completion of claim forms, transfer or copy of medical records, access or concierge fees, missed appointments, routine telephone calls, other clerical charges)

- Alternative Medicine (Acupuncture, Holistic medicine, Homeopathic medicine, Hypnosis, Aroma therapy, Massage and massage therapy, Reiki therapy; Herbal, vitamin or dietary products or therapies; Naturopathy; Thermography; Orthomolecular therapy; Contact reflex analysis; Bioenergial synchronization technique (BEST); Iridology-study of the iris; Auditory integration therapy (AIT); Colonic irrigation)

- Ancillary Services (vocational rehabilitation services. Employment counseling, relationship counseling for unmarried couples, pastoral counseling, expressive therapies, health education)

- Autopsies

- Searches for blood donors or transportation of blood.
- Breast Milk from a donor
- Cosmetic Services (Services to change the texture or look of skin, the size, shape or look of facial or body features; Surgery, reconstructive surgery, or other procedures that are cosmetic and not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically; Any service or supply that is a direct result of a non-Covered Service; Non-medically necessary treatment or services resulting from complications due to cosmetic or Experimental procedures; Breast augmentation or mastopexy procedures for correction of cosmetic physical imperfections, except as required by state or federal law regarding breast reconstruction and symmetry following a mastectomy or as provided under the Plan's Reconstructive Surgery benefit; Tattoo removal; Keloid treatment as a result of the piercing of any body part; Consultations or office visits for obtaining cosmetic or Experimental procedures; Cosmetic Botox injections; Penile implants; Cosmetic skin condition treatments by laser, light or other methods unless Medically Necessary)
    - This exclusion does not apply to: Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process; Surgery or procedures to correct congenital abnormalities that cause functional impairment; Surgery or procedures on newborn children to correct congenital abnormalities.
- Educational Services (self-training services, vocational training, tutorial services or testing required to complete Educational, degree ore residency requirements, testing or screening services for classroom performance except when services qualify as Early Intervention Services)
    - This exclusion does not apply to educational services covered under the Plan's benefits for Diabetic Insulin, Testing Supplies, Equipment, and Education, Diabetes Care Management, Lymphedema, Residential Treatment Services, Outpatient Prescription Drug Coverage, and some Preventive and Wellness Services for disease management and Reproductive Health Services.
- Hypnotherapy
- Massage Therapy
- Nature therapies
- Recreational therapies such as hobbies, arts and crafts unless provided under a program of treatment in a licensed Residential Treatment Facility
- Exercise or equine therapies;

- Work hardening programs.

As it relates to recreational therapies provided under a program of treatment in a residential treatment facility, those services will be covered and reimbursed in the per diem charge. By way of comparison, physical therapy services in a skilled nursing or in-patient rehabilitation are billed for services rendered on a per diem basis and will be covered.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See **45 CFR 146.137(c)(2).** Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:

(A) A detailed description of the factor;

(B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and

(C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also **FAQ 45** guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Clinical criteria applied in determining medical necessity are derived from independent third-parties and, internally, the Medical Policy Committee, which is comprised of medical directors and specialists from both medical/surgical, behavioral health, and substance use disorder specialties. These criteria originate from recognized medical literature, professional standards and protocols, and published research studies. Sentara uses the ASAM criteria for substance use disorders, and MCG guidelines for all other services unless no applicable ASAM or MCG guidelines exist for the service being requested, in which case Sentara will apply its internally-developed clinical policies. If no applicable internal clinical policies exist, the Medical Policy Committee performs a new technology assessment to determine whether the service is medically necessary.

Clinical Criteria Supporting Blanket Exclusions: Excluded services are defined in the Plan and no specific clinical criteria exist identifying excluded services. Many of the excluded benefits are non-essential and excluded in the EHB Benchmark Plan.

Step 3: Description of how factors are used in the design and application of the NQTL.

See **45 CFR 146.137(c)(3).** Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Sentara has developed medical policies that express its determination of whether certain services are medically necessary, and they are based upon a review of currently available clinical information. These medical policies can be found at:
https://www.sentarahealthplans.com/en/providers/policies/medical-policies

Medical policies are specific to a line of business. Restated, medical policies designated as commercial are applicable to commercial plans only and Medicaid policies are for Medicaid

plans only. For commercial plans, no MH/SUD internal clinical policies exist. For all MH services, MCG apply. For SUD services, ASAM criteria, as adopted by MCG, apply.

The internal medical policies adopted by Sentara are derived from a number of sources, including: American Society of Addiction Medicine ("ASAM"), Milliman Care Guidelines (MCG), Local Coverage Determinations (LCD), National Coverage Determinations (NCD), UpToDate, Hayes Technology Assessment, FDA review, and AMA guidelines, federal and state regulations, DMAS and CMS manuals. Specifically:

- ASAM: *See* https://www.asam.org/asam-criteria/about-the-asam-criteria#:~:text=The%20ASAM%20Criteria%20is%20the%20most%20widely%20used,transfer%20of%20patients%20with%20addiction%20and%20co-occurring% The ASAM Criteria includes the most widely used and comprehensive set of standards defining appropriate and medically necessary treatment for patients with addictions and co-occurring disorders.

- MCG: *See* Evidence-Based Care Guidance and Solutions | MCG Health. MCG consist of comprehensive clinical criteria that defines when a requested service is appropriate and medically necessary. The MCG constantly evolve and are updated annually. Specifically, Sentara uses MCG because MCG, including annual updates, are based on the latest scientific evidence, including but not limited to peer-reviewed papers, meaning that clinicians are reviewing one another's work. MCG further takes into consideration guidance from medical societies, like the American Medical Association or other specialty groups. Sentara uses MCG to support effective and safe evidence-based patient care.

- LCDs/NCDs: Local and National Coverage Determinations represent an evidence-based process to determine coverage for services covered by Medicare. Sentara utilizes LCDs and NCDs as a resource in reviewing "new technology" in services and treatment and in developing medical policies for commercial plans. LCDs serve as a resource when no NCD exists.

- UpToDate is a private company within the Wolters Kluwer conglomerate that compiles evidence based clinical guidelines and solutions. Sentara utilizes UpToDate as a resource and reference in reviewing "new technology" and in the development of its medical policies. When Sentara consults UpToDate in the development of a medical policy, a reference will be included in that specific clinical policy.

- Hayes Technology is associated with Symplr, a company that offers healthcare operational solutions. Hayes Technology compiles and analyzes new and emerging clinical practices. Sentara utilizes Hayes Technology as a resource and reference in reviewing "new technology" and in the development of its medical policies. When Sentara consults Hayes Technology in the development of a medical policy, a reference will be included in that specific clinical policy.

- DMAS and CMS manuals: Sentara uses DMAS and CMS manuals for the same reasons it consults with NCDs and LCDs in developing commercial clinical policies.

Sentara's intent in explaining the criteria above is to offer an explanation that can easily be understood by consumers. The reason that multiple sources are utilized is to ensure that Sentara has a wide range of information to consider when adopting medical policies or reviewing "new technology." Not one of these criteria is predominant or exclusive. Each medical policy identifies the resources and references utilized in adopting that specific policy.

Sentara, through its Medical Policy Committee promulgates internal clinical guidelines as recommendations for the clinical management of specific conditions. These include the following guidelines, which can be found at https://www.sentarahealthplans.com/en/providers/policies/clinical-guidelines:

- Behavioral Health Guidelines: ADHD Adult, ADHD Pediatric, Bipolar and Schizophrenia, Chronic Opioid Management, Depression Adult, Depression Pediatric, Major Depression, Monitoring for Metabolic Syndrome, Screening for Depression in Adults with Diabetes, Substance Use Disorders/Alcohol Adult, Substance Use Disorders/Alcohol Youth
- Cardiovascular Guidelines: Chest Pain, Congestive Heart Failure, Heart Failure with Preserved Ejection Fraction, Hypertension Guidelines, Lipid Screening and Management
- Ear, Nose and Throat Guidelines: Diagnosis and Management of Acute Otitis Media, Pharyngitis
- Endocrinology Guidelines: Diabetes Care
- Obstetric and Gynecology Guidelines: Cervical Cancer Screening Clinical Guidelines, Hyperemesis Gravidarum Protocol, OB/GYN Subspecialty Referral, Pelvic Mass Protocol, Perinatal and Postpartum Depression, Prenatal and Postpartum Care
- Orthopedic Guidelines: Acute Low Back Pain, Chronic Low Back Pain, Osteoporosis Guidelines
- Prevention and Treatment of Obesity Guidelines: Prevention and Management of Obesity (Adolescent/Children), Prevention and Management of Obesity (Adult)
- Preventive Health Guidelines: Adult Health Maintenance, Guidelines for Childhood Lead Poisoning Testing, Immunization Schedules-Adult-CDC, Immunization Schedules-Child and Adolescent-CDC, Pediatric Health Maintenance, Tobacco Cessation, Early Pediatric Screening, Diagnosis, and Treatment (EPSDT) Forms
- Pulmonary Guidelines: Asthma Guidelines and Supplement, COPD, Viral Upper

Respiratory Infection in Adults and Children

Clinical Guidelines serve as treatment guidance and are not used for utilization review or determinations of medical necessity.

For commercial lines of business, when no internal medical policies exist for any MH or M/S service, MCG is utilized without incorporation or supplementation of any internal guidelines or policies. The MCG incorporate the ASAM criteria, which Sentara utilizes exclusively for substance use disorder services. Below are examples of how MCG and ASAM are used with respect to specific services:

- ABA Therapy: Sentara utilizes MCG (without incorporation or supplementation of any internal guidelines or policies) and an individual's clinical documentation when determining medical necessity for ABA therapy. Sentara does not utilize any internal medical policy for ABA for commercial lines of business.

- IOP, Partial Hospitalization, Residential Treatment, Acute Psychiatric Hospital (Mental Health): Sentara utilizes MCG (without incorporation or supplementation of any internal guidelines or policies) and an individual's clinical documentation when determining medical necessity for intensive outpatient, partial hospitalization, residential treatment, and/or acute psychiatric hospital for mental health conditions, including eating disorders and schizophrenia. Sentara uses MCG for length of initial stay and concurrent review.

- IOP, Partial Hospitalization, Residential Treatment, Acute Psychiatric Hospital (Substance Use): Sentara utilizes ASAM (without incorporation or supplementation of any internal guidelines or policies) and an individual's clinical documentation when determining medical necessity for intensive outpatient, partial hospitalization, residential treatment, and/or acute psychiatric hospital for substance use disorders, including opioid use disorder or alcohol use disorder. Sentara uses ASAM for length of initial stay and concurrent review. ASAM clinical criteria are incorporated within MCG.

- Home Health, Skilled Nursing, and Inpatient Rehab: Sentara utilizes MCG (without incorporation or supplementation of any internal guidelines or policies) and an individual's clinical documentation when determining medical necessity for home health, skilled nursing facility, and/or inpatient rehabilitation services for M/S conditions, including recovering from a stroke. Sentara uses MCG for length of initial stay and concurrent review.

- Applied Behavioral Analysis, Transcranial Magnetic Stimulation, Electroconvulsive Therapy, and Medication Assisted Therapy: Sentara utilizes MCG (without incorporation or supplementation of any internal guidelines or policies) and an individual's clinical documentation when determining medical necessity for modalities such as applied behavior analysis, transcranial magnetic stimulation, electroconvulsive therapy, and medication assisted treatment. Prior authorization or a review for medical necessity is not

required for medication assisted treatment.

- PT/OT/ST: Sentara utilizes MCG (without incorporation or supplementation of any internal guidelines or policies) and clinical documentation when determining medical necessity for physical therapy, occupational therapy, and speech therapy. Sentara (through ASH) utilizes ASH's utilization review process and clinical documentation when determining medical necessity for chiropractic care.

Blanket Policy Exclusions:

There are no separate clinical criteria for excluded services.

Step 4: Demonstration of comparability and stringency as written.

See 45 CFR 146.137(c)(4). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.

- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Comparison of Medical Necessity Standards (including those for Emergency Medical Conditions) for MH/SUD and M/S:

Standards defined in Step One apply consistently and equally to M/S and MH/SUD conditions. Specifically, the standard as defined for Emergency Medical Condition includes analyses of not just a member's physical health, but also the mental/behavioral health of an individual which would place that individual in "serious jeopardy" if not treated.

Explanation of How Medical Necessity Criteria is Selected, Developed, and Adopted:

The Medical Policies and Clinical Guidelines express Sentara's determination of whether certain services are medically necessary, and they are based upon a review of currently available clinical information.

The Medical Policy Committee meets monthly and reviews at least annually all medical policies. The specific sources and references for each medical policy are identified within the policy, as well as all dates that each policy was reviewed and revised.

To the extent internal medical policies are not in place, clinical criteria follows MCG for M/S and MH and ASAM for SUD. The Medical Policy Committee annually reviews MCGs. The Medical Policy Committee also reviews the clinical criteria utilized by UM Vendor 2 and UM Vendor 3 in relation to oncology and advanced imaging services respectively.

The Medical Policy is comprised of 28 individuals with varying clinical or other specialties. Of the members of the Medical Policy Committee, 9 are considered MH/SUD experts and 13 are considered M/S experts in various specialties.

The Medical Policy Committee makes decisions for both SHP and SHIC.

Explanation for How Third-Party Criteria Are Selected and Analysis of Compliance with MHPAEA:

Carrier utilizes non-profit third-party criteria such as ASAM, CMS for National and Local Coverage Determinations,

Others include MCG, Hayes Technology and UpToDate. These third parties were selected based upon industry standard and reputation. As identified in the Medical Policies, a variety of sources and references are consulted to ensure a consistent and compliant approach to MHPAEA. Each policy identifies the sources and references consulted in developing that policy.

For commercial lines of business, when no internal medical policies exist for any MH or M/S

service, MCG are utilized without incorporation or supplementation of any internal guidelines or policies. The MCG incorporate the ASAM criteria, which Sentara utilizes exclusively for substance use disorder services.

Sentara understands the directive from the BOI to require that the Medical Policy Committee thoroughly review the entirety of the MH criteria and thoroughly review the entirety of the M/S criteria, including researching the sources of the development process to ensure comparability. The same process is required for comparing ASAM substance use criteria and MCG M/S criteria.

The Medical Policy Committee asserts that it conducts an annual review of all MCG utilized annually. The MCG Behavioral Health Care aligns with ASAM guidelines.

The "Summary of Guideline Development Policies and Procedures published by MCG Health," specific to the 30th edition, includes the following statement:

> MCG content for the clinical care of medical, surgical, and behavioral health patients is developed using the same overall methodology and evidentiary standards and aligns with the principles of regulatory requirements such as the Mental Health Parity and Addiction Equity Act (MHPAEA). Guidance for medical/surgical and mental health and substance-use disorders (MHSUDs) addresses quantitative and non-quantitative limitations in the same manner.
> Level of care guidelines for medical/surgical and MHSUD topics include an Optimal Recovery Course with best practice recommendations for day-by-day care within a facility. Guidance about the goal length of stay and other benchmarks is also provided in the same manner for medical/surgical and MHSUD content. There are no "fail first" requirements for admission to a level of care in the Behavioral Health Care guidelines. MCG care guidelines related to procedures, treatments, and medications may require completion of a trial of conservative or other treatment (e.g, physical therapy, medications) based on published evidence. These non-quantitative treatment limitations are based solely on the published medical literature and established best practices; limitations on duration or scope of treatment are derived from the best available evidence and are addressed similarly across medical/surgical and behavioral health content.

MCG Health further publishes the Summary of Changes upon adoption of new editions, which is reviewed and adopted by the Medical Policy Committee as new editions are published.

MCG Health attests that its guidelines are MHPAEA compliant:

https://www.mcg.com/care-guidelines/behavioral-healthcare/

https://content.naic.org/sites/default/files/national_meeting/MCG%20Presentation.pdf

Explanation Concerning Compliance of Internally Developed Clinical Criteria:

The standard of medical necessity as defined in the Plan is not altered by the development and implementation of clinical criteria and medical policies. Internal clinical criteria and medical policies are devised and implemented to be consistent with the definition of medical necessity. The Medical Policy Committee meets monthly and reviews at least annually all medical policies. The specific sources and references for each medical policy are identified within the policy, as well as all dates that each policy was reviewed and revised. To the extent separate medical policies are not in place, clinical criteria follows MCG. Examples of clinical guidelines and medical policies can be found at https://www.sentarahealthplans.com/en/providers/policies/clinical-guidelines

Comparison of Internal Medical Policies:

Sentara is limited in its ability to select and compare an internal MH/SUD medical policy and M/S policy because Sentara does not currently have any MH/SUD internal medical policies, as MCG apply to all MH services and ASAM criteria, as adopted by MCG, apply to all SUD services. In July 2021, Sentara implemented Sensory-Weighted Vest, BH 27, to address the medical necessity of the Sensory-Weighted Vest. Upon implementation, it appears there was no comparable MCG. The Medical Policy Committee reviewed the Weighted Vest in its assessment of "new technology" to create the new clinical policy. The clinical references consulted at implementation are identified on the medical policy and include Specialty Association Guidelines, Government Regulations, Hayes, UpToDate, NCDs and LCDs. The medical policy was reviewed in June 2024 with no changes referenced. In 2024, references including Hayes, CMS, MCG Health, DMAS and other clinical articles were identified. Comparably, in April 2024, Sentara implemented medical policy Gait Analysis and Surface Electromyography, Medical 345. Like BH 27 for Sensory-Weighted Vest, Gait Analysis and Surface Electromyography was reviewed by the Medical Policy Committee as a "new technology." The clinical references consulted at implementation include Specialty Association Guidelines, Government Regulations, Hayes, UpToDate, NCDs and LCDs. Specifically referenced are Hayes, CMSMCG, DMAS regulations and other identified clinical medical articles.

Sentara implements internal policies for a variety of reasons. As will be described below in the creation and implementation of the medical policy related to Gender Affirming Surgery, the impetus for medical policies may be a change in state or federal mandates or a response to an industry change or awareness of clinical utility. In certain circumstances, internal medical policies are adopted upon a recognition of clinical utility prior to the creation of a policy or clinical criteria from recognized third-parties, like MCG.

- Sentara implemented Surgical Policy 108: Gender Reaffirming Surgery, effective January 2017. One impetus for Surgical Policy 108 was the passage of Section 1557 of the Affordable Care Act, which prohibits discrimination on the basis of protected classes, including sex. The Act gave the Department of Health and Human Services ("DHHS") the authority to issue regulations implementing Section 1557, which it did in 2016. After legal

challenge, DHHS issued a new final rule in 2020 delegating discretion to the states. Prior to the 2020 Rule, the Virginia General Assembly passed Va. Code 38.2-3449.1, which prohibits commercial insurers from denying "medically necessary transition-related care." At the time of issuance, limited to no third-party clinical criteria existed in the face of federal and state mandates and transition in the industry. The medical policy has undergone revisions almost annually (2018, 2019, 2021, 2022, 2023, and 2024) representing the rigorous review by the Medical Policy Committee. The references identified represent the variety of sources considered by Sentara in implementing internal medical policies including, DHHS, Hayes, CMS, MCG, DMAS, and current literature from specialty groups such as the World Professional Association for Transgender Health.

- Sentara adopts proportionally more internal medical policies and clinical guidelines for M/S services than MH/SUD services. As represented by the list of medical policies, only two policies have been adopted for behavioral health for commercial policies, which results in utilization of MCG and ASAM criteria for MH/SUD requests for authorization.

The standard for medical necessity is not altered by Sentara's contracting with any third-party vendors. UM Vendor 1 is an industry specialty third-party that serves to administer chiropractic services. It applies its own definition of medical necessity and clinical guidelines, but does so in a manner consistent with the definition of "medical necessity" from Sentara's commercial health plans. UM Vendors 2 and 3 are industry specialty third-parties that serve to administer oncology treatment and advanced imaging services respectively. Both utilize Sentara's definition of medical necessity and industry specific clinical guidelines, as explained above. The Medical Policy Committee also reviews the clinical criteria utilized by UM Vendors 2 and 3 in relation to oncology and advanced imaging services respectively.

Clinical Guidelines and Medical Policies Do Not Substitute for Clinical Judgment:

The medical policies do not constitute medical advice or medical care. Clinical data in a particular case may necessitate or permit deviation from these Guidelines. The Sentara Health Guidelines are institutionally endorsed recommendations and are not intended as a substitute for clinical judgment.

Medical Directors may use individual consideration based on clinical documentation received and in conjunction with generally accepted standards of medical practice, federal and state regulations, criteria contained within MCG, and peer reviewed scientific literature. Additionally, when making these determinations, Sentara may also take into consideration recommendations from physician specialty societies (society whose representatives are certified by a board recognized by the American Board of Medical Specialties), and input from physicians practicing in related clinical fields. All decisions rendered are documented and may be escalated to other medical directors. Prior to any appeal, a member is entitled to reconsideration and a peer-to-peer review. If a decision is an adverse benefit determination, such decision is subject to the appeal process.

Medical Necessity Standard in Sentara's Manuals, Policies, Etc.:

Sentara has reviewed the following documents and has concluded that the definition of medical necessity has not been modified by any vendor and is applied consistently to M/S and MH/SUD services. Sentara does not use any third-party vendor for utilization review of MH/SUD services. In regard to clinical criteria, Sentara uses MCG for both M/S and MH services and MCG (incorporating ASAM) for SUD services. Documents reviewed:

Comparison of Clinical Criteria:

Sentara develops criteria for both M/S and MH/SUD utilizing both third-party criteria and various other references and sources as identified in internal clinical criteria. The clinical criteria for SUD relies heavily on ASAM, which is recognized as stating generally accepted standards of medical practice. Other clinical criteria are developed using a variety of sources and references to ensure comprehensive and thorough analysis of medical standards and practice.

Blanket Policy Exclusions:

Excluded services are defined in the Plan and no specific clinical criteria exist identifying excluded services. Many of the excluded benefits are non-essential and excluded in the EHB Benchmark Plan.

Step 5: Demonstration of comparability and stringency in operation.

See **45 CFR 146.137(c)(5).** The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect

or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Please see in-operation metrics and analyses in the following NQTLs: prior authorization, concurrent review, and retrospective review.

Step 6: Findings and conclusions.

See **45 CFR 146.137(c)(6).** The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the **FAQ 45** guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Findings and Conclusions:

Sentara defined the Medical Necessity NQTL and identified the Medical Policy Committee as the body that oversees development and review of all medical policies and clinical guidelines. Sentara identified all benefit exclusions under the commercial plan documents and reviewed those exclusions to conclude that no disparity exists between M/S and MH/SUD services. Carrier reviewed all "factors" i.e. information that determines how Medical Necessity applies to benefits, and sources for medical policies and clinical guidelines. Sentara provided access to all medical policies and clinical guidelines. Any internal medical policy or clinical guideline includes all resources utilized in development. Medical policies and clinical guidelines are derived from federal and state regulations, ASAM, Milliman Care Guidelines as well as including Local Coverage Determinations (LCD), National Coverage Determinations (NCD), UpToDate and Hayes Technology Assessment. For each medical policy, a reference section is included that identifies each source utilized in developing that policy. If no separate medical policy exists, the clinical criteria is derived from MCG.

Sentara performed an intensive analysis of the definition of medical necessity as stated in commercial plan documents, as compared to the application of the medical necessity definition as a NQTL in operation. As written, the definition of medical necessity in the commercial plan documents does not vary between MH/SUD benefits and M/S benefits. In conjunction with this review, Sentara reviewed the relationship of third-party vendors that provide utilization review services for certain categorical services: UM Vendor 1 for certain chiropractic services; UM Vendor 2 for medical and radiological oncology treatment; UM Vendor 3 for certain advanced imaging services. Sentara does not utilize a third-party vendor for utilization review of MH/SUD services. All of the third-party vendors with the exception of UM Vendor 1 utilize the definition of medical necessity in the commercial plan documents. UM Vendor 1's definition is set forth herein and is consistent with Sentara's definition of medical necessity.

In operation, Sentara confirmed that absent internal medical policies, it utilizes MCG for M/S and MH services. MCG incorporate ASAM standards for SUD treatment. In regard to internal medical

policies, only two apply to commercial lines of business.

The MPC implements internal medical policies, using a number of sources, which are defined herein along with explanations concerning their respective uses. Each internal medical policy identified the specific references and sources consulted. When no internal medical policy exists, Sentara uses MCG (as incorporating ASAM). The MPC reviews MCG annually for continued applicability and compliance. Sentara attached reviews published by MCG and examples of the MPC reviewing and adopting MCG and subsequent changes. Members of the MPC are identified by specialty representing a proportionate amount of members for behavioral health services.

Sentara appreciates that it must demonstrate a no more stringent application for medical necessity determination for MH/SUD services, as compared to M/S services. To satisfy this burden, Sentara reviewed internal medical policies, of which there are only two and compared one of those to the implementation of a M/S internal policy. Both policies identified the same processes for implementation. For SUD services Sentara utilizes MCG 30th edition (incorporating ASAM). The MPC committee reviews and approves MCG for M/H services, as it does for M/S services, demonstrating compliance with MHPAEA.

Analysis establishes Sentara is compliant with MHPAEA.

This analysis was completed in September 2026 by the following Sentara Departments: Utilization Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

EXPERIMENTAL/INVESTIGATIONAL/UNPROVEN (EIU):

ALL CLASSIFICATIONS

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See **45 CFR 146.137(c)(1).** Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also **FAQ 45** (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

Experimental or Investigational NQTL: Experimental or Investigational is care that is: (a) investigatory; or (b) an unproven service that does not meet generally accepted and professionally recognized standards of practice. *Sentara does not apply EIU as a NQTL and provides the following analysis related to Sentara's practice of issuing administrative denials for non-covered services. No Exclusion or Limitation ("E&L") is automatically excluded based upon an EIU determination.*

M/S Services Identified as E&Ls *(irrespective of whether services are provided inpatient, outpatient, in-network or out-of-network):*

- Alternative Medicine (Acupuncture, Holistic medicine, Homeopathic medicine, Hypnosis, Aroma therapy, Massage and massage therapy, Reiki therapy; Herbal, vitamin or dietary products or therapies; Naturopathy; Thermography; Orthomolecular therapy; Contact reflex analysis; Bioenergial synchronization technique (BEST); Iridology-study of the iris; Auditory integration therapy (AIT); Colonic irrigation)

- Ancillary Services (vocational rehabilitation services. Employment counseling, relationship counseling for unmarried couples, pastoral counseling, expressive therapies, health education)

- Biofeedback Therapy, neurofeedback, and related

- Cosmetic Services (Services to change the texture or look of skin, the size, shape or look of facial or body features; Surgery, reconstructive surgery, or other procedures that are cosmetic and not Medically Necessary to restore function or alleviate symptoms which can effectively be treated non-surgically; Any service or supply that is a direct result of a non-Covered Service; Non-medically necessary treatment or services resulting from complications due to cosmetic or Experimental procedures; Breast augmentation or mastopexy procedures for correction of cosmetic physical imperfections, except as required by state or federal law regarding breast reconstruction and symmetry following a mastectomy or as provided under the Plan's Reconstructive Surgery benefit; Tattoo removal; Keloid treatment as a result of the piercing of any body part; Consultations or office visits for obtaining cosmetic or Experimental procedures; Cosmetic Botox injections; Penile implants; Cosmetic skin condition treatments by laser, light or other methods unless Medically Necessary)

    - This exclusion does not apply to: Surgery or procedures to correct deformity caused by disease, trauma, or previous therapeutic process; Surgery or procedures to correct congenital abnormalities that cause functional impairment; Surgery or procedures on newborn children to correct congenital abnormalities.

- Educational Services (self-training services, vocational training, tutorial services or testing required to complete Educational, degree ore residency requirements, testing or screening services for classroom performance except when services qualify as Early

Intervention Services)
    - This exclusion does not apply to educational services covered under the Plan's benefits for Diabetic Insulin, Testing Supplies, Equipment, and Education, Diabetes Care Management, Lymphedema, Residential Treatment Services, Outpatient Prescription Drug Coverage, and some Preventive and Wellness Services for disease management and Reproductive Health Services.

- Hypnotherapy
- Massage Therapy
- Nature therapies
- Recreational therapies such as hobbies, arts and crafts unless provided under a program of treatment in a licensed Residential Treatment Facility
- Exercise or equine therapies;
- Work hardening programs.

Only two categories of services include a specific reference to EIU in the plan documents: chiropractic services (which can be categorized as outpatient services) and transplant services (which can be categorized as both inpatient and outpatient services). Both are M/S services and depending on plan type (whether the plan includes out-of-network benefits), both can be in-network or out-of-network services. Notably, while these services reference EIU, neither chiropractic nor transplant services are considered EIU "blanket" exclusions that always apply. Chiropractic and transplant services are reviewed for medical necessity.

Sentara distinguishes "administrative" E&Ls from those that implicate clinical medical necessity review. For example, in this EIU NQTL analysis, certain services like Administrative Services, Autopsies, Blood Donation and Breast Milk Donor are not included because they are administrative in nature. No E&L is automatically excluded based upon an EIU determination.

EIU NQTL Does Not Apply to Any MH/SUD Services:

EIU is not applied to any MH/SUD services in a manner that would automatically exclude coverage based on EIU. Requests for services not contemplated in plan documents are reviewed for medical necessity based upon presenting condition irrespective of the diagnosis.

E&Ls With Potential EIU Considerations:

Sentara's current plan language does not distinguish between those non-covered services that are "administrative" as compared to those non-covered services with clinical components, which may implicate EIU or questions as to clinical utility. As discussed in the Medical Necessity NQTL

Submission, for individual and small group plans, Sentara compiles its E&Ls from the EHB Benchmark Plan and federal and state law mandates and regulations. For large group plans, identical considerations apply with the exception of the EHB Benchmark Plan. No benefit exclusion identified as an E&L in the plan documents is identified based upon a determination that the exclusion is a blanket EIU. Rather, Sentara's E&Ls take into account whether the service has a clinical component. For example, work hardening programs are on Sentara's E&L list because such programs are occupational services and, by their nature, are not clinical services. Specifically, work hardening programs offer therapeutic services aimed at allowing an individual to regain the functions needed for a specific job. While Sentara does not specifically cover work hardening programs, Sentara does cover physical therapy and occupational therapy to allow members to regain physical function. Physical therapy and occupational therapy are clinical services aimed at improving member's health, as opposed to work hardening programs which are non-clinical and are aimed only at specific job-related functions.

As a matter of practice, E&Ls with clinical components are not treated as blanket exclusions and are reviewed for medical necessity. In application, services identified as E&Ls with clinical components such as cosmetic services, wilderness/nature therapy, equine therapy, and massage therapy are reviewed for medical necessity upon a request for authorization regardless of whether the service is M/S or MH/SUD. Specifically, when a request for authorization is received with any service or procedure code that does not comport with an internal medical policy or Milliman Care Guidelines, the utilization review nurse will forward the request to the Medical Policy Committee for review. The Medical Policy Committee will conduct a thorough review of peer reviewed literature. The completed review will be sent to the Medical Director for final review and determination. Medical Directors will utilize their professional judgment and individual considerations to select resources relating to the clinical circumstances of the member from the list below or as otherwise identified by the reviewer. In the absence of relevant peer reviewed literature, minimal available resources, and/or none of the identified entities have published guidelines or recommendations, the information will be considered by the Medical Director in the context of the member's benefit plan and apparent lack of peer reviewed evidence related to the coverage for the requested service. After review, the Medical Director will document his or her determination and the references used and the result is sent to the utilization review nurse for processing.

The Medical Policy Committee has historically reviewed certain services, such as nature/wilderness therapy in its review of "new" technology. By way of example, the Medical Policy Committee specifically reviewed Wilderness Therapy in February 2023. At that time, the Medical Policy Committee generally deemed Wilderness Therapy to lack clinical utility but indicated that requests should be reviewed for medical necessity. Since then, Milliman Care Guidelines ("MCG") has adopted clinical guidelines for Wilderness Therapy, which Sentara has adopted in lieu of using internally-developed criteria.

There are no HCPCS/CPT codes for identified E&Ls that are "always excluded" as EIU. Those E&Ls with recognized HCPCS codes are reviewed, as a matter of practice, for medical necessity

irrespective of diagnosis.

With respect to services that are always EIU, services that are EIU for certain conditions, and services that are potentially EIU: Sentara does not deny requests for authorization based on EIU. Restated, requests for authorization will be reviewed for medical necessity. If the service requested is determined to be not medically necessary because it lacks clinical utility when considered with an individual's clinical records, the service may be denied on that basis as not meeting medical necessity. There are no CPT/HCPCS codes that are identified as EIU.

To use the example above, a request for authorization for wilderness/nature therapy will not be denied as EIU. Rather, any such request will be reviewed for medical necessity in conjunction with clinical records to determine whether medical necessity is met, a component of which is whether there is clinical utility in the service requested. *See* Definition of Medical Necessity, which includes that the service must be in accordance with recognized standards of care for the Member's condition, disease, ailment, or injury; and appropriate with regard to standards of good medical practice.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See **45 CFR 146.137(c)(2).** Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:
  (A) A detailed description of the factor;
  (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
  (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also **FAQ 45** guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining

which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Standards Identified for Determining Whether a Service Could Constitute EIU:
Sentara does not apply EIU as a NQTL and does not deny requested services on the basis of EIU. The Plan documents define:

A drug, device, medical treatment, or procedure may be considered Experimental or Investigational if:

1. The majority of the medical community does not support the use of this drug, device, medical treatment, or procedure; or
2. The use of this drug, device, medical treatment, or procedure may have been shown to be unsafe and/or of no or questionable use as reported by current scientific literature and/or regulatory agencies; or
3. The research regarding this drug, device, medical treatment, or procedure may be so limited that an evaluation of safety and efficacy cannot be made; or
4. The drug or device is not approved for marketing by the Food and Drug Administration (FDA); or
5. The drug, device, or medical treatment is approved as Category B Non-Experimental/Investigational by the FDA.
6. The drug, device, medical treatment, or procedure is:
    a. Currently under study in a Phase I or II Clinical Trial; or
    b. An Experimental study/Investigational arm of a Phase III clinical study; or
    c. Otherwise under study to determine safety and efficacy/compare its safety and efficacy to current standards of care.

Standards include Hayes New Technology Summaries, national and regional carriers' guidelines, CMS guidelines, and guidance from governing medical bodies for respective services at issue. As explained above, as it relates to inpatient or outpatient services, Sentara does not deny or limit services based upon EIU. Rather, any request for authorization is reviewed for medical necessity based upon the applicable clinical criteria and the individual's clinical records. To the extent no

clinical criteria exists, the request is treated as a "new technology" request, as described herein.

The last three factors— "FDA requirements"—apply predominately to prescription drugs. To the extent the last three "FDA requirements" factors apply to coverage under medical policies, such treatments or devices are not excluded or otherwise denied for EIU and would be subject to a medical necessity review.

Sentara does not rely on a "Hierarchy of Evidence" as it relates to any EIU considerations. Sentara has implemented a policy outlining a determinations hierarchy for commercial utilization management decisions which is used for reviewing and processing requests for authorization. Specifically, the following hierarchy is used: Federal Regulations; State Regulations; Sentara Medical Policies; MCG CareWeb ("MCG"); and review of association guidelines, specialty and subspeciality associations, and peer reviewed literature.

Step 3: Description of how factors are used in the design and application of the NQTL.

See **45 CFR 146.137(c)(3).** Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources

from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Factor	Evidentiary Standard
The majority of the medical community does not support the use of this drug, device, medical treatment, or procedure	The Medical Policy Committee stays attuned to the policies and opinions of the medical community, specifically the governing medical bodies for the specific services at issue.
The use of this drug, device, medical treatment, or procedure may have been shown to be unsafe and/or of no or questionable use as reported by current scientific literature and/or regulatory agencies	The Medical Policy Committee monitors and reviews current scientific literature and considers current CMS guidelines and policies of other regional and national carriers.

The research regarding this drug, device, medical treatment, or procedure may be so limited that an evaluation of safety and efficacy cannot be made	The Medical Policy Committee monitors and reviews research and scientific literature and considers current policies of CMS and other regional and national carriers.
The drug or device is not approved for marketing by the Food and Drug Administration (FDA	Federal law requires that all drugs be shown to be safe and effective for their intended use prior to marketing. FDA approval is required by law
The drug, device, or medical treatment is approved as Category B Non-Experimental/Investigational by the FDA	CMS posts information regarding Investigational Device Exemption Studies ("IDEs") including the Study title, Sponsor name, NCT number, IDE number, and CMS approval date
The drug, device, medical treatment, or procedure is: • Currently under study in a Phase I or II Clinical Trial; or • An Experimental study/Investigational arm of a Phase III clinical study; or • Otherwise under study to determine safety and efficacy/compare its safety and efficacy to current standards of care.	Phase 1 clinical trials occur after research is approved by the FDA. Phase 1 tests whether the treatment is safe using a small sample of people. Phase 2 clinical trials tests whether the treatment works using a large group of people. Phase 3 clinical trials test whether the treatment is better than what is available. Following the clinical trials, a New Drug Application is filed with the FDA

Sentara does not deny or limit any inpatient or outpatient service, whether M/S or MH/SUD, on the basis of EIU or apply of the definition of EIU above including any determination as to the "majority of the medical community." The Medical Policy Committee stays attuned to the opinions of the medical community when making medical necessity determinations. In evaluating medical necessity determinations for inpatient or outpatient services, Sentara will consider whether services are in accordance with generally accepted standards of medical practice, federal and state regulations, criteria contained within MCG, and peer reviewed scientific literature. Additionally, when making these determinations, Sentara may also take into consideration recommendations from physician specialty societies (society whose representatives are certified by a board recognized by the American Board of Medical Specialties), input from physicians practicing in related clinical fields, and other relevant factors such as a member's clinical presentation. Examples of regulatory bodies or specialty associations include Centers for Medicare and Medicaid Services (CMS) and American Academy of Family Practice (AAFP).

Similarly, while Sentara does not deny or limit any inpatient or outpatient service, whether M/S or MH/SUD, on the basis of EIU or in the application of the definition of EIU above, the Medical Policy Committee does monitor and review scientific literature. The Medical Policy Committee performs a thorough review of the literature utilizing several resources including but not limited to PubMed literature search engines, published medical/clinical literature review, American Medical Association/Food and Drug Administration evaluations, independent third party

evaluations (Hayes, MCG, UpToDate), National and Local Coverage Determinations (NCD/LCD), material from regulatory agencies as updated, and annual review of Department of Medical Assistance Services (DMAS) manuals. Specifically, CMS guidelines are reviewed to determine industry coverage and interpretation variances for specific services.

When a specific service is under review, a worksheet and summary of all materials relevant to the subject service is reviewed and approved by the Medical Policy Medical Directors and presented for determination at MPC. Upon approval it is reviewed and approved by the Physician Led Committee (PLC) which includes community providers. Sentara does review other carriers' policies not exclusively, but as another source, when reviewing a specific service to gather as much information in the industry as possible.

With respect to EIU as it relates to pharmacy benefits:

- Sentara has an off-label drug/device use medical policy which applies to medical necessity for off-label use of a drug or device.

- For inpatient or outpatient services or treatments where the FDA is silent, Sentara will not consider any treatment EIU and thereby automatically excluded. Rather, any such treatment or service will be reviewed for medical necessity.

- For inpatient or outpatient services or treatment that are identified on any FDA list or are included in any trial, and to which no known medical policy or criteria exists, a "new technology" request will be initiated. Any request for "new technology" is clinically reviewed. The Medical Policy Committee performs a thorough review of the literature utilizing several resources including but not limited to PubMed literature search engines, published medical/clinical literature review, American Medical Association/Food and Drug Administration evaluations, Independent third party evaluations (Hayes, MCG, UpToDate), National and Local Coverage Determinations (NCD/LCD), material from regulatory agencies as updated, and annual review of Department of Medical Assistance Services (DMAS) manuals. A worksheet and summary of all materials relevant to the "new technology" is reviewed and approved by the Medical Policy Medical Directors and presented for determination at Medical Policy Committee.

- "Otherwise under study" means drug or device is in any phase of clinical trial.

To the extent an "and/or" with safety/effectiveness as requested by the BOI exists in regard to a EIU determination, Sentara will supplement this analysis with it response.

"New technology" requests and the creation/implementation of internal medical policies adopted by Sentara are derived from a number of sources, including: American Society of Addiction Medicine ("ASAM"), Milliman Care Guidelines (MCG), Local Coverage Determinations (LCD), National Coverage Determinations (NCD), UpToDate, Hayes Technology Assessment, FDA review, and AMA guidelines, federal and state regulations, DMAS and CMS manuals. When medical policies are adopted, they include the sources referenced. Specifically:

- ASAM: *See* https://www.asam.org/asam-criteria/about-the-asam-criteria#:~:text=The%20ASAM%20Criteria%20is%20the%20most%20widely%20used,transfer%20of%20patients%20with%20addiction%20and%20co-occurring% The ASAM Criteria includes the most widely used and comprehensive set of standards defining appropriate and medically necessary treatment for patients with addictions and co-occurring disorders.

- MCG: *See* Evidence-Based Care Guidance and Solutions | MCG Health. MCG consist of comprehensive clinical criteria that defines when a requested service is appropriate and medically necessary. The MCG constantly evolve and are updated annually. Specifically, Sentara uses MCG because MCG, including annual updates thereto, are based on the latest scientific evidence, including but not limited to peer-reviewed papers, meaning that clinicians are reviewing one another's work. MCG further takes into consideration guidance from medical societies, like the American Medical Association or other specialty groups. Sentara uses MCG to support effective and safe evidence-based patient care.

- LCDs/NCDs: Local and National Coverage Determinations represent an evidence-based process to determine coverage for services covered by Medicare. Sentara utilizes LCDs and NCDs as a resource in reviewing "new technology" in services and treatment and in developing medical policies for commercial plans. LCDs serve as a resource when no NCD exists.

- UpToDate is a private company within the Wolters Kluwer conglomerate that compiles evidence based clinical guidelines and solutions. Sentara utilizes UpToDate as a resource and reference in reviewing "new technology" and in the development of its medical policies. When Sentara consults UpToDate in the development of a medical policy, a reference will be included in that specific clinical policy.

- Hayes Technology is associated with Symplr, a company that offers healthcare operational solutions. Hayes Technology compiles and analyzes new and emerging clinical practices. Sentara utilizes Hayes Technology as a resource and reference in reviewing "new technology" and in the development of its medical policies. When Sentara consults Hayes Technology in the development of a medical policy, a reference will be included in that specific clinical policy.

- DMAS and CMS manuals: Sentara uses DMAS and CMS manuals for the same reasons it consults with NCDs and LCDs in developing commercial clinical policies.

The Medical Policy is comprised of 28 individuals with varying clinical or other specialties. Of the members of the Medical Policy Committee, 9 are considered MH/SUD experts and 13 are considered M/S experts in various specialties.

Voting members for recommendations of coverage decisions consist of the following: Health Plan Medical Directors, including the Behavioral Health Medical Directors, the Chief Medical Officer, VPs CCS (or proxy), Director of Pharmacy (or proxy) (for pharmaceutical items).

Step 4: Demonstration of comparability and stringency as written.

See 45 CFR 146.137(c)(4). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S

benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

As explained above, Sentara does not deny or limit inpatient or outpatient services (whether M/S or MH/SUD) based upon EIU under the definition in the plan or any definition of EIU. Rather, any request for authorization is reviewed for medical necessity based upon the applicable clinical criteria and the individual's clinical records. To the extent no clinical criteria exists, the request is treated as a "new technology" request.

"New technology" requests from 2019-2024 reveal 16 instances of review for MH services, 12 of which applied to Medicaid policies only. MPC reviews all Sentara medical policies annually and ad hoc when a need for change has been identified through legal mandate or otherwise. "New technology" review is conducted upon an authorization when no policy exists.

Comparison of EIU Standards and Policy Terms

The Plan definition of Experimental or Investigational is typical in the industry and comports to the standards utilized by Hayes and other carriers. Hayes research is trusted in the industry as unbiased and independent. Sentara does not deny or limit inpatient or outpatient services (whether M/S or MH/SUD) based upon EIU under the definition in the plan or any definition of EIU. Rather, any request for authorization is reviewed for medical necessity based upon the applicable clinical criteria and the individual's clinical records. To the extent no clinical criteria exists, the request is treated as a "new technology" request reviewed by the Medical Policy Committee.

The Medical Policy Committee is comprised of Medical Director and Specialists, including specialists in MH/SUD.

Comparison of Other Existing Written Documents

As explained in detail above, Sentara does not deny or limit inpatient or outpatient services (whether M/S or MH/SUD) based upon EIU under the definition in the Plan or any definition of EIU. To the extent a service (either M/S or MH/SUD) is clinical, rather than administrative, in nature and no clinical policy exists for such service, the Medical Policy Committee performs a "new technology" review using the factors described in detail above. All utilization management policies and new technology policies are designed and apply equally to M/S and MH/SUD services.

How Factors Are Comparably Applied

The definition of EIU set forth in the Plan and identified factors are not distinguished between M/S or MH/SUD services.

Reasons for Any Deviations or Variations

Sentara does not apply EIU as a NQTL. There are no differences in the design or application of EIU between MH/SUD benefits and M/S benefits.

Hierarchy of Evidence

As explained in detail above, Sentara does not deny or limit inpatient or outpatient services (whether M/S or MH/SUD) based upon EIU under the definition in the Plan or any definition of EIU. To the extent a service (either M/S or MH/SUD) is clinical, rather than administrative, in nature and no clinical policy exists for such service, the Medical Policy Committee performs a "new technology" review using the factors described in detail above. All utilization management policies and new technology policies are designed and apply equally to M/S and MH/SUD services.

The Medical Policy Committee does not follow a stringent hierarchy of sources/factors for determinations of what services are identified as E&Ls, which are derived from the EHB Benchmark Plan and federal and state law mandates. For certain services, the AMA and specific governing boards are more active and/or more literature is available. The Medical Policy Committee does heavily weigh Hayes research and positions taken by CMS, along with internal review of medical literature and research.

The Medical Policy Committee does not differ in the processes followed for EIU consideration of M/S procedures or treatment, as opposed to MH/SUD procedures or treatment, as Sentara does not deny or limit any inpatient or outpatient services based on EIU. The Committee itself is comprised of MH/SUD specialists and the extensive sources utilized apply to both M/S and MH/SUD services.

Sentara has implemented a policy outlining a determinations hierarchy for commercial utilization management decisions which is used for reviewing and processing requests for authorization. Only when there is a request for authorization for an individual member will treatment records be reviewed.

As it relates to "new technology" requests or the development of medical policies, clinicians conducting the research consult the following resources in no material order or hierarchy: PubMed literature search engine findings; published medical/clinical literature review; AMA/FDA and other 3rd party evaluations; independent 3rd party evaluations including those from Hayes, MCG, and UpToDate; NCDs, LCDs, and other local and national carrier determinations; material from other regulatory agencies as updated; annual review and approval of medial policies of delegated vendors; annual review of DMAS manuals and CMS manuals that are used for medical necessity determinations. Research is presented to the Medical Policy Committee.

Appeal Rights

In the context of the internal appeal process, any denial or reduction of benefits and/or nonpayment is treated as an Adverse Benefit Determination and subject to the appeal process outlined in the plans. Written notice of Adverse Benefit Determinations is required except for Urgent Claims, where notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notice of an Adverse Benefit Determination includes the following:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.
- An explanation of any applicable external appeal rights

Any member is entitled to receive, upon request and free of charge, reasonable access to, and

copies of, all documents, records, and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination. For denials due to Medical Necessity members are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances.

After notification of an Adverse Benefit Determination, a member has 180 days to request an appeal. Upon appeal, all comments, documents, records, and other information submitted is reviewed. Additional information may be provided. The clinical peer reviewer reviewing the appeal will not have participated in the original coverage decision. Should a member disagree with the Final Benefit Determination, an external appeal is available.

Blanket Exclusions

There are no blanket exclusions related exclusively to EIU. Specific references to EIU are made in the description of Chiropractic and Transplant services, as these service types are generally considered in the industry to raise EIU questions as to efficacy and safety concerns.

Adverse determinations as a result of medical necessity denials or benefit exclusions are eligible for appeal in accordance with same process described above. Members that have services that are denied based on a judgment as to the medical necessity, appropriateness, health care setting, level of care, or effectiveness of the health care service or treatment may request an external review.

Step 5: Demonstration of comparability and stringency in operation.

See **45 CFR 146.137(c)(5).** The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to

detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.

- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Discussion and Comparison of Data

2024 authorization and denial data revealed that no denials of authorization occurred in 2024 for MH/SUD services. Similarly, no denials occurred in 2023 and 2024 for EIU for MH/SUD or M/S. In 2023, 19 internal appeals and 26 external appeals occurred for medical/surgical benefits. Of the 19, 11 denials were overturned on internal appeal and of the 26, 8 denials were overturned on external appeal. For mental health services, 2 internal appeals occurred and 1 denial was overturned. There were no external appeals for mental health services in 2023. There were no substance use appeals internal or external appeals in 2023.

Sentara is conducting a review of data for 2025 (and 2026 to the extent it is available) in accordance with the guidelines provided by the Bureau of Insurance ("BOI") and will supplement this analysis once such data is finalized.

Step 6: Findings and conclusions.

See **45 CFR 146.137(c)(6).** The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

(6) See also the **FAQ 45** guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Findings and Conclusions

Sentara identified the definition of Experimental/Investigation/Unproven ("EIU") as set forth in the Plan, and identified the Medical Policy Committee as the body that oversees development and review of all medical policies, clinical guidelines, and determinations. No EIU specific exclusions are identified in Sentara's commercial plan documents, however, Sentara identified all E&Ls under the plans that have EIU implications. Sentara reviewed those exclusions to conclude that no disparity exists between M/S and MH/SUD services. Sentara reviewed all "factors" i.e. information that determines how E&Ls apply to benefits, sources utilized for EIU considerations, and evidentiary standards supporting use of those sources. Sources include Hayes New Technology Summaries, national and regional carriers' guidelines, CMS guidelines, and guidance from governing medical bodies for respective services at issue.

2024 authorization and denial data revealed that no denials of authorization occurred for MH/SUD services.

Sentara performed an intensive analysis of the definition of EIU as stated in commercial plan documents, as compared to the application of the EIU definition as a NQTL in operation. Sentara

acknowledges that the factors within the EIU definition are both subjective and allow for discretion in application, particularly in terms such as "majority of the medical community" and "current scientific literature and/or regulatory agencies." As written, the definition of EIU in the commercial plan documents does not vary as written between MH/SUD benefits and M/S benefits.

In operation, as it relates to inpatient and outpatient services, Sentara does not deny or limit services based upon EIU. Rather, Sentara reviews any request for authorization for medical necessity based upon the applicable clinical criteria and the individual's clinical records. Sentara's medical necessity review applies to both M/S and MH/SUD services. If clinical criteria exist for the service requested, Sentara applies the appropriate clinical criteria in conjunction with a review of the member's clinical documentation. This can include a peer-to-peer review. If no clinical criteria exist, Sentara reviews the service or treatment as a "new technology" to determine if that service meets medical necessity for treatment of the member. There are no blanket exclusions or denials based upon a determination that an inpatient or outpatient service is considered EIU.

Sentara appreciates that it must demonstrate a no more stringent application for MH/SUD services, as compared to M/S services. To accomplish this, Sentara has provided data for appeals of denials of M/S services as compared to denials of MH/SUD services for 2023 (2024 data was supplied with initial response). The data confirms that MH/SUD services are not being denied at a disproportionate rate, thereby satisfying compliance with MHPAEA. Sentara will supplement this analysis with data for 2025 (and 2026 to the extent possible) when it is finalized.

This analysis was completed in September 2026 by the following Sentara Departments: Utilization Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

PRIOR AUTHORIZATION: INPATIENT, IN-NETWORK

(No Prior Authorization is Required for Office Visits)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See **45 CFR 146.137(c)(1).** Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also **FAQ 45** (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

Clinical Review: Sentara defines the clinical review form of prior authorization as a medical necessity review that takes place prior to a service being performed. This is the only form of

preauthorization[1] Sentara uses. Thus, the remainder of this analysis will focus solely on the clinical review form of preauthorization.

There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Notification: Some carriers require notification from the provider to the carrier, and clinical review is not performed for coverage approval. Sentara does not use this form of preauthorization.

Non-Clinical Review: Some carriers require requests for coverage that are reviewed and approved by non-clinical personnel according to predetermined criteria, which is also referred to by multiple carriers as "fast certification." Sentara does not use this form of preauthorization.

Additionally, there is no prior authorization/medical necessity review for office visits by any staff, clinical or non-clinical. This includes any office visit, whether M/S or MH/SUD. Preauthorization is required, however, for surgical procedures when surgeries are performed in-office.

Vendor Involvement

A third-party vendor ("UM Vendor 1") conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate third-party vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a services agreement. UM Vendor 2 is URAC and NCQA accredited. Under the services agreement provides, UM Vendor 2 providers access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a services agreement.

[1] Preauthorization and prior authorization are used interchangeably throughout.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Specific Medical/Surgical Benefits to Which NQTL Applies

Pre-authorization is required for all inpatient services , both M/S and MH/SUD.

Specific MH/SUD Benefits to Which Prior Authorization Applies

Pre-authorization is required for all inpatient services , both M/S and MH/SUD.

There are a number of ways Sentara identifies which services are subject to prior authorization for clinical review. Specifically:

Plan Documents:

The HMO and PPO plan documents state the following:
"Some Covered Services under this Plan require Pre-Authorization to be Covered. Please read the entire section on Pre-Authorization in the EOC."

Defines Pre-Authorization as "an evaluation process which assesses the medical necessity of proposed treatment and checks to see that the treatment is being provided at the appropriate level of care."

Describes preauthorization and states: "On Your Schedule of Benefits, We tell You what services require pre-authorization before You receive them. You can also look in the What is Covered Section of this document or call Member Services to find out about Pre-Authorization."

Describes generally the types of services which require preauthorization, including: Inpatient hospitalization services; Partial hospitalization services; Residential treatment services; Non-emergency ambulance transport; Inpatient and outpatient surgery; Surgery in a physician's office; Single items of durable medical equipment and orthopedic and prosthetic appliances over [$750]; Rental of durable medical equipment and orthopedic and prosthetic appliances; Repair and replacement items of durable medical equipment and orthopedic and prosthetic appliances; Artificial prosthetic limbs; Prenatal maternity services (excluding recommended preventive care services, screenings, and one breast pump per pregnancy); Home health care; Skilled Nursing Facility care; Physical, occupational, and speech therapy; Cardiac, pulmonary, and vascular rehabilitation; IV therapy with medications; Inhalation therapy; Early intervention services; Clinical trials for treatment studies on cancer; Hospice services; Oral surgery; TMJ services; Tubal ligation; Hospitalization and anesthesia for dental procedures; Treatment of lymphedema; Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiography (MRA); Positron Emission Tomography (PET) scans; Computerized Axial Tomography (CT) scans; Computerized Axial Tomography Angiogram (CTA) scans; Sleep studies; transplant services; Injectable and infused medications, biologics, and IV therapy medications defined by Our Pharmacy Committee; Intensive outpatient programs (IOP); Medical, psychological and neuro psychological diagnostic procedures

and testing; Electro-convulsive therapy (ECT); Telemedicine service; Transcranial Magnetic Stimulation (TMS); Insulin pumps and insulin pump infusion sets and supplies; Chemotherapy and Chemotherapy Drugs; Radiation Therapy; Dialysis Services; Genetic Testing and Counseling. If Your plan includes any riders generally those services will require Pre-Authorization listed in the rider.

Define Covered Services and designate those which require prior authorization. These Services and others are then further defined.

Schedule of Benefits

States "Some benefits require Pre-Authorization before You receive them. These services ae marked with an * in this document."

The Schedules of Benefits designate the following service types as requiring preauthorization: outpatient therapies and services; outpatient dialysis; outpatient surgery; outpatient lab, diagnostic, imaging, and testing; outpatient advanced imaging, testing and scans; injectable and infused medications; maternity care; inpatient M/S services including inpatient hospital services, transplants, skilled nursing facility services; non-emergency transport; inpatient MH/SUD services including hospital services, residential treatment services, partial hospitalization, intensive outpatient program services, transcranial magnetic stimulation, electro-convulsive therapy, autism spectrum disorder, other outpatient services; diabetes treatment including insulin pumps, pump infusion sets and supplies, talking blood glucose meters, insulin, and needles and syringes for injection; prosthetic devices and components, repair, fitting, replacement and adjustment; durable medical equipment for items over $750, repair, replacement, and rental items; wigs following cancer treatment; early invention services including speech and language therapy, occupational therapy, physical therapy, assistance technology services and devices; home health care; private duty nursing; hospice care; reconstructive breast surgery for members who have had a mastectomy; infertility services including endometrial biopsies, semen analysis, hysterosalpingography, Sims-Huhner test, diagnostic laparoscopy; clinical trial services; allergy testing and serum; telemedicine services[2]; chiropractic services; hearing aids and related services for children 18 and younger

Provider Manual

The Provider Manual states:

"Except in the case of emergency treatment, prior authorization will be required for: all inpatient hospitalizations, all partial hospitalizations (mental health or substance abuse), all outpatient surgeries/short stays/observations and IV therapy and drug infusions, all skilled nursing facility admissions, all acute rehabilitation, all intensive outpatient programs, all out-of-area services or referrals to nonparticipating providers (prior to scheduling) for members that do not have out-of-network benefits included in their plan. All the following services require prior authorization regardless of the place of service: Commercial plan DME single purchased items greater than

[2] Please note that the Schedule of Benefits language will be revised, as prior authorization is not required for telemedicine services.

$750 and all rentals, orthotics/prosthetics, single purchased items greater than $750 and all rentals, repair, replacement, and duplicates, home health, hospice, IV infusions, plastic surgery, all rehabilitation programs (cardiac, vascular, vestibular, pulmonary, etc.), therapies (PT, OT, ST), applied behavioral analysis, early intervention services (part H certificate required), OB global notification, transplant services, human and synthetic tissue, oral surgery and related services, advanced imaging studies (PET, CT, CTA, MRI, MRA, MR-CT), sleep studies, hyperbaric therapy, electronic bone stimulator, any surgical or diagnostic procedure for which anesthesiology or conscious sedation is billed, injectable drugs indicated on the online prior-authorization forms, genetic testing (if covered by group/plan), bone densitometry if less than 24 months since last study."

Prior Authorization List: (accessible at http://pal.sentarahealthplans.com/)

Tool allows anyone to access and search for procedure code or description to determination whether prior authorization is required.

Procedure and Revenue Codes:

As previously stated, all inpatient services require prior authorization.

Certain services such as PT, OT, and ST, can be used for both MH/SUD and M/S conditions. Specific to these therapies, Sentara ensures MHPAEA compliance through benefit structure. Currently, no numerical visit limitations are placed on PT, OT, and ST for MH/SUD, unlike the annual visit limits for M/S. For other services such as non-emergency transport, Sentara does not preauthorize services strictly by diagnosis. If a medical necessity review is required for the service, it will include all pertinent clinical information required to make a determination based on the appropriate necessity criteria used whether that be internal medical policies or MCG (which incorporate ASAM). For example, Sentara tracks transportation authorizations but does not track whether authorization for non-emergency transportation was reviewed for an underlying M/S or MH/SUD condition.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See 45 CFR 146.137(c)(2). Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:
(A) A detailed description of the factor;

(B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and

(C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Sentara uses the following factors to determine the basis for requiring prior authorization for certain services:

- Industry standards in conformance with Centers for Medicare & Medicaid Services (CMS), Department of Medical Assistance Services (DMAS), Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and Milliman Care Guidelines (which incorporate American Society for Addiction Medicine (ASAM) Criteria)

- Excessive (high volume) variability in utilization. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization.

- High-Cost/High variability in cost. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards

and practices for identifying which services are subject to prior authorization.

Weight of Factors

Industry standards in conformance with an internal utilization management determinations hierarchy determine which services are subject to prior authorization. Specifically, Sentara has implemented a policy outlining a determinations hierarchy for commercial utilization management decisions which is used for reviewing and processing requests for authorization. Specifically, the following hierarchy is used: Federal Regulations; State Regulations; Sentara Medical Policies; MCG CareWeb ("MCG"); and review of association guidelines, specialty and subspeciality associations, and peer reviewed literature.

Sentara follows first the industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine which services are subject to prior authorization. As described in detail in the response to the Medical Necessity NQTL, Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed. The development of MCG or internal policies renders a service subject to prior authorization. There is little to no variation in the industry as to the services which require prior authorization. As described below in Step 3, Sentara does analyze and trend utilization review data and make determinations based upon that data. In operation, these trends impact M/S services more directly than MH/SUD because utilization of M/S outpatient services is greater, and more M/S outpatient services require prior authorization. Sentara utilizes this trending and benchmarking data but does not have any policy that defines when that data requires a change to prior authorization status.

Step 3: Description of how factors are used in the design and application of the NQTL.

See **45 CFR 146.137(c)(3).** Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

- Industry standards in conformance with CMS, DMAS, LCDs, NCDs, and Milliman Care Guidelines (which incorporate ASAM): Sentara follows first industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine

which services are subject to prior authorization. Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed (see Sentara's Medical Necessity NQTL Analysis). The development of MCG or internal policies renders a service subject to prior authorization. There is little to no variation in the industry as to the services which require prior authorization.

- Excessive (high volume)/variability in utilization: excessive utilization is measured by a number of metrics including authorization volume; denial volume, denial rates; days or admissions/100; average length of stay; observation days/1000, outpatient surgeries/1000, outpatient visits/1000. Trend analysis is considered, which includes: annualized cases/1,000; % change in annualized cases/1,000; annualized units/1,000; % change in annualized units; and Cost/Case for prior period and current period. Examples of these metrics are found in Commercial and Exchange Utilization Management Annual Evaluations and Trend Analysis Reports. Sentara also tracks utilization by authorization volume by CPT Code. Sentara is not aware of utilization rates as a factor for determining whether MH/SUD services require prior authorization. While utilization is tracked and trend analysis exists, utilization has not factored into any known decision to require prior authorization for any MH/SUD services.

- High-cost/High variability in cost: Sentara tracks allowed Per Member/Per Month ("PMPM") Data for outpatient categories of service. These PMPM are then benchmarked for comparison. Sentara is not aware of high cost or variability in cost as a factor for determining whether MH/SUD services require prior authorization. While utilization benchmarking exists, cost variability or high cost has not factored into any known decision to require prior authorization for any MH/SUD services.

Factors like utilization and cost, while tracked, trended and reviewed as compared to benchmarks, in operation, are not factors for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization.

The Prior Authorization List, available on Sentara's website, identifies all services subject to prior authorization. These services are subject to clinical review, and notification and non-clinical review are not implicated. These services identified on the PAL are not categorized by classification or subclassification. As noted, all inpatient services require preauthorization. The factors related to the services identified in the PAL are identified above.

Medical Policy Committee

The Medical Policy Committee makes determinations concerning which services are subject to preauthorization. The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties.

One objective of the MPC is to recommend, review, and approve authorization requirements for Health Plan services through collaboration with the Integrated Benefits Management Team ("IBMT") to ensure codes are configured in compliance with federal and state regulations and medical policies. The IBMT is a multi-department team that ensures decisions rendered by the MPC can be implemented operationally with any changes in configuration and coding. The UM Program Plan is reviewed and revised as necessary, but at least annually. The UM Program evaluation is conducted by the Clinical Care Services Vice-President, the UM Director, and the Commercial Lead Medical Director. The UM Program review is completed within 120 days of the fiscal year end (March 30). The workplan is presented and approved by the SHP Quality Improvement Committee. All changes to the UM Program are finalized by the MPC.

The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties. Specifically, voting members for recommendations of coverage decisions consist of the following: Health Plan Medical Directors, including the Behavioral Health Medical Directors, the Chief Medical Officer, VPs CCS (or proxy), and Director of Pharmacy (or designee) (for pharmaceutical items).

VPs CCS means the Vice President(s) of Clinical Care Services or his or her proxy for voting purposes on the MPC. VP Pharmacy means the Vice President of Pharmacy or his or her designee for pharmaceutical items.

The Medical Policy is comprised of 28 individuals with varying clinical or other specialties. Of the members of the Medical Policy Committee, 9 are considered MH/SUD experts and 13 are considered M/S experts in various specialties.

Step 4: Demonstration of comparability and stringency as written.

See **45 CFR 146.137(c)(4).** The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold

identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent

to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Regarding the factors, definitions, evidentiary standards, sources, and strategies described in Step Two and Step Three, Sentara provides the following information:

Documentation of Each Factor Identified and Defined in Step Two:

The following factors are implicated in determining whether Prior Authorization applies to certain services:

Service	Factors
All outpatient, M/S services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, M/S services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, MH/SUD services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria
All outpatient, MH/SUD services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria

Comparison of Existing Written Documents:

All plan terms and Sentara policies regarding utilization management, including prior authorization, are equally designed and applied to M/S and MH/SUD services with no variations.

The Authorization Process is defined in the Provider Manual and Sentara prior authorization policies. As it pertains to prior authorization, the MPC requires prior authorization for any service for which clinical criteria is established by MCG (inclusive of ASAM) and/or any internal clinical policy.

There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

How Factors Are Comparably Applied:

Sentara applies applicable industry standards (MCG for M/S and ASAM for MH/SUD) equally to all services in the respective classifications. Industry standards are applied without discretion, regardless of whether the particular service is M/S or MH/SUD. For services (either M/S or MH/SUD) for which there is no applicable industry standard, the Sentara MPC evaluates and reviews the requested service.

Reasons for Any Deviations or Variations:

There are no variations or deviations in the design or application of prior authorization between M/S and MH/SUD benefits.

Clinical Review Processes:

Members are notified of preauthorization requirements in the plan documents.

The Provider Manual notifies providers that prior authorization requests can be submitted through the Provider Portal or via facsimile. Prior authorization for urgent requests may be submitted by phone. Sentara follows federal and state regulations, including 45 CFR § 147.136, 29 CFR § 2560.503-1, § 38.2-305, § 38.2-3570, § 38.2-5803, 14VAC5-216-30, as well as the National Committee for Quality Assurance Guidelines for Timeliness of UM decisions. Requests for elective admissions must be submitted for prior authorization 14 days prior to scheduling an admission or procedure. Treatment by nonparticipating providers must receive prior authorization from Sentara in the same time frame as above. The requesting provider should receive an authorization for services within 14 days if all the necessary clinical information is provided with the initial authorization request and the service is covered under the member's benefit plan. Lack of clinical information to support authorization approval will delay processing. Urgent cases will be completed within 72 hours.

The utilization review process is initiated upon a request for prior authorization. The request for prior authorization is first reviewed by a clinician that could be a registered nurse, licensed practical nurse, clinical pharmacist, clinical psychologist, or Board certified Medical and Behavioral Health Physicians (Medical Directors). If a request for prior authorization results in any determination except an authorization for the service requested, the request for authorization is then reviewed by a Medical Director, who is a Board-certified physician. Only Medical Directors issue adverse benefit determinations. If that adverse benefit determination ultimately is appealed, the appeal review will be conducted by a Medical Director with a specialization in that area that did not participate in the adverse benefit determination.

There is a level of review between nurse review and peer-to-peer review where a physician reviews the submission without initiating a phone call with the treating provider. If the initial clinician review (which includes "Registered Nurses, Licensed Practical Nurses, Clinical Pharmacists, Clinical Psychologists, and Board certified Medical and Behavioral Health Physicians (Medical Directors)) in response to a request for prior authorization results in any determination except an authorization for the service requested, the request for authorization is then reviewed by a Medical Director. Nurses cannot render medical necessity denials or negotiate lower levels of care than what was requested by the treating provider. Only Medical Directors issue adverse benefit determinations. Individual consideration may be given when a plan provider initiates a referral for a covered service or to a provider outside of the network. If the Medical Director issues an adverse benefit determination, the provider has the option of requesting a peer review. Only medical directors can render medical necessity denials for both M/S an MH/SUD benefits. Medical Directors, both medical and behavioral health, are senior-level physicians or doctoral-level behavioral health practitioners who implement, provide supervision and oversight, and evaluate the UM program through their participation in authorization reviews, UM Committees, special UM projects, medical policy reviews, and the UM Program evaluation. Behavioral health physicians or doctoral-level behavioral healthcare practitioners additionally provide oversight and evaluation of the behavioral aspects of the UM program.

For commercial lines of business, when no internal medical policies exist for any MH or M/S service, MCG is utilized without incorporation or supplementation of any internal guidelines or policies. The MCG incorporate the ASAM criteria, which Sentara utilizes exclusively for substance use disorder services. Sentara does not deny a request for authorization simply because there are no established clinical criteria for the requested service. Any delegation of a request for authorization to the Medical Policy Committee is confined to a service for which there are no clinical guidelines (internal or MCG). The requested service then becomes subject to a technology assessment. It is considered part of the review at the request for authorization step. To the extent it is a considered a separate step, it applies consistently for M/S and MH/SUD requested services.

If an authorization request results in an adverse determination, providers or members have 180 days from notice of an adverse benefit determination to ask for an appeal. When Sentara reviews an appeal, Sentara looks at all comments, documents, records, and other information submitted to Sentara. Appeals involving medical necessity will be reviewed by a clinical peer reviewer who did not participate in the first coverage decision. When Sentara completes the appeal, Sentara will send written notification of the decision. If Sentara Health Plans doesn't change the initial decision the notice will include: 1. The specific reason for the decision; 2. The specific plan provisions Sentara Health Plans based the decision on; and 3. Information on any independent external appeal rights. In general, the internal appeal process must be exhausted prior to filing an independent external appeal. An exception exists for the treatment of cancer.

If an authorization request results in an adverse determination, the requesting provider may request a physician peer discussion. The treating physician will be given the opportunity to discuss the request with the reviewing medical director of the Plan if he or she disagrees with the determination. Sentara allows one peer discussion per denial and does not consider a peer review to be part of the appeal process.

A provider may also request a reconsideration of an adverse benefit determination on a member's behalf. A request for reconsideration is optional, and available only to a treating health care provider. A provider or member may file an appeal regardless of whether a provider requests a reconsideration. Sentara will decide on a reconsideration and notify the provider and the member in writing within ten (10) working days of the date of receipt of the request. A determination on reconsideration is made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor or peer of the treating provider on the panel. If Sentara denies the reconsideration request, the notice will include the criteria used and the clinical reason for the adverse benefit determination, the alternate length of treatment of any alternate recommendation, and appeal rights.

Peer to peer is initiated by the provider following an adverse benefit determination when the provider requests peer to peer review within five (5) business days from the date of notification of the denial. Peer to peer review does not automatically take place and remains at the discretion of the provider and does not count as an appeal. Medical directors do have discretion to contact the requesting/treating provider to request additional clinical information if necessary to render a decision. Sentara tracks peer to peer reviews. Sentara does not currently track whether peer to peer services are initiated by a provider or by a Medical Director. These peer to peer rates did not result in disparity in the denial rates. See Step 5 for more information. Sentara does not use consultations with third-party experts during the internal review process.

Case Management:

Healthcare service teams (case management services) are comprised of clinical professional staff, behavioral health clinicians, and nonclinical staff. These teams are integrated around populations of members in specified managed care products. This allows for a complete plan of care for the patient encompassing case management, behavioral health, and disease management services. Types of issues which may be referred to healthcare services:

- members with complex medical issues who utilize multiple services
- members who are nonadherent with treatment plans
- members who frequently utilize services without consulting PCP or specialist • members who frequently utilize the ER
- members who could benefit from disease management of heart failure, metabolic cardiovascular disease, asthma, COPD, or obesity
- neonatal care for premature and medically complex newborns (partnership with ProgenyHealth)

Requests for services (written or verbal) may be initiated by:

- provider

- member
- Sentara

A member's participation in case management services is optional and cost-sharing is not impacted.

Case management is a not a NQTL and does not impact prior authorization or coverage determinations. Sentara confirms that a decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time.

Case management is provided by a licensed Registered Nurse (RN) or Masters in Social Worker (MSW). Case managers work with hospital review teams and primary care physicians to assist with coordination and transition of care, and community resources. Case managers do not have the ability to "override" a treating physician's recommended course of treatment or deny any request for authorization. Only Medical Directors can issue adverse benefit determinations.

As explained above, any decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time. Further, case managers cannot overturn treatment recommendation or issue adverse benefit determinations. Case management is optional and designed for care coordination. Activities are aimed at improving member health through risk reduction and minimizing complications through education.

Examples of levels of care to which case management applies include severe behavioral health risk or chronic condition with co-morbidities (medical or behavioral). Sentara's case management policy complies with the most current NCQA standards. CCS Leadership (Director and VP) review the policy annually, which mirrors NCQA accreditation requirements. The policy is reviewed and approved by the overarching SHP Policy and Procedure Committee.

Tracking of Denials:

Sentara tracks turnaround times and reports all claim denials and closed internal and external appeals and complaints. Claim denials are tracked for the following codes, which include that the services were not medically necessary and services not preauthorized:

Code	Claim Denial Reasons
1	Does not meet step therapy protocol
2	Exceeds benefit limits (contractual)
3	Experimental/Investigational
4	Inappropriate level of care/inappropriate place of service/inappropriate treatment for condition or circumstance
5	Individual ineligible/not insured when the services were provided
6	Not a covered benefit/service contractually excluded
7	Not Medically Necessary
8	Provider not participating with the individual's plan
9	Provider/Facility not a covered provider/facility type for this service
10	Services not preauthorized/Referral not obtained
11	Exceeds deadline for timely filing - member responsible
12	COB - plan is secondary
13	Provider billed incorrectly
14	Incomplete information filed
15	PCP not selected
16	Amount exceeds UCR/Allowable Charge
17	Rejected - Drug Utilization Review
18	Prescription refill too soon

For appeals, Sentara tracks whether the denials were upheld, partially upheld or overturned in closed internal appeals and closed external reviews.

Sentara follows NCQA mandates regarding the tracking of approvals and denials. If a requested service (level of care) is requested and denied, it is tracked as a denial, even if a lower level of care was authorized. This is accurate for both M/S and MH/SUD services.

For authorization requests, Sentara tracks authorization volume by decision, including approvals, denials, and partial denials. Sentara also tracks the denial rate by episode type (i.e., inpatient M/S, inpatient MH/SUD, outpatient M/S, and outpatient MH/SUD).

Sentara follows a standard process for administrative denials. Specifically, Sentara processes administrative denials in the following circumstances: (i) services are not a covered member benefit or (ii) member is not eligible under the Plan. This policy applies to both M/S and MH/SUD services. As shown in the data included herewith, administrative denials are subject to appeals but such denials and appeals are tracked separately for denials and appeals related to medical necessity.

Tracking of Prior Authorization versus Concurrent Review

Prior authorization is tracked separately from concurrent authorizations.

Sentara uses the terms "concurrent review" and "concurrent service authorization" synonymously. Concurrent review is conducted within 72 hours of receiving the request provided that Sentara receives the request at least 24 hours prior to expiration of the previously approved time period or number of treatments. If the prior authorization has expired, the request is treated as a new request for prior authorization.

Extent of Medical Records Required

Sentara may request medical records for review. Listed below are the current medical record standards:

- Comprehensive history and physical, including the history of present illness and relevant psychiatric history
- Documentation of allergies and adverse reactions to medications
- Problem list
- Medications management and reconciliation
- Clinical findings and evaluations documented for each visit
- Preventive services and risk screenings
- Diagnoses, including documentation for behavioral health
- Substance use assessment
- Mental status examination
- Treatment planning
- Evidence of continuity of care

The standards above apply equally to M/S and MH/SUD.

Appeal Rights

The timeframes to review appeals are compliant with NCQA standards and identical for M/S and MH/SUD appeal of authorization denials. Providers and members have 180 days from notice of an adverse benefits determination to request an appeal. For pre-service appeals, Sentara must respond within 30 days. Following one level of internal appeal, a request for an external appeal is available.

External review appeal rights apply to both M/S and MH/SUD benefits. There is no difference in application of an external review. A member or provider can appeal any decision (whether M/S or MH/SUD) regardless of whether the member accepts and receives a lower level of care.

In the context of the internal appeal process, any denial or reduction of benefits and/or nonpayment based upon a determination of medical necessity is treated as an Adverse Benefit Determination and subject to the appeal process outlined in the plans. Written notice of Adverse Benefit Determinations is required except for Urgent Claims, where notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notice of an Adverse Benefit Determination includes the following:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.

Any member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination. For denials due to Medical Necessity, members are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances.

After notification of an Adverse Benefit Determination, a member has 180 days to request an appeal. Upon appeal, all comments, documents, records, and other information submitted is reviewed. Additional information may be provided. The clinical peer reviewer reviewing the appeal will not have participated in the original coverage decision. Should a member disagree with the Final Benefit Determination, an external appeal is available.

Vendor Involvement

Information related to Sentara's UM vendors is below. Notably, no vendor relationship exists for utilization management for MH/SUD services. Further, Sentara reviews and adjudicates all appeals for all M/S and MH/SUD services.

A third-party vendor ("UM Vendor 1") conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a master services agreement. UM Vendor 2 is URAC and NCQA accredited. UM Vendor 2 provides access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a vendor services agreement.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. The clinical guidelines are available at https://www1.radmd.com/all-health-plans/sentara-health-plans. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Separate Operating Departments or Divisions

There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Urgent Care Requests

Urgent request/expedited review is appropriate when application of time frame for making routine or non-life threatening care determinations that:

- Could seriously jeopardize the life or health of the member or the members ability to regain maximum function, or
- Could seriously jeopardize the life, health or safety of the member or others due to the members psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested.

One factor of the definition of urgent requests contemplates: "In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested." That opinion is not questioned in terms of the 72 hour review time for the request. Said another way, Sentara does not question the urgency requested for the 72 hour review time if presented by a treating physician.

An urgent request is not different than an expedited review. An expedited review is defined in the Provider Manual as "a request for medical care or services where application of time frame for making routine or non-life threatening care determinations that:

- Could seriously jeopardize the life or health of the member or the members ability to regain maximum function, or
- Could seriously jeopardize the life, health or safety of the member or others due to the members psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested.

Sentara utilizes the same process for urgent requests for M/S and MH/SUD benefit.

Step 5: Demonstration of comparability and stringency in operation.

See 45 CFR 146.137(c)(5). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Data:

The data provided herein is for Virginia fully-insured plans in 2023 and 2024. Specifically, the following products were analyzed:

Sentara Direct M Silver 6600 Ded, Sentara Direct M Bronze 7200 Ded, Sentara Direct Vantage Silver 4000 Ded 250 Rx Ded, Sentara Direct Vantage Gold 2000 Ded, BAE Systems - POS 200/15/20% LG 2017, UVA Consortium - VANT EQUIT 3200/10% LG, Sentara Direct Plus Gold 2000 Ded, Sentara Direct Plus Gold 500 Ded 200 Rx Ded, Hampton Roads Transit EQUITY PLUS 3500/10% LG, UVA Consortium PLUS EQUITY 3200/10% LG

Sentara will supplement this analysis with 2025 data when it becomes available.

UM Program Audits:

Sentara audits monthly its utilization management processes. Sentara audit its monthly and quarterly utilization report that includes for example:

o Days/1000, Admissions/1000

o Average length of stay (ALOS)

o Observation days/1000

o Readmission rate for both medical and behavioral health services

o Outpatient surgeries/1000

o Outpatient visits/1000

o Milliman Benchmarking

o High-Dollar claims

o Complex medical conditions

o Authorizations provided to non-participating providers

Sentara conducts an annual evaluation, which includes an evaluation of vendors performing utilization management services for Sentara.

In addition, Sentara conducts an annual evaluation of its utilization management program, which also includes an evaluation of vendors performing utilization management services for Sentara.

Sentara follows NCQA mandates regarding the tracking of approvals and denials. If a requested service (level of care) is requested and denied, it is tracked as a denial, even if a lower level of care was authorized. This is accurate for both M/S and MH/SUD services.

For authorization requests, Sentara tracks authorization volume by decision, including approvals, denials, and partial denials. For example:

- 2023: 58,786 requests for authorization; 54,841 approvals; 3,970 denials; and 119 partial denials. Of these authorization requests, 328 (306 approved) were for outpatient behavioral health services and 53,197 (49,626 approved) were for outpatient M/S services. See UM Exhibit.

- 2024: 76,871 requests for authorization; 68,618 approvals; 8,409 denials; and 176 partial denials. Of these requests for authorization, 496 (462 approved) were for outpatient behavioral health services and 69,079 (61,484 approved) were for outpatient M/S services. See UM Exhibit.

Sentara also tracks the denial rate by episode type:

- 2023: grand total denial rate 6.95%; 7.99% inpatient M/S; 6.3% inpatient behavioral health; 6.87% outpatient M/S; 6.71% outpatient behavioral health

- 2024: grand total denial rate 11.16%; 10.06% inpatient M/S; 6.28% inpatient behavioral health; 11.34% outpatient M/S; 6.85% outpatient behavioral health

In Summary, as it relates to outpatient services:

2023 Analysis

Total Auths: 58,786

- M/S OP: 53,197
    - Approved: 49,626
    - Denied: 3,537
        - Administrative denial, lack of member eligibility: 302
        - Administrative denial, mandated paperwork not provided: 1
        - Administrative denial, non-covered service: 495
        - Administrative denial, benefit exhausted: 9
        - Denied, member coverage: 2
        - Denied, non-participating provider: 116
        - Denied, not a covered benefit: 51
        - Denied, not medically necessary: 2412
        - Denied on appeal: 3
        - Denied peer to peer: 25
    - Partial denial: 118
    - MD referral rate: 3.4%
    - Denial rate: 6.87%

- MH/SUD OP: 328
    - Approved: 306
    - Denied: 21
        - Administrative denial, non-covered service: 11
        - Administrative denial, lack of member eligibility: 4
        - Denied, non-participating provider: 6
    - Partial denial: 1
    - MD referral rate: 14.6%
    - Denial rate: 6.71%

2024 Analysis

Total Auths: 76,871

- M/S OP: 69,079

    - Approved: 61.484
    - Denied: 7,666
        - Administrative denial, lack of member eligibility: 304
        - Administrative denial, mandated paperwork not provided: 3
        - Administrative denial, non-covered service: 390
        - Administrative denial, benefit exhausted:
        - Denied, member coverage: 2
        - Denied, non-participating provider: 160
        - Denied, not a covered benefit: 58
        - Denied, not medically necessary: 1187
        - Denied, on appeal: 2
        - Denied, peer to peer: 22
    - Partial denial: 174
    - MD referral rate: 3.1%
    - Denial rate: 11.34%

- MH/SUD OP: 496
    - Approved: 462
    - Denied: 32
        - Administrative denial, non-covered service: 19
        - Administrative denial, lack of member eligibility: 8
        - Denied, non-participating provider: 2
        - Denied, not medically necessary: 3
    - Partial denial: 2
    - MD referral rate: 21.2%
    - Denial rate: 6.85%

Appeals Data:

2023: Appeals Data is included herewith in the UM Exhibit.

2024: Appeals Data is included herewith in the UM Exhibit.

For outpatient services, the authorization volume by review can be reported as follows:

2023: Outpatient MH/SUD

328 Requests for Authorization: 212 Non-urgent preservice; 111 expedited; 5 post-service.

2023: Outpatient M/S

53,197 Requests for Authorization: 39,106 Nonurgent Preservice; 9861 Urgent Preservice; 3,987 Post-service; and 473 standard.

2024: Outpatient MH/SUD

496 Requests for Authorization: 211 Expedited; 196 Non-urgent preservice; 72 Non-Urgent preservice 12 standard

2024: Outpatient M/S

69,072 Requests for Authorization: 43,513 Non-urgent preservice; 15,682 Non-urgent preservice; 5,414 Urgent Preservice; 2,982 Post-service.

UM Exhibit.

Turnaround Times: Data concerning turnaround times is discussed extensively in the Commercial and Exchange Utilization Management Annual Evaluations. As a snapshot for outpatient services from 2024 annual evaluation:

2024 Outpatient MH/SUD NCQA Performance:

	Expedited	Nonurgent Pre-Service	Post Service	Urgent Concurrent: 72 hours
	Days	Days	Days	Days
Average of Processing Standard	3	15	30	3
Average of Actual TAT	1.1	2.4	10.8	0.1



2024 Outpatient M/S NCQA Performance:

	Expedited	Nonurgent Pre-Service	Post Service	Urgent Concurrent: 24 hours	Urgent Pre-Service
	Days	Days	Days	Days	Days
Average of Processing Standard	3	15	30	1	3
Average of Actual TAT	0.7	5.0	8.5	1.0	0.4



No denials occurred for MH or SUD services for any commercial plan in 2024.

Sentara collected authorization data as requested for 2023 and 2024 to determine if denials were disproportionate for MH/SUD outpatient services as compared to M/S outpatient services.

In 2023, for outpatient services, there were a total of 55,525 requests for authorizations. Of these requests for authorization, 53,197 were for outpatient M/S services and 328 were for MH/SUD outpatient services. As for outpatient M/S services, 49,626 were approved and

3,537 were denied. The denial rate was 6.87% for M/S services. Of the 3,537 denials, 2,537 were denied for medical necessity or 71.72%. As it relates to MH/SUD outpatient services, 306 were approved and 21 were denied. The denial rate was 6.71%, slightly lower than the denial rate for M/S outpatient services. Of the 21 denials, 1 was partially denied and none were denied for medical necessity, representing 0%. With this data, Sentara does not see disparity in the application of its utilization management program, as the denial rate is below that for M/S services. Insight into the reasons for denial of requests for outpatient services support this conclusion, as not one of the 21 denials for MH/SUD were for medical necessity, as compared to 71.72% for M/S.

Similar trends occurred in 2024, for outpatient services, there were a total of 69,575 requests for authorizations. Of these authorizations, 69,079 were for outpatient M/S services and 496 were for MH/SUD services. As for outpatient M/S services, 61,484 were approved and 7,666 were denied. The denial rate was 11.34% for M/S services. As it relates to MH/SUD outpatient services, 462 were approved and 32 were denied. The denial rate was 6.85%, substantially lower than the denial rate for M/S outpatient services. Of the 32 denials, 3 were denied for medical necessity. With this data, Sentara does not see disparity in the application of its utilization management program, as the denial rate is well below that for M/S services. Insight into the reasons for denial support this conclusion, as only 7.9% of the denials for MH/SUD were for medical necessity.

Physician review – In analyzing physician review, Sentara's main objective was to determine if the MH/SUD physician reviewers were applying discretion in a way that was more stringent or arbitrary than how M/S physicians applied discretion and to determine if they were adhering to criteria in a fashion that was no more stringent than M/S physicians' adherence to criteria. Sentara further studied MD (Medical Director) referral rates and discovered that percentages of requests for authorizations referred for Medical Director review are significantly higher in MH/SUD outpatient services. In 2023, 3.4% of M/S outpatient requests for authorization were referred to MD review, as compared to 14.6% of MH/SUD outpatient requests for authorization. In 2024, 3.1% of M/S outpatient requests for authorizations were referred to MD Review as compared to 21.2% for MH/SUD outpatient services. Given that only a fraction of the denials for MH/SUD services were denied for medical necessity, MD referrals appear to be a positive review protocol and physician review is not causing any disparate impact.

In reviewing peer-to-peer review data, the objectives were largely the same. While significantly more M/S outpatient services are subject to peer review than MH/SUD outpatient services, the denial rates are much lower for MH/SUD outpatient services. With such few instances of peer-to-peer review, 1 total in 2023, it is difficult to determine any trends, however, denial rates indicate that utilization review is not being more stringently applied to MH/SUD outpatient services.

Appeal data further confirms that no disparity exists as to utilization review. In 2023, for MH/SUD services, 7appeals occurred throughout the commercial line of business and none of the 7 appeals were medical necessity appeals. In 2024, there were 5 appeals for MH/SUD services and only 1 appeal concerned medical necessity.

Sentara further compared TAT and noticed an area of improvement. The TAT for MH/SUD outpatient services, while still better than the NCQA standard, was 1.1 days for expedited review, as compared to 0.7 days for M/S.

Step 6: Findings and conclusions.

See **45 CFR 146.137(c)(6).** The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the FAQ 45 guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara provided a definition of Preauthorization NQTL and identified the outpatient services subject to preauthorization, referencing the documents which specify those services, including the Prior Authorization List. For Step 1, Sentara provided information as to all vendors that provide utilization review services and produced the contractual documents related to those services. Sentara provided the factors and sources considered when requiring certain outpatient services be subject to preauthorization. Sentara noted that for MH/SUD outpatient services, the applicable factor is industry standards, including CMS, DMAS, LCDs, NCDs, and Milliman Clinical Guidelines. Sentara provided data including, but not limited to, authorization and denials, authorization by priority, MD referral rates, peer-to-peer reviews, audit results and appeals. Sentara completed the comparative analysis, set forth in Step Four above.

The analysis establishes Sentara is compliant with MHPAEA.

This analysis was completed in September 2026 by the following Sentara Departments: Utilization Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

PRIOR AUTHORIZATION: INPATIENT, OUT-OF-NETWORK

(NO PRIOR AUTHORIZATION IS REQUIRED FOR OFFICE VISITS)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See 45 CFR 146.137(c)(1). Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also FAQ 45 (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

Clinical Review: Sentara defines the clinical review form of prior authorization as a medical necessity review that takes place prior to a service being performed. This is the only form of

preauthorization[1] Sentara uses. Thus, the remainder of this analysis will focus solely on the clinical review form of preauthorization.

There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Notification: Some carriers require notification from the provider to the carrier, and clinical review is not performed for coverage approval. Sentara does not use this form of preauthorization.

Non-Clinical Review: Some carriers require requests for coverage that are reviewed and approved by non-clinical personnel according to predetermined criteria, which is also referred to by multiple carriers as "fast certification." Sentara does not use this form of preauthorization.

Additionally, there is no prior authorization/medical necessity review for office visits by any staff, clinical or non-clinical. This includes any office visit, whether M/S or MH/SUD. Preauthorization is required, however, for surgical procedures when surgeries are performed in-office.

Vendor Involvement

A third-party vendor ("UM Vendor 1") conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate third-party vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a services agreement. UM Vendor 2 is URAC and NCQA accredited. Under the services agreement provides, UM Vendor 2 providers access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a services agreement.

[1] Preauthorization and prior authorization are used interchangeably throughout.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Specific Medical/Surgical Benefits to Which NQTL Applies

Pre-authorization is required for all inpatient services , both M/S and MH/SUD.

Specific MH/SUD Benefits to Which Prior Authorization Applies

Pre-authorization is required for all inpatient services , both M/S and MH/SUD.

There are a number of ways Sentara identifies which services are subject to prior authorization for clinical review. Specifically:

Plan Documents:

The HMO and PPO plan documents state the following:
"Some Covered Services under this Plan require Pre-Authorization to be Covered. Please read the entire section on Pre-Authorization in the EOC."

Defines Pre-Authorization as "an evaluation process which assesses the medical necessity of proposed treatment and checks to see that the treatment is being provided at the appropriate level of care."

Describes preauthorization and states: "On Your Schedule of Benefits, We tell You what services require pre-authorization before You receive them. You can also look in the What is Covered Section of this document or call Member Services to find out about Pre-Authorization."

Describes generally the types of services which require preauthorization, including: Inpatient hospitalization services; Partial hospitalization services; Residential treatment services; Non-emergency ambulance transport; Inpatient and outpatient surgery; Surgery in a physician's office; Single items of durable medical equipment and orthopedic and prosthetic appliances over [$750]; Rental of durable medical equipment and orthopedic and prosthetic appliances; Repair and replacement items of durable medical equipment and orthopedic and prosthetic appliances; Artificial prosthetic limbs; Prenatal maternity services (excluding recommended preventive care services, screenings, and one breast pump per pregnancy); Home health care; Skilled Nursing Facility care; Physical, occupational, and speech therapy; Cardiac, pulmonary, and vascular rehabilitation; IV therapy with medications; Inhalation therapy; Early intervention services; Clinical trials for treatment studies on cancer; Hospice services; Oral surgery; TMJ services; Tubal ligation; Hospitalization and anesthesia for dental procedures; Treatment of lymphedema; Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiography (MRA); Positron Emission Tomography (PET) scans; Computerized Axial Tomography (CT) scans; Computerized Axial Tomography Angiogram (CTA) scans; Sleep studies; transplant services; Injectable and infused medications, biologics, and IV therapy medications defined by Our Pharmacy Committee; Intensive outpatient programs (IOP); Medical, psychological and neuro psychological diagnostic procedures

and testing; Electro-convulsive therapy (ECT); Telemedicine service; Transcranial Magnetic Stimulation (TMS); Insulin pumps and insulin pump infusion sets and supplies; Chemotherapy and Chemotherapy Drugs; Radiation Therapy; Dialysis Services; Genetic Testing and Counseling. If Your plan includes any riders generally those services will require Pre-Authorization listed in the rider.

Define Covered Services and designate those which require prior authorization. These Services and others are then further defined.

Schedule of Benefits

States "Some benefits require Pre-Authorization before You receive them. These services ae marked with an * in this document."

The Schedules of Benefits designate the following service types as requiring preauthorization: outpatient therapies and services; outpatient dialysis; outpatient surgery; outpatient lab, diagnostic, imaging, and testing; outpatient advanced imaging, testing and scans; injectable and infused medications; maternity care; inpatient M/S services including inpatient hospital services, transplants, skilled nursing facility services; non-emergency transport; inpatient MH/SUD services including hospital services, residential treatment services, partial hospitalization, intensive outpatient program services, transcranial magnetic stimulation, electro-convulsive therapy, autism spectrum disorder, other outpatient services; diabetes treatment including insulin pumps, pump infusion sets and supplies, talking blood glucose meters, insulin, and needles and syringes for injection; prosthetic devices and components, repair, fitting, replacement and adjustment; durable medical equipment for items over $750, repair, replacement, and rental items; wigs following cancer treatment; early invention services including speech and language therapy, occupational therapy, physical therapy, assistance technology services and devices; home health care; private duty nursing; hospice care; reconstructive breast surgery for members who have had a mastectomy; infertility services including endometrial biopsies, semen analysis, hysterosalpingography, Sims-Huhner test, diagnostic laparoscopy; clinical trial services; allergy testing and serum; telemedicine services[2]; chiropractic services; hearing aids and related services for children 18 and younger

Provider Manual

The Provider Manual states:

"Except in the case of emergency treatment, prior authorization will be required for: all inpatient hospitalizations, all partial hospitalizations (mental health or substance abuse), all outpatient surgeries/short stays/observations and IV therapy and drug infusions, all skilled nursing facility admissions, all acute rehabilitation, all intensive outpatient programs, all out-of-area services or referrals to nonparticipating providers (prior to scheduling) for members that do not have out-of-network benefits included in their plan. All the following services require prior authorization regardless of the place of service: Commercial plan DME single purchased items greater than

[2] Please note that the Schedule of Benefits language will be revised, as prior authorization is not required for telemedicine services.

$750 and all rentals, orthotics/prosthetics, single purchased items greater than $750 and all rentals, repair, replacement, and duplicates, home health, hospice, IV infusions, plastic surgery, all rehabilitation programs (cardiac, vascular, vestibular, pulmonary, etc.), therapies (PT, OT, ST), applied behavioral analysis, early intervention services (part H certificate required), OB global notification, transplant services, human and synthetic tissue, oral surgery and related services, advanced imaging studies (PET, CT, CTA, MRI, MRA, MR-CT), sleep studies, hyperbaric therapy, electronic bone stimulator, any surgical or diagnostic procedure for which anesthesiology or conscious sedation is billed, injectable drugs indicated on the online prior-authorization forms, genetic testing (if covered by group/plan), bone densitometry if less than 24 months since last study."

Prior Authorization List: (accessible at http://pal.sentarahealthplans.com/)

Tool allows anyone to access and search for procedure code or description to determination whether prior authorization is required.

Procedure and Revenue Codes:

As previously stated, all inpatient services require prior authorization.

Certain services such as PT, OT, and ST, can be used for both MH/SUD and M/S conditions. Specific to these therapies, Sentara ensures MHPAEA compliance through benefit structure. Currently, no numerical visit limitations are placed on PT, OT, and ST for MH/SUD, unlike the annual visit limits for M/S. For other services such as non-emergency transport, Sentara does not preauthorize services strictly by diagnosis. If a medical necessity review is required for the service, it will include all pertinent clinical information required to make a determination based on the appropriate necessity criteria used whether that be internal medical policies or MCG (which incorporate ASAM). For example, Sentara tracks transportation authorizations but does not track whether authorization for non-emergency transportation was reviewed for an underlying M/S or MH/SUD condition.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See 45 CFR 146.137(c)(2). Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:
(A) A detailed description of the factor;

(B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and

(C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Sentara uses the following factors to determine the basis for requiring prior authorization for certain services:

- Industry standards in conformance with Centers for Medicare & Medicaid Services (CMS), Department of Medical Assistance Services (DMAS), Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and Milliman Care Guidelines (which incorporate American Society for Addiction Medicine (ASAM) Criteria)

- Excessive (high volume) variability in utilization. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization.

- High-Cost/High variability in cost. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards

and practices for identifying which services are subject to prior authorization.

Weight of Factors

Industry standards in conformance with an internal utilization management determinations hierarchy determine which services are subject to prior authorization. Specifically, Sentara has implemented a policy outlining a determinations hierarchy for commercial utilization management decisions which is used for reviewing and processing requests for authorization. Specifically, the following hierarchy is used: Federal Regulations; State Regulations; Sentara Medical Policies; MCG CareWeb ("MCG"); and review of association guidelines, specialty and subspeciality associations, and peer reviewed literature.

Sentara follows first the industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine which services are subject to prior authorization. As described in detail in the response to the Medical Necessity NQTL, Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed. The development of MCG or internal policies renders a service subject to prior authorization. There is little to no variation in the industry as to the services which require prior authorization. As described below in Step 3, Sentara does analyze and trend utilization review data and make determinations based upon that data. In operation, these trends impact M/S services more directly than MH/SUD because utilization of M/S outpatient services is greater, and more M/S outpatient services require prior authorization. Sentara utilizes this trending and benchmarking data but does not have any policy that defines when that data requires a change to prior authorization status.

Step 3: Description of how factors are used in the design and application of the NQTL.

See **45 CFR 146.137(c)(3).** Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

- Industry standards in conformance with CMS, DMAS, LCDs, NCDs, and Milliman Care Guidelines (which incorporate ASAM): Sentara follows first industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine

which services are subject to prior authorization. Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed (see Sentara's Medical Necessity NQTL Analysis). The development of MCG or internal policies renders a service subject to prior authorization. There is little to no variation in the industry as to the services which require prior authorization.

- Excessive (high volume)/variability in utilization: excessive utilization is measured by a number of metrics including authorization volume; denial volume, denial rates; days or admissions/100; average length of stay; observation days/1000, outpatient surgeries/1000, outpatient visits/1000. Trend analysis is considered, which includes: annualized cases/1,000; % change in annualized cases/1,000; annualized units/1,000; % change in annualized units; and Cost/Case for prior period and current period. Examples of these metrics are found in Commercial and Exchange Utilization Management Annual Evaluations and Trend Analysis Reports. Sentara also tracks utilization by authorization volume by CPT Code. Sentara is not aware of utilization rates as a factor for determining whether MH/SUD services require prior authorization. While utilization is tracked and trend analysis exists, utilization has not factored into any known decision to require prior authorization for any MH/SUD services.

- High-cost/High variability in cost: Sentara tracks allowed Per Member/Per Month ("PMPM") Data for outpatient categories of service. These PMPM are then benchmarked for comparison. Sentara is not aware of high cost or variability in cost as a factor for determining whether MH/SUD services require prior authorization. While utilization benchmarking exists, cost variability or high cost has not factored into any known decision to require prior authorization for any MH/SUD services.

Factors like utilization and cost, while tracked, trended and reviewed as compared to benchmarks, in operation, are not factors for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization.

The Prior Authorization List, available on Sentara's website, identifies all services subject to prior authorization. These services are subject to clinical review, and notification and non-clinical review are not implicated. These services identified on the PAL are not categorized by classification or subclassification. As noted, all inpatient services require preauthorization. The factors related to the services identified in the PAL are identified above.

Medical Policy Committee

The Medical Policy Committee makes determinations concerning which services are subject to preauthorization. The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties.

One objective of the MPC is to recommend, review, and approve authorization requirements for Health Plan services through collaboration with the Integrated Benefits Management Team ("IBMT") to ensure codes are configured in compliance with federal and state regulations and medical policies. The IBMT is a multi-department team that ensures decisions rendered by the MPC can be implemented operationally with any changes in configuration and coding. The UM Program Plan is reviewed and revised as necessary, but at least annually. The UM Program evaluation is conducted by the Clinical Care Services Vice-President, the UM Director, and the Commercial Lead Medical Director. The UM Program review is completed within 120 days of the fiscal year end (March 30). The workplan is presented and approved by the SHP Quality Improvement Committee. All changes to the UM Program are finalized by the MPC.

The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties. Specifically, voting members for recommendations of coverage decisions consist of the following: Health Plan Medical Directors, including the Behavioral Health Medical Directors, the Chief Medical Officer, VPs CCS (or proxy), and Director of Pharmacy (or designee) (for pharmaceutical items).

VPs CCS means the Vice President(s) of Clinical Care Services or his or her proxy for voting purposes on the MPC. VP Pharmacy means the Vice President of Pharmacy or his or her designee for pharmaceutical items.

The Medical Policy is comprised of 28 individuals with varying clinical or other specialties. Of the members of the Medical Policy Committee, 9 are considered MH/SUD experts and 13 are considered M/S experts in various specialties.

Step 4: Demonstration of comparability and stringency as written.

See **45 CFR 146.137(c)(4).** The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold

identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent

to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Regarding the factors, definitions, evidentiary standards, sources, and strategies described in Step Two and Step Three, Sentara provides the following information:

Documentation of Each Factor Identified and Defined in Step Two:

The following factors are implicated in determining whether Prior Authorization applies to certain services:

Service	Factors
All outpatient, M/S services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, M/S services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, MH/SUD services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria
All outpatient, MH/SUD services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria

Comparison of Existing Written Documents:

All plan terms and Sentara policies regarding utilization management, including prior authorization, are equally designed and applied to M/S and MH/SUD services with no variations.

The Authorization Process is defined in the Provider Manual and Sentara prior authorization policies. As it pertains to prior authorization, the MPC requires prior authorization for any service for which clinical criteria is established by MCG (inclusive of ASAM) and/or any internal clinical policy.

There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

How Factors Are Comparably Applied:

Sentara applies applicable industry standards (MCG for M/S and ASAM for MH/SUD) equally to all services in the respective classifications. Industry standards are applied without discretion, regardless of whether the particular service is M/S or MH/SUD. For services (either M/S or MH/SUD) for which there is no applicable industry standard, the Sentara MPC evaluates and reviews the requested service.

Reasons for Any Deviations or Variations:

There are no variations or deviations in the design or application of prior authorization between M/S and MH/SUD benefits.

Clinical Review Processes:

Members are notified of preauthorization requirements in the plan documents.

The Provider Manual notifies providers that prior authorization requests can be submitted through the Provider Portal or via facsimile. Prior authorization for urgent requests may be submitted by phone. Sentara follows federal and state regulations, including 45 CFR § 147.136, 29 CFR § 2560.503-1, § 38.2-305, § 38.2-3570, § 38.2-5803, 14VAC5-216-30, as well as the National Committee for Quality Assurance Guidelines for Timeliness of UM decisions. Requests for elective admissions must be submitted for prior authorization 14 days prior to scheduling an admission or procedure. Treatment by nonparticipating providers must receive prior authorization from Sentara in the same time frame as above. The requesting provider should receive an authorization for services within 14 days if all the necessary clinical information is provided with the initial authorization request and the service is covered under the member's benefit plan. Lack of clinical information to support authorization approval will delay processing. Urgent cases will be completed within 72 hours.

The utilization review process is initiated upon a request for prior authorization. The request for prior authorization is first reviewed by a clinician that could be a registered nurse, licensed practical nurse, clinical pharmacist, clinical psychologist, or Board certified Medical and Behavioral Health Physicians (Medical Directors). If a request for prior authorization results in any determination except an authorization for the service requested, the request for authorization is then reviewed by a Medical Director, who is a Board-certified physician. Only Medical Directors issue adverse benefit determinations. If that adverse benefit determination ultimately is appealed, the appeal review will be conducted by a Medical Director with a specialization in that area that did not participate in the adverse benefit determination.

There is a level of review between nurse review and peer-to-peer review where a physician reviews the submission without initiating a phone call with the treating provider. If the initial clinician review (which includes "Registered Nurses, Licensed Practical Nurses, Clinical Pharmacists, Clinical Psychologists, and Board certified Medical and Behavioral Health Physicians (Medical Directors)) in response to a request for prior authorization results in any determination except an authorization for the service requested, the request for authorization is then reviewed by a Medical Director. Nurses cannot render medical necessity denials or negotiate lower levels of care than what was requested by the treating provider. Only Medical Directors issue adverse benefit determinations. Individual consideration may be given when a plan provider initiates a referral for a covered service or to a provider outside of the network. If the Medical Director issues an adverse benefit determination, the provider has the option of requesting a peer review. Only medical directors can render medical necessity denials for both M/S an MH/SUD benefits. Medical Directors, both medical and behavioral health, are senior-level physicians or doctoral-level behavioral health practitioners who implement, provide supervision and oversight, and evaluate the UM program through their participation in authorization reviews, UM Committees, special UM projects, medical policy reviews, and the UM Program evaluation. Behavioral health physicians or doctoral-level behavioral healthcare practitioners additionally provide oversight and evaluation of the behavioral aspects of the UM program.

For commercial lines of business, when no internal medical policies exist for any MH or M/S service, MCG is utilized without incorporation or supplementation of any internal guidelines or policies. The MCG incorporate the ASAM criteria, which Sentara utilizes exclusively for substance use disorder services. Sentara does not deny a request for authorization simply because there are no established clinical criteria for the requested service. Any delegation of a request for authorization to the Medical Policy Committee is confined to a service for which there are no clinical guidelines (internal or MCG). The requested service then becomes subject to a technology assessment. It is considered part of the review at the request for authorization step. To the extent it is a considered a separate step, it applies consistently for M/S and MH/SUD requested services.

If an authorization request results in an adverse determination, providers or members have 180 days from notice of an adverse benefit determination to ask for an appeal. When Sentara reviews an appeal, Sentara looks at all comments, documents, records, and other information submitted to Sentara. Appeals involving medical necessity will be reviewed by a clinical peer reviewer who did not participate in the first coverage decision. When Sentara completes the appeal, Sentara will send written notification of the decision. If Sentara Health Plans doesn't change the initial decision the notice will include: 1. The specific reason for the decision; 2. The specific plan provisions Sentara Health Plans based the decision on; and 3. Information on any independent external appeal rights. In general, the internal appeal process must be exhausted prior to filing an independent external appeal. An exception exists for the treatment of cancer.

If an authorization request results in an adverse determination, the requesting provider may request a physician peer discussion. The treating physician will be given the opportunity to discuss the request with the reviewing medical director of the Plan if he or she disagrees with the determination. Sentara allows one peer discussion per denial and does not consider a peer review to be part of the appeal process.

A provider may also request a reconsideration of an adverse benefit determination on a member's behalf. A request for reconsideration is optional, and available only to a treating health care provider. A provider or member may file an appeal regardless of whether a provider requests a reconsideration. Sentara will decide on a reconsideration and notify the provider and the member in writing within ten (10) working days of the date of receipt of the request. A determination on reconsideration is made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor or peer of the treating provider on the panel. If Sentara denies the reconsideration request, the notice will include the criteria used and the clinical reason for the adverse benefit determination, the alternate length of treatment of any alternate recommendation, and appeal rights.

Peer to peer is initiated by the provider following an adverse benefit determination when the provider requests peer to peer review within five (5) business days from the date of notification of the denial. Peer to peer review does not automatically take place and remains at the discretion of the provider and does not count as an appeal. Medical directors do have discretion to contact the requesting/treating provider to request additional clinical information if necessary to render a decision. Sentara tracks peer to peer reviews. Sentara does not currently track whether peer to peer services are initiated by a provider or by a Medical Director. These peer to peer rates did not result in disparity in the denial rates. See Step 5 for more information. Sentara does not use consultations with third-party experts during the internal review process.

Case Management:

Healthcare service teams (case management services) are comprised of clinical professional staff, behavioral health clinicians, and nonclinical staff. These teams are integrated around populations of members in specified managed care products. This allows for a complete plan of care for the patient encompassing case management, behavioral health, and disease management services. Types of issues which may be referred to healthcare services:

- members with complex medical issues who utilize multiple services
- members who are nonadherent with treatment plans
- members who frequently utilize services without consulting PCP or specialist • members who frequently utilize the ER
- members who could benefit from disease management of heart failure, metabolic cardiovascular disease, asthma, COPD, or obesity
- neonatal care for premature and medically complex newborns (partnership with ProgenyHealth)

Requests for services (written or verbal) may be initiated by:

- provider

- member
- Sentara

A member's participation in case management services is optional and cost-sharing is not impacted.

Case management is a not a NQTL and does not impact prior authorization or coverage determinations. Sentara confirms that a decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time.

Case management is provided by a licensed Registered Nurse (RN) or Masters in Social Worker (MSW). Case managers work with hospital review teams and primary care physicians to assist with coordination and transition of care, and community resources. Case managers do not have the ability to "override" a treating physician's recommended course of treatment or deny any request for authorization. Only Medical Directors can issue adverse benefit determinations.

As explained above, any decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time. Further, case managers cannot overturn treatment recommendation or issue adverse benefit determinations. Case management is optional and designed for care coordination. Activities are aimed at improving member health through risk reduction and minimizing complications through education.

Examples of levels of care to which case management applies include severe behavioral health risk or chronic condition with co-morbidities (medical or behavioral). Sentara's case management policy complies with the most current NCQA standards. CCS Leadership (Director and VP) review the policy annually, which mirrors NCQA accreditation requirements. The policy is reviewed and approved by the overarching SHP Policy and Procedure Committee.

Tracking of Denials:

Sentara tracks turnaround times and reports all claim denials and closed internal and external appeals and complaints. Claim denials are tracked for the following codes, which include that the services were not medically necessary and services not preauthorized:

Code	Claim Denial Reasons
1	Does not meet step therapy protocol
2	Exceeds benefit limits (contractual)
3	Experimental/Investigational
4	Inappropriate level of care/inappropriate place of service/inappropriate treatment for condition or circumstance
5	Individual ineligible/not insured when the services were provided
6	Not a covered benefit/service contractually excluded
7	Not Medically Necessary
8	Provider not participating with the individual's plan
9	Provider/Facility not a covered provider/facility type for this service
10	Services not preauthorized/Referral not obtained
11	Exceeds deadline for timely filing - member responsible
12	COB - plan is secondary
13	Provider billed incorrectly
14	Incomplete information filed
15	PCP not selected
16	Amount exceeds UCR/Allowable Charge
17	Rejected - Drug Utilization Review
18	Prescription refill too soon

For appeals, Sentara tracks whether the denials were upheld, partially upheld or overturned in closed internal appeals and closed external reviews.

Sentara follows NCQA mandates regarding the tracking of approvals and denials. If a requested service (level of care) is requested and denied, it is tracked as a denial, even if a lower level of care was authorized. This is accurate for both M/S and MH/SUD services.

For authorization requests, Sentara tracks authorization volume by decision, including approvals, denials, and partial denials. Sentara also tracks the denial rate by episode type (i.e., inpatient M/S, inpatient MH/SUD, outpatient M/S, and outpatient MH/SUD).

Sentara follows a standard process for administrative denials. Specifically, Sentara processes administrative denials in the following circumstances: (i) services are not a covered member benefit or (ii) member is not eligible under the Plan. This policy applies to both M/S and MH/SUD services. As shown in the data included herewith, administrative denials are subject to appeals but such denials and appeals are tracked separately for denials and appeals related to medical necessity.

Tracking of Prior Authorization versus Concurrent Review

Prior authorization is tracked separately from concurrent authorizations.

Sentara uses the terms "concurrent review" and "concurrent service authorization" synonymously. Concurrent review is conducted within 72 hours of receiving the request provided that Sentara receives the request at least 24 hours prior to expiration of the previously approved time period or number of treatments. If the prior authorization has expired, the request is treated as a new request for prior authorization.

Extent of Medical Records Required

Sentara may request medical records for review. Listed below are the current medical record standards:

- Comprehensive history and physical, including the history of present illness and relevant psychiatric history
- Documentation of allergies and adverse reactions to medications
- Problem list
- Medications management and reconciliation
- Clinical findings and evaluations documented for each visit
- Preventive services and risk screenings
- Diagnoses, including documentation for behavioral health
- Substance use assessment
- Mental status examination
- Treatment planning
- Evidence of continuity of care

The standards above apply equally to M/S and MH/SUD.

Appeal Rights

The timeframes to review appeals are compliant with NCQA standards and identical for M/S and MH/SUD appeal of authorization denials. Providers and members have 180 days from notice of an adverse benefits determination to request an appeal. For pre-service appeals, Sentara must respond within 30 days. Following one level of internal appeal, a request for an external appeal is available.

External review appeal rights apply to both M/S and MH/SUD benefits. There is no difference in application of an external review. A member or provider can appeal any decision (whether M/S or MH/SUD) regardless of whether the member accepts and receives a lower level of care.

In the context of the internal appeal process, any denial or reduction of benefits and/or nonpayment based upon a determination of medical necessity is treated as an Adverse Benefit Determination and subject to the appeal process outlined in the plans. Written notice of Adverse Benefit Determinations is required except for Urgent Claims, where notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notice of an Adverse Benefit Determination includes the following:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.

Any member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination. For denials due to Medical Necessity, members are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances.

After notification of an Adverse Benefit Determination, a member has 180 days to request an appeal. Upon appeal, all comments, documents, records, and other information submitted is reviewed. Additional information may be provided. The clinical peer reviewer reviewing the appeal will not have participated in the original coverage decision. Should a member disagree with the Final Benefit Determination, an external appeal is available.

Vendor Involvement

Information related to Sentara's UM vendors is below. Notably, no vendor relationship exists for utilization management for MH/SUD services. Further, Sentara reviews and adjudicates all appeals for all M/S and MH/SUD services.

A third-party vendor ("UM Vendor 1") conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a master services agreement. UM Vendor 2 is URAC and NCQA accredited. UM Vendor 2 provides access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a vendor services agreement.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. The clinical guidelines are available at https://www1.radmd.com/all-health-plans/sentara-health-plans. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Separate Operating Departments or Divisions

There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Urgent Care Requests

Urgent request/expedited review is appropriate when application of time frame for making routine or non-life threatening care determinations that:

- Could seriously jeopardize the life or health of the member or the members ability to regain maximum function, or
- Could seriously jeopardize the life, health or safety of the member or others due to the members psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested.

One factor of the definition of urgent requests contemplates: "In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested." That opinion is not questioned in terms of the 72 hour review time for the request. Said another way, Sentara does not question the urgency requested for the 72 hour review time if presented by a treating physician.

An urgent request is not different than an expedited review. An expedited review is defined in the Provider Manual as "a request for medical care or services where application of time frame for making routine or non-life threatening care determinations that:

- Could seriously jeopardize the life or health of the member or the members ability to regain maximum function, or
- Could seriously jeopardize the life, health or safety of the member or others due to the members psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested.

Sentara utilizes the same process for urgent requests for M/S and MH/SUD benefit.

Step 5: Demonstration of comparability and stringency in operation.

See 45 CFR 146.137(c)(5). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Data:

The data provided herein is for Virginia fully-insured plans in 2023 and 2024. Specifically, the following products were analyzed:

Sentara Direct M Silver 6600 Ded, Sentara Direct M Bronze 7200 Ded, Sentara Direct Vantage Silver 4000 Ded 250 Rx Ded, Sentara Direct Vantage Gold 2000 Ded, BAE Systems - POS 200/15/20% LG 2017, UVA Consortium - VANT EQUIT 3200/10% LG, Sentara Direct Plus Gold 2000 Ded, Sentara Direct Plus Gold 500 Ded 200 Rx Ded, Hampton Roads Transit EQUITY PLUS 3500/10% LG, UVA Consortium PLUS EQUITY 3200/10% LG

Sentara will supplement this analysis with 2025 data when it becomes available.

UM Program Audits:

Sentara audits monthly its utilization management processes. Sentara audit its monthly and quarterly utilization report that includes for example:

o Days/1000, Admissions/1000

o Average length of stay (ALOS)

o Observation days/1000

o Readmission rate for both medical and behavioral health services

o Outpatient surgeries/1000

o Outpatient visits/1000

o Milliman Benchmarking

o High-Dollar claims

o Complex medical conditions

o Authorizations provided to non-participating providers

Sentara conducts an annual evaluation, which includes an evaluation of vendors performing utilization management services for Sentara.

In addition, Sentara conducts an annual evaluation of its utilization management program, which also includes an evaluation of vendors performing utilization management services for Sentara.

Sentara follows NCQA mandates regarding the tracking of approvals and denials. If a requested service (level of care) is requested and denied, it is tracked as a denial, even if a lower level of care was authorized. This is accurate for both M/S and MH/SUD services.

For authorization requests, Sentara tracks authorization volume by decision, including approvals, denials, and partial denials. For example:

- 2023: 58,786 requests for authorization; 54,841 approvals; 3,970 denials; and 119 partial denials. Of these authorization requests, 328 (306 approved) were for outpatient behavioral health services and 53,197 (49,626 approved) were for outpatient M/S services. See UM Exhibit.

- 2024: 76,871 requests for authorization; 68,618 approvals; 8,409 denials; and 176 partial denials. Of these requests for authorization, 496 (462 approved) were for outpatient behavioral health services and 69,079 (61,484 approved) were for outpatient M/S services. See UM Exhibit.

Sentara also tracks the denial rate by episode type:

- 2023: grand total denial rate 6.95%; 7.99% inpatient M/S; 6.3% inpatient behavioral health; 6.87% outpatient M/S; 6.71% outpatient behavioral health

- 2024: grand total denial rate 11.16%; 10.06% inpatient M/S; 6.28% inpatient behavioral health; 11.34% outpatient M/S; 6.85% outpatient behavioral health

In Summary, as it relates to outpatient services:

2023 Analysis

Total Auths: 58,786

- M/S OP: 53,197
    - Approved: 49,626
    - Denied: 3,537
        - Administrative denial, lack of member eligibility: 302
        - Administrative denial, mandated paperwork not provided: 1
        - Administrative denial, non-covered service: 495
        - Administrative denial, benefit exhausted: 9
        - Denied, member coverage: 2
        - Denied, non-participating provider: 116
        - Denied, not a covered benefit: 51
        - Denied, not medically necessary: 2412
        - Denied on appeal: 3
        - Denied peer to peer: 25
    - Partial denial: 118
    - MD referral rate: 3.4%
    - Denial rate: 6.87%

- MH/SUD OP: 328
    - Approved: 306
    - Denied: 21
        - Administrative denial, non-covered service: 11
        - Administrative denial, lack of member eligibility: 4
        - Denied, non-participating provider: 6
    - Partial denial: 1
    - MD referral rate: 14.6%
    - Denial rate: 6.71%

2024 Analysis

Total Auths: 76,871

- M/S OP: 69,079
  - Approved: 61.484
  - Denied: 7,666
    - Administrative denial, lack of member eligibility: 304
    - Administrative denial, mandated paperwork not provided: 3
    - Administrative denial, non-covered service: 390
    - Administrative denial, benefit exhausted:
    - Denied, member coverage: 2
    - Denied, non-participating provider: 160
    - Denied, not a covered benefit: 58
    - Denied, not medically necessary: 1187
    - Denied, on appeal: 2
    - Denied, peer to peer: 22
  - Partial denial: 174
  - MD referral rate: 3.1%
  - Denial rate: 11.34%

- MH/SUD OP: 496
  - Approved: 462
  - Denied: 32
    - Administrative denial, non-covered service: 19
    - Administrative denial, lack of member eligibility: 8
    - Denied, non-participating provider: 2
    - Denied, not medically necessary: 3
  - Partial denial: 2
  - MD referral rate: 21.2%
  - Denial rate: 6.85%

Appeals Data:

2023: Current Appeals Data is included herewith in the UM Exhibit.

2024: Current Appeals Data is included herewith in the UM Exhibit.

For outpatient services, the authorization volume by review can be reported as follows:

2023: Outpatient MH/SUD

328 Requests for Authorization: 212 Non-urgent preservice; 111 expedited; 5 post-service.

2023: Outpatient M/S

53,197 Requests for Authorization: 39,106 Nonurgent Preservice; 9861 Urgent Preservice;

3,987 Post-service; and 473 standard.

2024: Outpatient MH/SUD

496 Requests for Authorization: 211 Expedited; 196 Non-urgent preservice; 72 Non-Urgent preservice 12 standard

2024: Outpatient M/S

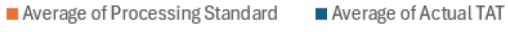
69,072 Requests for Authorization: 43,513 Non-urgent preservice; 15,682 Non-urgent preservice; 5,414 Urgent Preservice; 2,982 Post-service.

UM Exhibit.

Turnaround Times: Data concerning turnaround times is discussed extensively in the Commercial and Exchange Utilization Management Annual Evaluations. As a snapshot for outpatient services from 2024 annual evaluation:

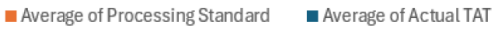
2024 Outpatient MH/SUD NCQA Performance:

	Expedited	Nonurgent Pre-Service	Post Service	Urgent Concurrent: 72 hours
	Days	Days	Days	Days
Average of Processing Standard	3	15	30	3
Average of Actual TAT	1.1	2.4	10.8	0.1



2024 Outpatient M/S NCQA Performance:

	Expedited	Nonurgent Pre-Service	Post Service	Urgent Concurrent: 24 hours	Urgent Pre-Service
	Days	Days	Days	Days	Days
Average of Processing Standard	3	15	30	1	3
Average of Actual TAT	0.7	5.0	8.5	1.0	0.4



No denials occurred for MH or SUD services for any commercial plan in 2024.

Sentara collected authorization data as requested for 2023 and 2024 to determine if denials were disproportionate for MH/SUD outpatient services as compared to M/S outpatient services.

In 2023, for outpatient services, there were a total of 55,525 requests for authorizations. Of these requests for authorization, 53,197 were for outpatient M/S services and 328 were for

MH/SUD outpatient services. As for outpatient M/S services, 49,626 were approved and 3,537 were denied. The denial rate was 6.87% for M/S services. Of the 3,537 denials, 2,537 were denied for medical necessity or 71.72%. As it relates to MH/SUD outpatient services, 306 were approved and 21 were denied. The denial rate was 6.71%, slightly lower than the denial rate for M/S outpatient services. Of the 21 denials, 1 was partially denied and none were denied for medical necessity, representing 0%. With this data, Sentara does not see disparity in the application of its utilization management program, as the denial rate is below that for M/S services. Insight into the reasons for denial of requests for outpatient services support this conclusion, as not one of the 21 denials for MH/SUD were for medical necessity, as compared to 71.72% for M/S.

Similar trends occurred in 2024, for outpatient services, there were a total of 69,575 requests for authorizations. Of these authorizations, 69,079 were for outpatient M/S services and 496 were for MH/SUD services. As for outpatient M/S services, 61,484 were approved and 7,666 were denied. The denial rate was 11.34% for M/S services. As it relates to MH/SUD outpatient services, 462 were approved and 32 were denied. The denial rate was 6.85%, substantially lower than the denial rate for M/S outpatient services. Of the 32 denials, 3 were denied for medical necessity. With this data, Sentara does not see disparity in the application of its utilization management program, as the denial rate is well below that for M/S services. Insight into the reasons for denial support this conclusion, as only 7.9% of the denials for MH/SUD were for medical necessity.

Physician review – In analyzing physician review, Sentara's main objective was to determine if the MH/SUD physician reviewers were applying discretion in a way that was more stringent or arbitrary than how M/S physicians applied discretion and to determine if they were adhering to criteria in a fashion that was no more stringent than M/S physicians' adherence to criteria. Sentara further studied MD (Medical Director) referral rates and discovered that percentages of requests for authorizations referred for Medical Director review are significantly higher in MH/SUD outpatient services. In 2023, 3.4% of M/S outpatient requests for authorization were referred to MD review, as compared to 14.6% of MH/SUD outpatient requests for authorization. In 2024, 3.1% of M/S outpatient requests for authorizations were referred to MD Review as compared to 21.2% for MH/SUD outpatient services. Given that only a fraction of the denials for MH/SUD services were denied for medical necessity, MD referrals appear to be a positive review protocol and physician review is not causing any disparate impact.

In reviewing peer-to-peer review data, the objectives were largely the same. While significantly more M/S outpatient services are subject to peer review than MH/SUD outpatient services, the denial rates are much lower for MH/SUD outpatient services. With such few instances of peer-to-peer review, 1 total in 2023, it is difficult to determine any trends, however, denial rates indicate that utilization review is not being more stringently applied to MH/SUD outpatient services.

Appeal data further confirms that no disparity exists as to utilization review. In 2023, for MH/SUD services, 7appeals occurred throughout the commercial line of business and none

of the 7 appeals were medical necessity appeals. In 2024, there were 5 appeals for MH/SUD services and only 1 appeal concerned medical necessity.

Sentara further compared TAT and noticed an area of improvement. The TAT for MH/SUD outpatient services, while still better than the NCQA standard, was 1.1 days for expedited review, as compared to 0.7 days for M/S.

Step 6: Findings and conclusions.

See **45 CFR 146.137(c)(6).** The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the FAQ 45 guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara provided a definition of Preauthorization NQTL and identified the outpatient services subject to preauthorization, referencing the documents which specify those services, including the Prior Authorization List. For Step 1, Sentara provided information as to all vendors that provide utilization review services and produced the contractual documents related to those services. Sentara provided the factors and sources considered when requiring certain outpatient services be subject to preauthorization. Sentara noted that for MH/SUD outpatient services, the applicable factor is industry standards, including CMS, DMAS, LCDs, NCDs, and Milliman Clinical Guidelines. Sentara provided data including, but not limited to, authorization and denials, authorization by priority, MD referral rates, peer-to-peer reviews, audit results and appeals. Sentara completed the comparative analysis, set forth in Step Four above.

The analysis establishes Sentara is compliant with MHPAEA.

This analysis was completed in September 2026 by the following Sentara Departments: Utilization Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

PRIOR AUTHORIZATION: OUTPATIENT, IN-NETWORK

(NO PRIOR AUTHORIZATION IS REQUIRED FOR OFFICE VISITS)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See 45 CFR 146.137(c)(1). Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also FAQ 45 (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

Clinical Review: Sentara defines the clinical review form of prior authorization as a medical necessity review that takes place prior to a service being performed. This is the only form of

preauthorization[1] Sentara uses. Thus, the remainder of this analysis will focus solely on the clinical review form of preauthorization.

There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Notification: Some carriers require notification from the provider to the carrier, and clinical review is not performed for coverage approval. Sentara does not use this form of preauthorization.

Non-Clinical Review: Some carriers require requests for coverage that are reviewed and approved by non-clinical personnel according to predetermined criteria, which is also referred to by multiple carriers as "fast certification." Sentara does not use this form of preauthorization.

Additionally, there is no prior authorization/medical necessity review for office visits by any staff, clinical or non-clinical. This includes any office visit, whether M/S or MH/SUD. Preauthorization is required, however, for surgical procedures when surgeries are performed in-office.

Vendor Involvement

A third-party vendor ("UM Vendor 1") conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate third-party vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a services agreement. UM Vendor 2 is URAC and NCQA accredited. Under the services agreement provides, UM Vendor 2 providers access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a services agreement.

[1] Preauthorization and prior authorization are used interchangeably throughout.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Specific Medical/Surgical Benefits to Which NQTL Applies

Pre-authorization is required for services defined in the commercial plan documents as other covered outpatient services, including: surgery, testing procedures, advanced imaging (MRI, MRA, PET, CT, etc.), hospice, rehabilitative and habilitative services, other therapy services, and home health care.

Surgery: surgical services on an outpatient or office basis. Covered Services include: (i) accepted surgical and cutting procedures; (ii) procedures to correct congenital abnormalities that cause functional impairment, newborn congenital abnormalities or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery; (iii) invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of the brain or spine; (iv) endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy; (v) treatment of fractures and dislocations; (vi) pre-operative and post-operative care; (vii) hypodermic needles, syringes, surgical dressings, splints and other surgical supplies; (viii) physician, nursing, and other support services; (ix) services and anesthesia provided by an anesthesiologist when Medically Necessary and appropriate for your condition; (x) blood and blood products and administration.

Outpatient Advanced Imaging including (i) diagnostic Radiology including X-rays, mammograms, ultrasound, doppler studies, or nuclear medicine; (ii) diagnostic Lab and pathology services or tests; (iii) diagnostic Hearing and Vision tests; (iv) diagnostic Electrocardiograms (EKGs), electroencephalograms (EEGs) and Echocardiograms; (iv) Advanced Diagnostic Imaging procedures including Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS), Positron Emission Tomography (PET Scans), Computerized Axial Tomography (CT Scans), Computerized Axial Tomography Angiogram (CTA Scans), Single Photon Emission Computed Tomography (SPECT Scans), QCT Bone Densitometry, PET/CT Fusion scans, Diagnostic CT Colonography, and nuclear cardiology; (v) professional services for test interpretation, X-ray reading, lab interpretation, and scan reading; (vi) diagnostic Sleep Testing; (vii) tests ordered before a surgery or Admission; (viii) BRCA and fetal screening; (ix) genetic testing and counseling is Covered when Medically Necessary.

Hospice means a coordinated program of home and inpatient care provided directly or under the direction of a licensed Hospice. We cover palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal Illness, whose medical prognosis is death within six months, provided by a medically directed

interdisciplinary team.

Rehabilitative and Habilitative Services: including: (i) Physical therapy (PT); (ii) occupational therapy (OT); (iii) speech therapy (ST); (iv) cardiac rehabilitation; (v) pulmonary rehabilitation; (vi) chiropractic/Osteopathic Manipulation therapy.

Other Therapy Services including: (i) Radiation Therapy is treatment of an Illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration, treatment planning, and certain other Covered Services; (ii) Respiratory Therapy includes the use of dry or moist gases in the lungs, Non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; bronco pulmonary drainage and breathing exercises; (iii) Chemotherapy includes treatment of an Illness by chemical or biological antineoplastic agents. The criteria for establishing cost sharing applicable to orally administered cancer chemotherapy drugs and cancer chemotherapy drugs that are administered intravenously or by injection will be consistently applied within the same plan; (iv) IV Infusion Therapy includes nursing, durable medical equipment and drug services that are delivered and administered to you through an IV. Also includes Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See also INFUSION SERVICES; (v) Vascular rehabilitation; (vi)Vestibular rehabilitation.

Home Health Care Skilled Services: services provided by an organization licensed by the State and operating within the scope of its license when such services provide for the care and treatment of a homebound Member in his or her home under a treatment plan established and approved in writing by his/her ordering Physician, as required for the proper treatment of the Injury or Illness, in place of inpatient treatment in a Hospital or Skilled Nursing Facility.

Home Private Duty Nurse Services: services of a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in the home when the RN or LPN is not a relative or family member.

Specific MH/SUD Benefits to Which Prior Authorization Applies

Pre-authorization is required for services defined in the plan documents as covered outpatient services including: partial hospitalization, intensive outpatient therapy, electro-convulsive therapy, Applied Behavior Analysis, Transcranial Magnetic Stimulation. Partial/intensive

outpatient services, partial hospitalization, and Diagnostic and Laboratory Services and Testing are specified in the EOC.

Applied Behavior Analysis: design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Partial Day/Intensive Outpatient Services: Services include an approved outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive, and multi-disciplinary treatment. Programs will provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. This also includes intensive outpatient programs for the treatment of mental health & substance use disorders which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

Partial Hospitalization: licensed or approved outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of mental health disorders or alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

There are a number of ways Sentara identifies which services are subject to prior authorization for clinical review. Specifically:

Plan Documents:

The HMO and PPO plan documents state the following:
"Some Covered Services under this Plan require Pre-Authorization to be Covered. Please read the entire section on Pre-Authorization in the EOC."

Defines Pre-Authorization as "an evaluation process which assesses the medical necessity of proposed treatment and checks to see that the treatment is being provided at the appropriate level of care."

Describes preauthorization and states: "On Your Schedule of Benefits, We tell You what services require pre-authorization before You receive them. You can also look in the What is Covered Section of this document or call Member Services to find out about Pre-Authorization."

Describes generally the types of services which require preauthorization, including: Inpatient hospitalization services; Partial hospitalization services; Residential treatment services; Non-emergency ambulance transport; Inpatient and outpatient surgery; Surgery in a physician's office; Single items of durable medical equipment and orthopedic and prosthetic appliances over [$750]; Rental of durable medical equipment and orthopedic and prosthetic appliances; Repair and replacement items of durable medical equipment and orthopedic and prosthetic appliances; Artificial prosthetic limbs; Prenatal maternity services (excluding recommended preventive care services, screenings, and one breast pump per pregnancy); Home health care; Skilled Nursing Facility care; Physical, occupational, and speech therapy; Cardiac, pulmonary, and vascular rehabilitation; IV therapy with medications; Inhalation therapy; Early intervention services; Clinical trials for treatment studies on cancer; Hospice services; Oral surgery; TMJ services; Tubal ligation; Hospitalization and anesthesia for dental procedures; Treatment of lymphedema; Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiography (MRA); Positron Emission Tomography (PET) scans; Computerized Axial Tomography (CT) scans; Computerized Axial Tomography Angiogram (CTA) scans; Sleep studies; transplant services; Injectable and infused medications, biologics, and IV therapy medications defined by Our Pharmacy Committee; Intensive outpatient programs (IOP); Medical, psychological and neuro psychological diagnostic procedures and testing; Electro-convulsive therapy (ECT); Telemedicine service; Transcranial Magnetic Stimulation (TMS); Insulin pumps and insulin pump infusion sets and supplies; Chemotherapy and Chemotherapy Drugs; Radiation Therapy; Dialysis Services; Genetic Testing and Counseling. If Your plan includes any riders generally those services will require Pre-Authorization listed in the rider.

Define Covered Services and designate those which require prior authorization. These Services and others are then further defined.

Schedule of Benefits

States "Some benefits require Pre-Authorization before You receive them. These services ae marked with an * in this document."

The Schedules of Benefits designate the following service types as requiring preauthorization: outpatient therapies and services; outpatient dialysis; outpatient surgery; outpatient lab, diagnostic, imaging, and testing; outpatient advanced imaging, testing and scans; injectable and infused medications; maternity care; inpatient M/S services including inpatient hospital services, transplants, skilled nursing facility services; non-emergency transport; inpatient MH/SUD services including hospital services, residential treatment services, partial hospitalization, intensive outpatient program services, transcranial magnetic stimulation, electro-convulsive therapy, autism spectrum disorder, other outpatient services; diabetes treatment including insulin pumps, pump infusion sets and supplies, talking blood glucose meters, insulin, and needles and syringes for injection; prosthetic devices and components, repair, fitting, replacement and adjustment; durable medical equipment for items over $750, repair, replacement, and rental items; wigs following cancer treatment; early invention services including speech and language therapy, occupational therapy, physical therapy, assistance technology services and devices; home health care; private duty nursing; hospice care; reconstructive breast surgery for members

who have had a mastectomy; infertility services including endometrial biopsies, semen analysis, hysterosalpingography, Sims-Huhner test, diagnostic laparoscopy; clinical trial services; allergy testing and serum; telemedicine services[2]; chiropractic services; hearing aids and related services for children 18 and younger

Provider Manual

The Provider Manual states:

"Except in the case of emergency treatment, prior authorization will be required for: all inpatient hospitalizations, all partial hospitalizations (mental health or substance abuse), all outpatient surgeries/short stays/observations and IV therapy and drug infusions, all skilled nursing facility admissions, all acute rehabilitation, all intensive outpatient programs, all out-of-area services or referrals to nonparticipating providers (prior to scheduling) for members that do not have out-of-network benefits included in their plan. All the following services require prior authorization regardless of the place of service: Commercial plan DME single purchased items greater than $750 and all rentals, orthotics/prosthetics, single purchased items greater than $750 and all rentals, repair, replacement, and duplicates, home health, hospice, IV infusions, plastic surgery, all rehabilitation programs (cardiac, vascular, vestibular, pulmonary, etc.), therapies (PT, OT, ST), applied behavioral analysis, early intervention services (part H certificate required), OB global notification, transplant services, human and synthetic tissue, oral surgery and related services, advanced imaging studies (PET, CT, CTA, MRI, MRA, MR-CT), sleep studies, hyperbaric therapy, electronic bone stimulator, any surgical or diagnostic procedure for which anesthesiology or conscious sedation is billed, injectable drugs indicated on the online prior-authorization forms, genetic testing (if covered by group/plan), bone densitometry if less than 24 months since last study."

Prior Authorization List: (accessible at http://pal.sentarahealthplans.com/)

Tool allows anyone to access and search for procedure code or description to determination whether prior authorization is required.

Procedure and Revenue Codes:

As previously stated, all inpatient services require prior authorization.

Certain services such as PT, OT, and ST, can be used for both MH/SUD and M/S conditions. Specific to these therapies, Sentara ensures MHPAEA compliance through benefit structure. Currently, no numerical visit limitations are placed on PT, OT, and ST for MH/SUD, unlike the annual visit limits for M/S. For other services such as non-emergency transport, Sentara does not preauthorize services strictly by diagnosis. If a medical necessity review is required for the service, it will include all pertinent clinical information required to make a determination based on the appropriate necessity criteria used whether that be internal medical policies or MCG (which incorporate ASAM). For example, Sentara tracks transportation authorizations but does

[2] Please note that the Schedule of Benefits language will be revised, as prior authorization is not required for telemedicine services.

not track whether authorization for non-emergency transportation was reviewed for an underlying M/S or MH/SUD condition.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See 45 CFR 146.137(c)(2). Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:
  (A) A detailed description of the factor;
  (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
  (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Sentara uses the following factors to determine the basis for requiring prior authorization for certain services:

- Industry standards in conformance with Centers for Medicare & Medicaid Services (CMS), Department of Medical Assistance Services (DMAS), Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and Milliman Care Guidelines (which incorporate American Society for Addiction Medicine (ASAM) Criteria)

- Excessive (high volume) variability in utilization. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization.

- High-Cost/High variability in cost. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization.

Weight of Factors

Industry standards in conformance with an internal utilization management determinations hierarchy determine which services are subject to prior authorization. Specifically, Sentara has implemented a policy outlining a determinations hierarchy for commercial utilization management decisions which is used for reviewing and processing requests for authorization. Specifically, the following hierarchy is used: Federal Regulations; State Regulations; Sentara Medical Policies; MCG CareWeb ("MCG"); and review of association guidelines, specialty and subspeciality associations, and peer reviewed literature.

Sentara follows first the industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine which services are subject to prior authorization. As described in detail in the response to the Medical Necessity NQTL, Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed. The development of MCG or internal policies renders a service subject to prior authorization. There is little to no variation in the industry as to the services which require prior authorization. As described below in Step 3, Sentara does analyze and trend utilization review data and make determinations based upon that data. In operation, these trends impact M/S services more directly than MH/SUD because utilization of M/S outpatient services is greater, and more M/S outpatient services require prior authorization. Sentara utilizes this trending and benchmarking data but does not have any policy that defines when that data requires a change to prior authorization status.

Step 3: Description of how factors are used in the design and application of the NQTL.

See 45 CFR 146.137(c)(3). Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the

NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].

- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

- Industry standards in conformance with CMS, DMAS, LCDs, NCDs, and Milliman Care Guidelines (which incorporate ASAM): Sentara follows first industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine which services are subject to prior authorization. Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed (see Sentara's Medical Necessity NQTL Analysis). The development of MCG or internal policies renders a service subject to prior authorization. There is little to no variation in the industry as to the services which require prior authorization.

- Excessive (high volume)/variability in utilization: excessive utilization is measured by a number of metrics including authorization volume; denial volume, denial rates; days or admissions/100; average length of stay; observation days/1000, outpatient surgeries/1000, outpatient visits/1000. Trend analysis is considered, which includes: annualized cases/1,000; % change in annualized cases/1,000; annualized units/1,000; % change in annualized units; and Cost/Case for prior period and current period. Examples of these metrics are found in Commercial and Exchange Utilization Management Annual Evaluations and Trend Analysis Reports. Sentara also tracks utilization by authorization volume by CPT Code. Sentara is not aware of utilization rates as a factor for determining whether MH/SUD services require prior authorization. While utilization is tracked and trend analysis exists, utilization has not factored into any known decision to require prior authorization for any MH/SUD services.

- High-cost/High variability in cost: Sentara tracks allowed Per Member/Per Month ("PMPM") Data for outpatient categories of service. These PMPM are then benchmarked for comparison. Sentara is not aware of high cost or variability in cost as a factor for determining whether MH/SUD services require prior authorization. While utilization benchmarking exists, cost variability or high cost has not factored into any known decision to require prior authorization for any MH/SUD services.

Factors like utilization and cost, while tracked, trended and reviewed as compared to benchmarks, in operation, are not factors for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization.

The Prior Authorization List, available on Sentara's website, identifies all services subject to prior authorization. These services are subject to clinical review, and notification and non-clinical review are not implicated. These services identified on the PAL are not categorized by classification or subclassification. As noted, all inpatient services require preauthorization. The factors related to the services identified in the PAL are identified above.

Medical Policy Committee

The Medical Policy Committee makes determinations concerning which services are subject to preauthorization. The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties.

One objective of the MPC is to recommend, review, and approve authorization requirements for Health Plan services through collaboration with the Integrated Benefits Management Team ("IBMT") to ensure codes are configured in compliance with federal and state regulations and medical policies. The IBMT is a multi-department team that ensures decisions rendered by the MPC can be implemented operationally with any changes in configuration and coding. The UM Program Plan is reviewed and revised as necessary, but at least annually. The UM Program evaluation is conducted by the Clinical Care Services Vice-President, the UM Director, and the Commercial Lead Medical Director. The UM Program review is completed within 120 days of the fiscal year end (March 30). The workplan is presented and approved by the SHP Quality Improvement Committee. All changes to the UM Program are finalized by the MPC.

The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties. Specifically, voting members for recommendations of coverage decisions consist of the following: Health Plan Medical Directors, including the Behavioral Health Medical Directors, the Chief Medical Officer, VPs CCS (or proxy), and Director of Pharmacy (or designee) (for pharmaceutical items).

VPs CCS means the Vice President(s) of Clinical Care Services or his or her proxy for voting purposes on the MPC. VP Pharmacy means the Vice President of Pharmacy or his or her designee for pharmaceutical items.

The Medical Policy is comprised of 28 individuals with varying clinical or other specialties. Of the members of the Medical Policy Committee, 9 are considered MH/SUD experts and 13 are considered M/S experts in various specialties.

Step 4: Demonstration of comparability and stringency as written.

See 45 CFR 146.137(c)(4). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Regarding the factors, definitions, evidentiary standards, sources, and strategies described in Step Two and Step Three, Sentara provides the following information:

Documentation of Each Factor Identified and Defined in Step Two:

The following factors are implicated in determining whether Prior Authorization applies to certain services:

Service	Factors

All outpatient, M/S services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, M/S services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, MH/SUD services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria
All outpatient, MH/SUD services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria

Comparison of Existing Written Documents:

All plan terms and Sentara policies regarding utilization management, including prior authorization, are equally designed and applied to M/S and MH/SUD services with no variations.

The Authorization Process is defined in the Provider Manual and Sentara prior authorization policies. As it pertains to prior authorization, the MPC requires prior authorization for any service for which clinical criteria is established by MCG (inclusive of ASAM) and/or any internal clinical policy.

There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

How Factors Are Comparably Applied:

Sentara applies applicable industry standards (MCG for M/S and ASAM for MH/SUD) equally to all services in the respective classifications. Industry standards are applied without discretion, regardless of whether the particular service is M/S or MH/SUD. For services (either M/S or MH/SUD) for which there is no applicable industry standard, the Sentara MPC evaluates and reviews the requested service.

Reasons for Any Deviations or Variations:

There are no variations or deviations in the design or application of prior authorization between M/S and MH/SUD benefits.

Clinical Review Processes:

Members are notified of preauthorization requirements in the plan documents.

The Provider Manual notifies providers that prior authorization requests can be submitted through the Provider Portal or via facsimile. Prior authorization for urgent requests may be submitted by phone. Sentara follows federal and state regulations, including 45 CFR § 147.136, 29 CFR §

2560.503-1, § 38.2-305, § 38.2-3570, § 38.2-5803, 14VAC5-216-30, as well as the National Committee for Quality Assurance Guidelines for Timeliness of UM decisions. Requests for elective admissions must be submitted for prior authorization 14 days prior to scheduling an admission or procedure. Treatment by nonparticipating providers must receive prior authorization from Sentara in the same time frame as above. The requesting provider should receive an authorization for services within 14 days if all the necessary clinical information is provided with the initial authorization request and the service is covered under the member's benefit plan. Lack of clinical information to support authorization approval will delay processing. Urgent cases will be completed within 72 hours.

The utilization review process is initiated upon a request for prior authorization. The request for prior authorization is first reviewed by a clinician that could be a registered nurse, licensed practical nurse, clinical pharmacist, clinical psychologist, or Board certified Medical and Behavioral Health Physicians (Medical Directors). If a request for prior authorization results in any determination except an authorization for the service requested, the request for authorization is then reviewed by a Medical Director, who is a Board-certified physician. Only Medical Directors issue adverse benefit determinations. If that adverse benefit determination ultimately is appealed, the appeal review will be conducted by a Medical Director with a specialization in that area that did not participate in the adverse benefit determination.

There is a level of review between nurse review and peer-to-peer review where a physician reviews the submission without initiating a phone call with the treating provider. If the initial clinician review (which includes "Registered Nurses, Licensed Practical Nurses, Clinical Pharmacists, Clinical Psychologists, and Board certified Medical and Behavioral Health Physicians (Medical Directors)) in response to a request for prior authorization results in any determination except an authorization for the service requested, the request for authorization is then reviewed by a Medical Director. Nurses cannot render medical necessity denials or negotiate lower levels of care than what was requested by the treating provider. Only Medical Directors issue adverse benefit determinations. Individual consideration may be given when a plan provider initiates a referral for a covered service or to a provider outside of the network. If the Medical Director issues an adverse benefit determination, the provider has the option of requesting a peer review. Only medical directors can render medical necessity denials for both M/S an MH/SUD benefits. Medical Directors, both medical and behavioral health, are senior-level physicians or doctoral-level behavioral health practitioners who implement, provide supervision and oversight, and evaluate the UM program through their participation in authorization reviews, UM Committees, special UM projects, medical policy reviews, and the UM Program evaluation. Behavioral health physicians or doctoral-level behavioral healthcare practitioners additionally provide oversight and evaluation of the behavioral aspects of the UM program.

For commercial lines of business, when no internal medical policies exist for any MH or M/S service, MCG is utilized without incorporation or supplementation of any internal guidelines or policies. The MCG incorporate the ASAM criteria, which Sentara utilizes exclusively for substance use disorder services. Sentara does not deny a request for authorization simply because there are no established clinical criteria for the requested service. Any delegation of a request for authorization to the Medical Policy Committee is confined to a service for which there are no clinical guidelines (internal or MCG). The requested service then becomes subject to a technology

assessment. It is considered part of the review at the request for authorization step. To the extent it is a considered a separate step, it applies consistently for M/S and MH/SUD requested services.

If an authorization request results in an adverse determination, providers or members have 180 days from notice of an adverse benefit determination to ask for an appeal. When Sentara reviews an appeal, Sentara looks at all comments, documents, records, and other information submitted to Sentara. Appeals involving medical necessity will be reviewed by a clinical peer reviewer who did not participate in the first coverage decision. When Sentara completes the appeal, Sentara will send written notification of the decision. If Sentara Health Plans doesn't change the initial decision the notice will include: 1. The specific reason for the decision; 2. The specific plan provisions Sentara Health Plans based the decision on; and 3. Information on any independent external appeal rights. In general, the internal appeal process must be exhausted prior to filing an independent external appeal. An exception exists for the treatment of cancer.

If an authorization request results in an adverse determination, the requesting provider may request a physician peer discussion. The treating physician will be given the opportunity to discuss the request with the reviewing medical director of the Plan if he or she disagrees with the determination. Sentara allows one peer discussion per denial and does not consider a peer review to be part of the appeal process.

A provider may also request a reconsideration of an adverse benefit determination on a member's behalf. A request for reconsideration is optional, and available only to a treating health care provider. A provider or member may file an appeal regardless of whether a provider requests a reconsideration. Sentara will decide on a reconsideration and notify the provider and the member in writing within ten (10) working days of the date of receipt of the request. A determination on reconsideration is made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor or peer of the treating provider on the panel. If Sentara denies the reconsideration request, the notice will include the criteria used and the clinical reason for the adverse benefit determination, the alternate length of treatment of any alternate recommendation, and appeal rights.

Peer to peer is initiated by the provider following an adverse benefit determination when the provider requests peer to peer review within five (5) business days from the date of notification of the denial. Peer to peer review does not automatically take place and remains at the discretion of the provider and does not count as an appeal. Medical directors do have discretion to contact the requesting/treating provider to request additional clinical information if necessary to render a decision. Sentara tracks peer to peer reviews. Sentara does not currently track whether peer to peer services are initiated by a provider or by a Medical Director. These peer to peer rates did not result in disparity in the denial rates. See Step 5 for more information. Sentara does not use consultations with third-party experts during the internal review process.

Case Management:

Healthcare service teams (case management services) are comprised of clinical professional staff, behavioral health clinicians, and nonclinical staff. These teams are integrated around populations of members in specified managed care products. This allows for a complete plan of care for the

patient encompassing case management, behavioral health, and disease management services. Types of issues which may be referred to healthcare services:

- members with complex medical issues who utilize multiple services
- members who are nonadherent with treatment plans
- members who frequently utilize services without consulting PCP or specialist • members who frequently utilize the ER
- members who could benefit from disease management of heart failure, metabolic cardiovascular disease, asthma, COPD, or obesity
- neonatal care for premature and medically complex newborns (partnership with ProgenyHealth)

Requests for services (written or verbal) may be initiated by:

- provider
- member
- Sentara

A member's participation in case management services is optional and cost-sharing is not impacted.

Case management is a not a NQTL and does not impact prior authorization or coverage determinations. Sentara confirms that a decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time.

Case management is provided by a licensed Registered Nurse (RN) or Masters in Social Worker (MSW). Case managers work with hospital review teams and primary care physicians to assist with coordination and transition of care, and community resources. Case managers do not have the ability to "override" a treating physician's recommended course of treatment or deny any request for authorization. Only Medical Directors can issue adverse benefit determinations.

As explained above, any decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time. Further, case managers cannot overturn treatment recommendation or issue adverse benefit determinations. Case management is optional and designed for care coordination. Activities are aimed at improving member health through risk reduction and minimizing complications through education.

Examples of levels of care to which case management applies include severe behavioral health risk or chronic condition with co-morbidities (medical or behavioral). Sentara's case management

policy complies with the most current NCQA standards. CCS Leadership (Director and VP) review the policy annually, which mirrors NCQA accreditation requirements. The policy is reviewed and approved by the overarching SHP Policy and Procedure Committee.

Tracking of Denials:

Sentara tracks turnaround times and reports all claim denials and closed internal and external appeals and complaints. Claim denials are tracked for the following codes, which include that the services were not medically necessary and services not preauthorized:

Code	Claim Denial Reasons
1	Does not meet step therapy protocol
2	Exceeds benefit limits (contractual)
3	Experimental/Investigational
4	Inappropriate level of care/inappropriate place of service/inappropriate treatment for condition or circumstance
5	Individual ineligible/not insured when the services were provided
6	Not a covered benefit/service contractually excluded
7	Not Medically Necessary
8	Provider not participating with the individual's plan
9	Provider/Facility not a covered provider/facility type for this service
10	Services not preauthorized/Referral not obtained
11	Exceeds deadline for timely filing - member responsible
12	COB - plan is secondary
13	Provider billed incorrectly
14	Incomplete information filed
15	PCP not selected
16	Amount exceeds UCR/Allowable Charge
17	Rejected - Drug Utilization Review
18	Prescription refill too soon

For appeals, Sentara tracks whether the denials were upheld, partially upheld or overturned in closed internal appeals and closed external reviews.

Sentara follows NCQA mandates regarding the tracking of approvals and denials. If a requested service (level of care) is requested and denied, it is tracked as a denial, even if a lower level of care was authorized. This is accurate for both M/S and MH/SUD services.

For authorization requests, Sentara tracks authorization volume by decision, including approvals, denials, and partial denials. Sentara also tracks the denial rate by episode type (i.e., inpatient M/S, inpatient MH/SUD, outpatient M/S, and outpatient MH/SUD).

Sentara follows a standard process for administrative denials. Specifically, Sentara processes administrative denials in the following circumstances: (i) services are not a covered member benefit or (ii) member is not eligible under the Plan. This policy applies to both M/S and MH/SUD services. As shown in the data included herewith, administrative denials are subject to appeals but such denials and appeals are tracked separately for denials and appeals related to medical necessity.

Tracking of Prior Authorization versus Concurrent Review

Prior authorization is tracked separately from concurrent authorizations.

Sentara uses the terms “concurrent review” and “concurrent service authorization” synonymously. Concurrent review is conducted within 72 hours of receiving the request provided that Sentara receives the request at least 24 hours prior to expiration of the previously approved time period or number of treatments. If the prior authorization has expired, the request is treated as a new request for prior authorization.

Extent of Medical Records Required

Sentara may request medical records for review. Listed below are the current medical record standards:

- Comprehensive history and physical, including the history of present illness and relevant psychiatric history
- Documentation of allergies and adverse reactions to medications
- Problem list
- Medications management and reconciliation
- Clinical findings and evaluations documented for each visit
- Preventive services and risk screenings
- Diagnoses, including documentation for behavioral health
- Substance use assessment
- Mental status examination
- Treatment planning
- Evidence of continuity of care

The standards above apply equally to M/S and MH/SUD.

Appeal Rights

The timeframes to review appeals are compliant with NCQA standards and identical for M/S and MH/SUD appeal of authorization denials. Providers and members have 180 days from notice of an adverse benefits determination to request an appeal. For pre-service appeals, Sentara must respond within 30 days. Following one level of internal appeal, a request for an external appeal is available.

External review appeal rights apply to both M/S and MH/SUD benefits. There is no difference in application of an external review. A member or provider can appeal any decision (whether M/S or MH/SUD) regardless of whether the member accepts and receives a lower level of care.

In the context of the internal appeal process, any denial or reduction of benefits and/or nonpayment based upon a determination of medical necessity is treated as an Adverse Benefit Determination and subject to the appeal process outlined in the plans. Written notice of Adverse

Benefit Determinations is required except for Urgent Claims, where notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notice of an Adverse Benefit Determination includes the following:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.

Any member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination. For denials due to Medical Necessity, members are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances.

After notification of an Adverse Benefit Determination, a member has 180 days to request an appeal. Upon appeal, all comments, documents, records, and other information submitted is reviewed. Additional information may be provided. The clinical peer reviewer reviewing the appeal will not have participated in the original coverage decision. Should a member disagree with the Final Benefit Determination, an external appeal is available.

Vendor Involvement

Information related to Sentara's UM vendors is below. Notably, no vendor relationship exists for utilization management for MH/SUD services. Further, Sentara reviews and adjudicates all appeals for all M/S and MH/SUD services.

A third-party vendor ("UM Vendor 1") conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a master services agreement. UM Vendor 2 is URAC and NCQA accredited. UM Vendor 2 provides access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a vendor services agreement.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. The clinical guidelines are available at https://www1.radmd.com/all-health-plans/sentara-health-plans. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Separate Operating Departments or Divisions

There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Urgent Care Requests

Urgent request/expedited review is appropriate when application of time frame for making routine or non-life threatening care determinations that:

- Could seriously jeopardize the life or health of the member or the members ability to regain maximum function, or
- Could seriously jeopardize the life, health or safety of the member or others due to the members psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested.

One factor of the definition of urgent requests contemplates: "In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested." That opinion is not questioned in terms of the 72 hour review time for the request. Said another way, Sentara does not question the urgency requested for the 72 hour review time if presented by a treating physician.

An urgent request is not different than an expedited review. An expedited review is defined in the Provider Manual as "a request for medical care or services where application of time frame for making routine or non-life threatening care determinations that:

• Could seriously jeopardize the life or health of the member or the members ability to regain maximum function, or

• Could seriously jeopardize the life, health or safety of the member or others due to the members psychological state, or

• In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested.

Sentara utilizes the same process for urgent requests for M/S and MH/SUD benefit.

Step 5: Demonstration of comparability and stringency in operation.

See **45 CFR 146.137(c)(5).** The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits

and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Data:

The data provided herein is for Virginia fully-insured plans in 2023 and 2024. Specifically, the following products were analyzed:

Sentara Direct M Silver 6600 Ded, Sentara Direct M Bronze 7200 Ded, Sentara Direct Vantage Silver 4000 Ded 250 Rx Ded, Sentara Direct Vantage Gold 2000 Ded, BAE Systems - POS 200/15/20% LG 2017, UVA Consortium - VANT EQUIT 3200/10% LG, Sentara Direct Plus Gold 2000 Ded, Sentara Direct Plus Gold 500 Ded 200 Rx Ded, Hampton Roads Transit EQUITY PLUS 3500/10% LG, UVA Consortium PLUS EQUITY 3200/10% LG

Sentara will supplement this analysis with 2025 data when it becomes available.

UM Program Audits:

Sentara audits monthly its utilization management processes. Sentara audit its monthly and quarterly utilization report that includes for example:

o Days/1000, Admissions/1000

o Average length of stay (ALOS)

o Observation days/1000

o Readmission rate for both medical and behavioral health services

o Outpatient surgeries/1000

o Outpatient visits/1000

o Milliman Benchmarking

o High-Dollar claims

o Complex medical conditions

o Authorizations provided to non-participating providers

Sentara conducts an annual evaluation, which includes an evaluation of vendors performing utilization management services for Sentara.

In addition, Sentara conducts an annual evaluation of its utilization management program, which also includes an evaluation of vendors performing utilization management services for Sentara.

Sentara follows NCQA mandates regarding the tracking of approvals and denials. If a requested service (level of care) is requested and denied, it is tracked as a denial, even if a lower level of care was authorized. This is accurate for both M/S and MH/SUD services.

For authorization requests, Sentara tracks authorization volume by decision, including approvals, denials, and partial denials. For example:

- 2023: 58,786 requests for authorization; 54,841 approvals; 3,970 denials; and 119 partial denials. Of these authorization requests, 328 (306 approved) were for outpatient behavioral health services and 53,197 (49,626 approved) were for outpatient M/S services. See UM Exhibit.

- 2024: 76,871 requests for authorization; 68,618 approvals; 8,409 denials; and 176 partial denials. Of these requests for authorization, 496 (462 approved) were for outpatient behavioral health services and 69,079 (61,484 approved) were for outpatient M/S services. See UM Exhibit.

Sentara also tracks the denial rate by episode type:

- 2023: grand total denial rate 6.95%; 7.99% inpatient M/S; 6.3% inpatient behavioral health; 6.87% outpatient M/S; 6.71% outpatient behavioral health

- 2024: grand total denial rate 11.16%; 10.06% inpatient M/S; 6.28% inpatient behavioral health; 11.34% outpatient M/S; 6.85% outpatient behavioral health

In Summary, as it relates to outpatient services:

2023 Analysis

Total Auths: 58,786

- M/S OP: 53,197
    - Approved: 49,626
    - Denied: 3,537
        - Administrative denial, lack of member eligibility: 302
        - Administrative denial, mandated paperwork not provided: 1
        - Administrative denial, non-covered service: 495
        - Administrative denial, benefit exhausted: 9
        - Denied, member coverage: 2
        - Denied, non-participating provider: 116
        - Denied, not a covered benefit: 51
        - Denied, not medically necessary: 2412
        - Denied on appeal: 3
        - Denied peer to peer: 25
    - Partial denial: 118
    - MD referral rate: 3.4%
    - Denial rate: 6.87%

- MH/SUD OP: 328
    - Approved: 306
    - Denied: 21

        - Administrative denial, non-covered service: 11
        - Administrative denial, lack of member eligibility: 4
        - Denied, non-participating provider: 6
    - Partial denial: 1
    - MD referral rate: 14.6%
    - Denial rate: 6.71%

2024 Analysis

Total Auths: 76,871

- M/S OP: 69,079
    - Approved: 61.484
    - Denied: 7,666
        - Administrative denial, lack of member eligibility: 304
        - Administrative denial, mandated paperwork not provided: 3
        - Administrative denial, non-covered service: 390
        - Administrative denial, benefit exhausted:
        - Denied, member coverage: 2
        - Denied, non-participating provider: 160
        - Denied, not a covered benefit: 58
        - Denied, not medically necessary: 1187
        - Denied, on appeal: 2
        - Denied, peer to peer: 22
    - Partial denial: 174
    - MD referral rate: 3.1%
    - Denial rate: 11.34%

- MH/SUD OP: 496
    - Approved: 462
    - Denied: 32
        - Administrative denial, non-covered service: 19
        - Administrative denial, lack of member eligibility: 8
        - Denied, non-participating provider: 2
        - Denied, not medically necessary: 3
    - Partial denial: 2
    - MD referral rate: 21.2%
    - Denial rate: 6.85%

Appeals Data:

2023: Current Appeals Data is included herewith in the UM Exhibit.

2024: Current Appeals Data is included herewith in the UM Exhibit.

For outpatient services, the authorization volume by review can be reported as follows:

2023: Outpatient MH/SUD

328 Requests for Authorization: 212 Non-urgent preservice; 111 expedited; 5 post-service.

2023: Outpatient M/S

53,197 Requests for Authorization: 39,106 Nonurgent Preservice; 9861 Urgent Preservice; 3,987 Post-service; and 473 standard.

2024: Outpatient MH/SUD

496 Requests for Authorization: 211 Expedited; 196 Non-urgent preservice; 72 Non-Urgent preservice 12 standard

2024: Outpatient M/S

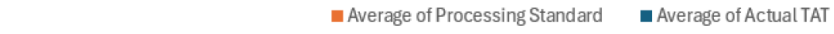
69,072 Requests for Authorization: 43,513 Non-urgent preservice; 15,682 Non-urgent preservice; 5,414 Urgent Preservice; 2,982 Post-service.

UM Exhibit.

Turnaround Times: Data concerning turnaround times is discussed extensively in the Commercial and Exchange Utilization Management Annual Evaluations. As a snapshot for outpatient services from 2024 annual evaluation:

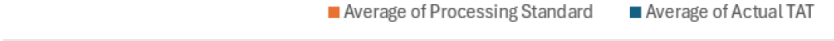
2024 Outpatient MH/SUD NCQA Performance:

	Expedited	Nonurgent Pre-Service	Post Service	Urgent Concurrent: 72 hours
	Days	Days	Days	Days
Average of Processing Standard	3	15	30	3
Average of Actual TAT	1.1	2.4	10.8	0.1



2024 Outpatient M/S NCQA Performance:

	Expedited	Nonurgent Pre-Service	Post Service	Urgent Concurrent: 24 hours	Urgent Pre-Service
	Days	Days	Days	Days	Days
Average of Processing Standard	3	15	30	1	3
Average of Actual TAT	0.7	5.0	8.5	1.0	0.4



No denials occurred for MH or SUD services for any commercial plan in 2024.

Sentara collected authorization data as requested for 2023 and 2024 to determine if denials were disproportionate for MH/SUD outpatient services as compared to M/S outpatient services.

In 2023, for outpatient services, there were a total of 55,525 requests for authorizations. Of these requests for authorization, 53,197 were for outpatient M/S services and 328 were for MH/SUD outpatient services. As for outpatient M/S services, 49,626 were approved and 3,537 were denied. The denial rate was 6.87% for M/S services. Of the 3,537 denials, 2,537 were denied for medical necessity or 71.72%. As it relates to MH/SUD outpatient services, 306 were approved and 21 were denied. The denial rate was 6.71%, slightly lower than the denial rate for M/S outpatient services. Of the 21 denials, 1 was partially denied and none were denied for medical necessity, representing 0%. With this data, Sentara does not see disparity in the application of its utilization management program, as the denial rate is below that for M/S services. Insight into the reasons for denial of requests for outpatient services support this conclusion, as not one of the 21 denials for MH/SUD were for medical necessity, as compared to 71.72% for M/S.

Similar trends occurred in 2024, for outpatient services, there were a total of 69,575 requests for authorizations. Of these authorizations, 69,079 were for outpatient M/S services and 496 were for MH/SUD services. As for outpatient M/S services, 61,484 were approved and 7,666 were denied. The denial rate was 11.34% for M/S services. As it relates to MH/SUD outpatient services, 462 were approved and 32 were denied. The denial rate was 6.85%, substantially lower than the denial rate for M/S outpatient services. Of the 32 denials, 3 were denied for medical necessity. With this data, Sentara does not see disparity in the application of its utilization management program, as the denial rate is well below that for M/S services. Insight into the reasons for denial support this conclusion, as only 7.9% of the denials for MH/SUD were for medical necessity.

Physician review – In analyzing physician review, Sentara's main objective was to determine if the MH/SUD physician reviewers were applying discretion in a way that was more stringent or arbitrary than how M/S physicians applied discretion and to determine if they were adhering to criteria in a fashion that was no more stringent than M/S physicians' adherence to criteria. Sentara further studied MD (Medical Director) referral rates and discovered that percentages of requests for authorizations referred for Medical Director review are significantly higher in MH/SUD outpatient services. In 2023, 3.4% of M/S outpatient requests for authorization were referred to MD review, as compared to 14.6% of MH/SUD outpatient requests for authorization. In 2024, 3.1% of M/S outpatient requests for authorizations were referred to MD Review as compared to 21.2% for MH/SUD outpatient services. Given that only a fraction of the denials for MH/SUD services were denied for medical necessity, MD referrals appear to be a positive review protocol and physician review is not causing any disparate impact.

In reviewing peer-to-peer review data, the objectives were largely the same. While significantly more M/S outpatient services are subject to peer review than MH/SUD

outpatient services, the denial rates are much lower for MH/SUD outpatient services. With such few instances of peer-to-peer review, 1 total in 2023, it is difficult to determine any trends, however, denial rates indicate that utilization review is not being more stringently applied to MH/SUD outpatient services.

Appeal data further confirms that no disparity exists as to utilization review. In 2023, for MH/SUD services, 7appeals occurred throughout the commercial line of business and none of the 7 appeals were medical necessity appeals. In 2024, there were 5 appeals for MH/SUD services and only 1 appeal concerned medical necessity.

Sentara further compared TAT and noticed an area of improvement. The TAT for MH/SUD outpatient services, while still better than the NCQA standard, was 1.1 days for expedited review, as compared to 0.7 days for M/S.

Step 6: Findings and conclusions.

See **45 CFR 146.137(c)(6).** The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the

design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the FAQ 45 guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara provided a definition of Preauthorization NQTL and identified the outpatient services subject to preauthorization, referencing the documents which specify those services, including the Prior Authorization List. For Step 1, Sentara provided information as to all vendors that provide utilization review services and produced the contractual documents related to those services. Sentara provided the factors and sources considered when requiring certain outpatient services be subject to preauthorization. Sentara noted that for MH/SUD outpatient services, the applicable factor is industry standards, including CMS, DMAS, LCDs, NCDs, and Milliman Clinical Guidelines. Sentara provided data including, but not limited to, authorization and denials, authorization by priority, MD referral rates, peer-to-peer reviews, audit results and appeals. Sentara completed the comparative analysis, set forth in Step Four above.

The analysis establishes Sentara is compliant with MHPAEA.

This analysis was completed in September 2026 by the following Sentara Departments: Utilization Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

PRIOR AUTHORIZATION: OUTPATIENT, OUT-OF-NETWORK

(NO PRIOR AUTHORIZATION IS REQUIRED FOR OFFICE VISITS)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See **45 CFR 146.137(c)(1).** Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also **FAQ 45** (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

Clinical Review: Sentara defines the clinical review form of prior authorization as a medical necessity review that takes place prior to a service being performed. This is the only form of

preauthorization[1] Sentara uses. Thus, the remainder of this analysis will focus solely on the clinical review form of preauthorization.

There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Notification: Some carriers require notification from the provider to the carrier, and clinical review is not performed for coverage approval. Sentara does not use this form of preauthorization.

Non-Clinical Review: Some carriers require requests for coverage that are reviewed and approved by non-clinical personnel according to predetermined criteria, which is also referred to by multiple carriers as "fast certification." Sentara does not use this form of preauthorization.

Additionally, there is no prior authorization/medical necessity review for office visits by any staff, clinical or non-clinical. This includes any office visit, whether M/S or MH/SUD. Preauthorization is required, however, for surgical procedures when surgeries are performed in-office.

Vendor Involvement

A third-party vendor ("UM Vendor 1") conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate third-party vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a services agreement. UM Vendor 2 is URAC and NCQA accredited. Under the services agreement provides, UM Vendor 2 providers access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a services agreement.

[1] Preauthorization and prior authorization are used interchangeably throughout.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Specific Medical/Surgical Benefits to Which NQTL Applies

Pre-authorization is required for services defined in the commercial plan documents as other covered outpatient services, including: surgery, testing procedures, advanced imaging (MRI, MRA, PET, CT, etc.), hospice, rehabilitative and habilitative services, other therapy services, and home health care.

Surgery: surgical services on an outpatient or office basis. Covered Services include: (i) accepted surgical and cutting procedures; (ii) procedures to correct congenital abnormalities that cause functional impairment, newborn congenital abnormalities or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery; (iii) invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of the brain or spine; (iv) endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy; (v) treatment of fractures and dislocations; (vi) pre-operative and post-operative care; (vii) hypodermic needles, syringes, surgical dressings, splints and other surgical supplies; (viii) physician, nursing, and other support services; (ix) services and anesthesia provided by an anesthesiologist when Medically Necessary and appropriate for your condition; (x) blood and blood products and administration.

Outpatient Advanced Imaging including (i) diagnostic Radiology including X-rays, mammograms, ultrasound, doppler studies, or nuclear medicine; (ii) diagnostic Lab and pathology services or tests; (iii) diagnostic Hearing and Vision tests; (iv) diagnostic Electrocardiograms (EKGs), electroencephalograms (EEGs) and Echocardiograms; (iv) Advanced Diagnostic Imaging procedures including Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS), Positron Emission Tomography (PET Scans), Computerized Axial Tomography (CT Scans), Computerized Axial Tomography Angiogram (CTA Scans), Single Photon Emission Computed Tomography (SPECT Scans), QCT Bone Densitometry, PET/CT Fusion scans, Diagnostic CT Colonography, and nuclear cardiology; (v) professional services for test interpretation, X-ray reading, lab interpretation, and scan reading; (vi) diagnostic Sleep Testing; (vii) tests ordered before a surgery or Admission; (viii) BRCA and fetal screening; (ix) genetic testing and counseling is Covered when Medically Necessary.

Hospice means a coordinated program of home and inpatient care provided directly or under the direction of a licensed Hospice. We cover palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal Illness, whose medical prognosis is death within six months, provided by a medically directed

interdisciplinary team.

Rehabilitative and Habilitative Services: including: (i) Physical therapy (PT); (ii) occupational therapy (OT); (iii) speech therapy (ST); (iv) cardiac rehabilitation; (v) pulmonary rehabilitation; (vi) chiropractic/Osteopathic Manipulation therapy.

Other Therapy Services including: (i) Radiation Therapy is treatment of an Illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy, brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration, treatment planning, and certain other Covered Services; (ii) Respiratory Therapy includes the use of dry or moist gases in the lungs, Non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; bronco pulmonary drainage and breathing exercises; (iii) Chemotherapy includes treatment of an Illness by chemical or biological antineoplastic agents. The criteria for establishing cost sharing applicable to orally administered cancer chemotherapy drugs and cancer chemotherapy drugs that are administered intravenously or by injection will be consistently applied within the same plan; (iv) IV Infusion Therapy includes nursing, durable medical equipment and drug services that are delivered and administered to you through an IV. Also includes Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See also INFUSION SERVICES; (v) Vascular rehabilitation; (vi)Vestibular rehabilitation.

Home Health Care Skilled Services: services provided by an organization licensed by the State and operating within the scope of its license when such services provide for the care and treatment of a homebound Member in his or her home under a treatment plan established and approved in writing by his/her ordering Physician, as required for the proper treatment of the Injury or Illness, in place of inpatient treatment in a Hospital or Skilled Nursing Facility.

Home Private Duty Nurse Services: services of a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in the home when the RN or LPN is not a relative or family member.

Specific MH/SUD Benefits to Which Prior Authorization Applies

Pre-authorization is required for services defined in the plan documents as covered outpatient services including: partial hospitalization, intensive outpatient therapy, electro-convulsive therapy, Applied Behavior Analysis, Transcranial Magnetic Stimulation. Partial/intensive

outpatient services, partial hospitalization, and Diagnostic and Laboratory Services and Testing are specified in the EOC.

Applied Behavior Analysis: design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Partial Day/Intensive Outpatient Services: Services include an approved outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive, and multi-disciplinary treatment. Programs will provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. This also includes intensive outpatient programs for the treatment of mental health & substance use disorders which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

Partial Hospitalization: licensed or approved outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of mental health disorders or alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

There are a number of ways Sentara identifies which services are subject to prior authorization for clinical review. Specifically:

Plan Documents:

The HMO and PPO plan documents state the following:
"Some Covered Services under this Plan require Pre-Authorization to be Covered. Please read the entire section on Pre-Authorization in the EOC."

Defines Pre-Authorization as "an evaluation process which assesses the medical necessity of proposed treatment and checks to see that the treatment is being provided at the appropriate level of care."

Describes preauthorization and states: "On Your Schedule of Benefits, We tell You what services require pre-authorization before You receive them. You can also look in the What is Covered Section of this document or call Member Services to find out about Pre-Authorization."

Describes generally the types of services which require preauthorization, including: Inpatient hospitalization services; Partial hospitalization services; Residential treatment services; Non-emergency ambulance transport; Inpatient and outpatient surgery; Surgery in a physician's office; Single items of durable medical equipment and orthopedic and prosthetic appliances over [$750]; Rental of durable medical equipment and orthopedic and prosthetic appliances; Repair and replacement items of durable medical equipment and orthopedic and prosthetic appliances; Artificial prosthetic limbs; Prenatal maternity services (excluding recommended preventive care services, screenings, and one breast pump per pregnancy); Home health care; Skilled Nursing Facility care; Physical, occupational, and speech therapy; Cardiac, pulmonary, and vascular rehabilitation; IV therapy with medications; Inhalation therapy; Early intervention services; Clinical trials for treatment studies on cancer; Hospice services; Oral surgery; TMJ services; Tubal ligation; Hospitalization and anesthesia for dental procedures; Treatment of lymphedema; Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiography (MRA); Positron Emission Tomography (PET) scans; Computerized Axial Tomography (CT) scans; Computerized Axial Tomography Angiogram (CTA) scans; Sleep studies; transplant services; Injectable and infused medications, biologics, and IV therapy medications defined by Our Pharmacy Committee; Intensive outpatient programs (IOP); Medical, psychological and neuro psychological diagnostic procedures and testing; Electro-convulsive therapy (ECT); Telemedicine service; Transcranial Magnetic Stimulation (TMS); Insulin pumps and insulin pump infusion sets and supplies; Chemotherapy and Chemotherapy Drugs; Radiation Therapy; Dialysis Services; Genetic Testing and Counseling. If Your plan includes any riders generally those services will require Pre-Authorization listed in the rider.

Define Covered Services and designate those which require prior authorization. These Services and others are then further defined.

Schedule of Benefits

States "Some benefits require Pre-Authorization before You receive them. These services ae marked with an * in this document."

The Schedules of Benefits designate the following service types as requiring preauthorization: outpatient therapies and services; outpatient dialysis; outpatient surgery; outpatient lab, diagnostic, imaging, and testing; outpatient advanced imaging, testing and scans; injectable and infused medications; maternity care; inpatient M/S services including inpatient hospital services, transplants, skilled nursing facility services; non-emergency transport; inpatient MH/SUD services including hospital services, residential treatment services, partial hospitalization, intensive outpatient program services, transcranial magnetic stimulation, electro-convulsive therapy, autism spectrum disorder, other outpatient services; diabetes treatment including insulin pumps, pump infusion sets and supplies, talking blood glucose meters, insulin, and needles and syringes for injection; prosthetic devices and components, repair, fitting, replacement and adjustment; durable medical equipment for items over $750, repair, replacement, and rental items; wigs following cancer treatment; early invention services including speech and language therapy, occupational therapy, physical therapy, assistance technology services and devices; home health care; private duty nursing; hospice care; reconstructive breast surgery for members

who have had a mastectomy; infertility services including endometrial biopsies, semen analysis, hysterosalpingography, Sims-Huhner test, diagnostic laparoscopy; clinical trial services; allergy testing and serum; telemedicine services[2]; chiropractic services; hearing aids and related services for children 18 and younger

Provider Manual

The Provider Manual states:

"Except in the case of emergency treatment, prior authorization will be required for: all inpatient hospitalizations, all partial hospitalizations (mental health or substance abuse), all outpatient surgeries/short stays/observations and IV therapy and drug infusions, all skilled nursing facility admissions, all acute rehabilitation, all intensive outpatient programs, all out-of-area services or referrals to nonparticipating providers (prior to scheduling) for members that do not have out-of-network benefits included in their plan. All the following services require prior authorization regardless of the place of service: Commercial plan DME single purchased items greater than $750 and all rentals, orthotics/prosthetics, single purchased items greater than $750 and all rentals, repair, replacement, and duplicates, home health, hospice, IV infusions, plastic surgery, all rehabilitation programs (cardiac, vascular, vestibular, pulmonary, etc.), therapies (PT, OT, ST), applied behavioral analysis, early intervention services (part H certificate required), OB global notification, transplant services, human and synthetic tissue, oral surgery and related services, advanced imaging studies (PET, CT, CTA, MRI, MRA, MR-CT), sleep studies, hyperbaric therapy, electronic bone stimulator, any surgical or diagnostic procedure for which anesthesiology or conscious sedation is billed, injectable drugs indicated on the online prior-authorization forms, genetic testing (if covered by group/plan), bone densitometry if less than 24 months since last study."

Prior Authorization List: (accessible at http://pal.sentarahealthplans.com/)

Tool allows anyone to access and search for procedure code or description to determination whether prior authorization is required.

Procedure and Revenue Codes:

As previously stated, all inpatient services require prior authorization.

Certain services such as PT, OT, and ST, can be used for both MH/SUD and M/S conditions. Specific to these therapies, Sentara ensures MHPAEA compliance through benefit structure. Currently, no numerical visit limitations are placed on PT, OT, and ST for MH/SUD, unlike the annual visit limits for M/S. For other services such as non-emergency transport, Sentara does not preauthorize services strictly by diagnosis. If a medical necessity review is required for the service, it will include all pertinent clinical information required to make a determination based on the appropriate necessity criteria used whether that be internal medical policies or MCG (which incorporate ASAM). For example, Sentara tracks transportation authorizations but does

[2] Please note that the Schedule of Benefits language will be revised, as prior authorization is not required for telemedicine services.

not track whether authorization for non-emergency transportation was reviewed for an underlying M/S or MH/SUD condition.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See **45 CFR 146.137(c)(2).** Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:
  (A) A detailed description of the factor;
  (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
  (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also **FAQ 45** guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Sentara uses the following factors to determine the basis for requiring prior authorization for certain services:

- Industry standards in conformance with Centers for Medicare & Medicaid Services (CMS), Department of Medical Assistance Services (DMAS), Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and Milliman Care Guidelines (which incorporate American Society for Addiction Medicine (ASAM) Criteria)

- Excessive (high volume) variability in utilization. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization.

- High-Cost/High variability in cost. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization.

Weight of Factors

Industry standards in conformance with an internal utilization management determinations hierarchy determine which services are subject to prior authorization. Specifically, Sentara has implemented a policy outlining a determinations hierarchy for commercial utilization management decisions which is used for reviewing and processing requests for authorization. Specifically, the following hierarchy is used: Federal Regulations; State Regulations; Sentara Medical Policies; MCG CareWeb ("MCG"); and review of association guidelines, specialty and subspeciality associations, and peer reviewed literature.

Sentara follows first the industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine which services are subject to prior authorization. As described in detail in the response to the Medical Necessity NQTL, Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed. The development of MCG or internal policies renders a service subject to prior authorization. There is little to no variation in the industry as to the services which require prior authorization. As described below in Step 3, Sentara does analyze and trend utilization review data and make determinations based upon that data. In operation, these trends impact M/S services more directly than MH/SUD because utilization of M/S outpatient services is greater, and more M/S outpatient services require prior authorization. Sentara utilizes this trending and benchmarking data but does not have any policy that defines when that data requires a change to prior authorization status.

Step 3: Description of how factors are used in the design and application of the NQTL.

See 45 CFR 146.137(c)(3). Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the

NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].

- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

- Industry standards in conformance with CMS, DMAS, LCDs, NCDs, and Milliman Care Guidelines (which incorporate ASAM): Sentara follows first industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine which services are subject to prior authorization. Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed (see Sentara's Medical Necessity NQTL Analysis). The development of MCG or internal policies renders a service subject to prior authorization. There is little to no variation in the industry as to the services which require prior authorization.

- Excessive (high volume)/variability in utilization: excessive utilization is measured by a number of metrics including authorization volume; denial volume, denial rates; days or admissions/100; average length of stay; observation days/1000, outpatient surgeries/1000, outpatient visits/1000. Trend analysis is considered, which includes: annualized cases/1,000; % change in annualized cases/1,000; annualized units/1,000; % change in annualized units; and Cost/Case for prior period and current period. Examples of these metrics are found in Commercial and Exchange Utilization Management Annual Evaluations and Trend Analysis Reports. Sentara also tracks utilization by authorization volume by CPT Code. Sentara is not aware of utilization rates as a factor for determining whether MH/SUD services require prior authorization. While utilization is tracked and trend analysis exists, utilization has not factored into any known decision to require prior authorization for any MH/SUD services.

- High-cost/High variability in cost: Sentara tracks allowed Per Member/Per Month ("PMPM") Data for outpatient categories of service. These PMPM are then benchmarked for comparison. Sentara is not aware of high cost or variability in cost as a factor for determining whether MH/SUD services require prior authorization. While utilization benchmarking exists, cost variability or high cost has not factored into any known decision to require prior authorization for any MH/SUD services.

Factors like utilization and cost, while tracked, trended and reviewed as compared to benchmarks, in operation, are not factors for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization.

The Prior Authorization List, available on Sentara's website, identifies all services subject to prior authorization. These services are subject to clinical review, and notification and non-clinical review are not implicated. These services identified on the PAL are not categorized by classification or subclassification. As noted, all inpatient services require preauthorization. The factors related to the services identified in the PAL are identified above.

Medical Policy Committee

The Medical Policy Committee makes determinations concerning which services are subject to preauthorization. The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties.

One objective of the MPC is to recommend, review, and approve authorization requirements for Health Plan services through collaboration with the Integrated Benefits Management Team ("IBMT") to ensure codes are configured in compliance with federal and state regulations and medical policies. The IBMT is a multi-department team that ensures decisions rendered by the MPC can be implemented operationally with any changes in configuration and coding. The UM Program Plan is reviewed and revised as necessary, but at least annually. The UM Program evaluation is conducted by the Clinical Care Services Vice-President, the UM Director, and the Commercial Lead Medical Director. The UM Program review is completed within 120 days of the fiscal year end (March 30). The workplan is presented and approved by the SHP Quality Improvement Committee. All changes to the UM Program are finalized by the MPC.

The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties. Specifically, voting members for recommendations of coverage decisions consist of the following: Health Plan Medical Directors, including the Behavioral Health Medical Directors, the Chief Medical Officer, VPs CCS (or proxy), and Director of Pharmacy (or designee) (for pharmaceutical items).

VPs CCS means the Vice President(s) of Clinical Care Services or his or her proxy for voting purposes on the MPC. VP Pharmacy means the Vice President of Pharmacy or his or her designee for pharmaceutical items.

The Medical Policy is comprised of 28 individuals with varying clinical or other specialties. Of the members of the Medical Policy Committee, 9 are considered MH/SUD experts and 13 are considered M/S experts in various specialties.

Step 4: Demonstration of comparability and stringency as written.

See 45 CFR 146.137(c)(4). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Regarding the factors, definitions, evidentiary standards, sources, and strategies described in Step Two and Step Three, Sentara provides the following information:

Documentation of Each Factor Identified and Defined in Step Two:

The following factors are implicated in determining whether Prior Authorization applies to certain services:

Service	Factors

All outpatient, M/S services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, M/S services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, MH/SUD services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria
All outpatient, MH/SUD services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria

Comparison of Existing Written Documents:

All plan terms and Sentara policies regarding utilization management, including prior authorization, are equally designed and applied to M/S and MH/SUD services with no variations.

The Authorization Process is defined in the Provider Manual and Sentara prior authorization policies. As it pertains to prior authorization, the MPC requires prior authorization for any service for which clinical criteria is established by MCG (inclusive of ASAM) and/or any internal clinical policy.

There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

How Factors Are Comparably Applied:

Sentara applies applicable industry standards (MCG for M/S and ASAM for MH/SUD) equally to all services in the respective classifications. Industry standards are applied without discretion, regardless of whether the particular service is M/S or MH/SUD. For services (either M/S or MH/SUD) for which there is no applicable industry standard, the Sentara MPC evaluates and reviews the requested service.

Reasons for Any Deviations or Variations:

There are no variations or deviations in the design or application of prior authorization between M/S and MH/SUD benefits.

Clinical Review Processes:

Members are notified of preauthorization requirements in the plan documents.

The Provider Manual notifies providers that prior authorization requests can be submitted through the Provider Portal or via facsimile. Prior authorization for urgent requests may be submitted by phone. Sentara follows federal and state regulations, including 45 CFR § 147.136, 29 CFR §

2560.503-1, § 38.2-305, § 38.2-3570, § 38.2-5803, 14VAC5-216-30, as well as the National Committee for Quality Assurance Guidelines for Timeliness of UM decisions. Requests for elective admissions must be submitted for prior authorization 14 days prior to scheduling an admission or procedure. Treatment by nonparticipating providers must receive prior authorization from Sentara in the same time frame as above. The requesting provider should receive an authorization for services within 14 days if all the necessary clinical information is provided with the initial authorization request and the service is covered under the member's benefit plan. Lack of clinical information to support authorization approval will delay processing. Urgent cases will be completed within 72 hours.

The utilization review process is initiated upon a request for prior authorization. The request for prior authorization is first reviewed by a clinician that could be a registered nurse, licensed practical nurse, clinical pharmacist, clinical psychologist, or Board certified Medical and Behavioral Health Physicians (Medical Directors). If a request for prior authorization results in any determination except an authorization for the service requested, the request for authorization is then reviewed by a Medical Director, who is a Board-certified physician. Only Medical Directors issue adverse benefit determinations. If that adverse benefit determination ultimately is appealed, the appeal review will be conducted by a Medical Director with a specialization in that area that did not participate in the adverse benefit determination.

There is a level of review between nurse review and peer-to-peer review where a physician reviews the submission without initiating a phone call with the treating provider. If the initial clinician review (which includes "Registered Nurses, Licensed Practical Nurses, Clinical Pharmacists, Clinical Psychologists, and Board certified Medical and Behavioral Health Physicians (Medical Directors)) in response to a request for prior authorization results in any determination except an authorization for the service requested, the request for authorization is then reviewed by a Medical Director. Nurses cannot render medical necessity denials or negotiate lower levels of care than what was requested by the treating provider. Only Medical Directors issue adverse benefit determinations. Individual consideration may be given when a plan provider initiates a referral for a covered service or to a provider outside of the network. If the Medical Director issues an adverse benefit determination, the provider has the option of requesting a peer review. Only medical directors can render medical necessity denials for both M/S an MH/SUD benefits. Medical Directors, both medical and behavioral health, are senior-level physicians or doctoral-level behavioral health practitioners who implement, provide supervision and oversight, and evaluate the UM program through their participation in authorization reviews, UM Committees, special UM projects, medical policy reviews, and the UM Program evaluation. Behavioral health physicians or doctoral-level behavioral healthcare practitioners additionally provide oversight and evaluation of the behavioral aspects of the UM program.

For commercial lines of business, when no internal medical policies exist for any MH or M/S service, MCG is utilized without incorporation or supplementation of any internal guidelines or policies. The MCG incorporate the ASAM criteria, which Sentara utilizes exclusively for substance use disorder services. Sentara does not deny a request for authorization simply because there are no established clinical criteria for the requested service. Any delegation of a request for authorization to the Medical Policy Committee is confined to a service for which there are no clinical guidelines (internal or MCG). The requested service then becomes subject to a technology

assessment. It is considered part of the review at the request for authorization step. To the extent it is a considered a separate step, it applies consistently for M/S and MH/SUD requested services.

If an authorization request results in an adverse determination, providers or members have 180 days from notice of an adverse benefit determination to ask for an appeal. When Sentara reviews an appeal, Sentara looks at all comments, documents, records, and other information submitted to Sentara. Appeals involving medical necessity will be reviewed by a clinical peer reviewer who did not participate in the first coverage decision. When Sentara completes the appeal, Sentara will send written notification of the decision. If Sentara Health Plans doesn't change the initial decision the notice will include: 1. The specific reason for the decision; 2. The specific plan provisions Sentara Health Plans based the decision on; and 3. Information on any independent external appeal rights. In general, the internal appeal process must be exhausted prior to filing an independent external appeal. An exception exists for the treatment of cancer.

If an authorization request results in an adverse determination, the requesting provider may request a physician peer discussion. The treating physician will be given the opportunity to discuss the request with the reviewing medical director of the Plan if he or she disagrees with the determination. Sentara allows one peer discussion per denial and does not consider a peer review to be part of the appeal process.

A provider may also request a reconsideration of an adverse benefit determination on a member's behalf. A request for reconsideration is optional, and available only to a treating health care provider. A provider or member may file an appeal regardless of whether a provider requests a reconsideration. Sentara will decide on a reconsideration and notify the provider and the member in writing within ten (10) working days of the date of receipt of the request. A determination on reconsideration is made by a physician advisor, peer of the treating health care provider, or a panel of other appropriate health care providers with at least one physician advisor or peer of the treating provider on the panel. If Sentara denies the reconsideration request, the notice will include the criteria used and the clinical reason for the adverse benefit determination, the alternate length of treatment of any alternate recommendation, and appeal rights.

Peer to peer is initiated by the provider following an adverse benefit determination when the provider requests peer to peer review within five (5) business days from the date of notification of the denial. Peer to peer review does not automatically take place and remains at the discretion of the provider and does not count as an appeal. Medical directors do have discretion to contact the requesting/treating provider to request additional clinical information if necessary to render a decision. Sentara tracks peer to peer reviews. Sentara does not currently track whether peer to peer services are initiated by a provider or by a Medical Director. These peer to peer rates did not result in disparity in the denial rates. See Step 5 for more information. Sentara does not use consultations with third-party experts during the internal review process.

Case Management:

Healthcare service teams (case management services) are comprised of clinical professional staff, behavioral health clinicians, and nonclinical staff. These teams are integrated around populations of members in specified managed care products. This allows for a complete plan of care for the

patient encompassing case management, behavioral health, and disease management services. Types of issues which may be referred to healthcare services:

- members with complex medical issues who utilize multiple services
- members who are nonadherent with treatment plans
- members who frequently utilize services without consulting PCP or specialist • members who frequently utilize the ER
- members who could benefit from disease management of heart failure, metabolic cardiovascular disease, asthma, COPD, or obesity
- neonatal care for premature and medically complex newborns (partnership with ProgenyHealth)

Requests for services (written or verbal) may be initiated by:

- provider
- member
- Sentara

A member's participation in case management services is optional and cost-sharing is not impacted.

Case management is a not a NQTL and does not impact prior authorization or coverage determinations. Sentara confirms that a decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time.

Case management is provided by a licensed Registered Nurse (RN) or Masters in Social Worker (MSW). Case managers work with hospital review teams and primary care physicians to assist with coordination and transition of care, and community resources. Case managers do not have the ability to "override" a treating physician's recommended course of treatment or deny any request for authorization. Only Medical Directors can issue adverse benefit determinations.

As explained above, any decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time. Further, case managers cannot overturn treatment recommendation or issue adverse benefit determinations. Case management is optional and designed for care coordination. Activities are aimed at improving member health through risk reduction and minimizing complications through education.

Examples of levels of care to which case management applies include severe behavioral health risk or chronic condition with co-morbidities (medical or behavioral). Sentara's case management

policy complies with the most current NCQA standards. CCS Leadership (Director and VP) review the policy annually, which mirrors NCQA accreditation requirements. The policy is reviewed and approved by the overarching SHP Policy and Procedure Committee.

Tracking of Denials:

Sentara tracks turnaround times and reports all claim denials and closed internal and external appeals and complaints. Claim denials are tracked for the following codes, which include that the services were not medically necessary and services not preauthorized:

Code	Claim Denial Reasons
1	Does not meet step therapy protocol
2	Exceeds benefit limits (contractual)
3	Experimental/Investigational
4	Inappropriate level of care/inappropriate place of service/inappropriate treatment for condition or circumstance
5	Individual ineligible/not insured when the services were provided
6	Not a covered benefit/service contractually excluded
7	Not Medically Necessary
8	Provider not participating with the individual's plan
9	Provider/Facility not a covered provider/facility type for this service
10	Services not preauthorized/Referral not obtained
11	Exceeds deadline for timely filing - member responsible
12	COB - plan is secondary
13	Provider billed incorrectly
14	Incomplete information filed
15	PCP not selected
16	Amount exceeds UCR/Allowable Charge
17	Rejected - Drug Utilization Review
18	Prescription refill too soon

For appeals, Sentara tracks whether the denials were upheld, partially upheld or overturned in closed internal appeals and closed external reviews.

Sentara follows NCQA mandates regarding the tracking of approvals and denials. If a requested service (level of care) is requested and denied, it is tracked as a denial, even if a lower level of care was authorized. This is accurate for both M/S and MH/SUD services.

For authorization requests, Sentara tracks authorization volume by decision, including approvals, denials, and partial denials. Sentara also tracks the denial rate by episode type (i.e., inpatient M/S, inpatient MH/SUD, outpatient M/S, and outpatient MH/SUD).

Sentara follows a standard process for administrative denials. Specifically, Sentara processes administrative denials in the following circumstances: (i) services are not a covered member benefit or (ii) member is not eligible under the Plan. This policy applies to both M/S and MH/SUD services. As shown in the data included herewith, administrative denials are subject to appeals but such denials and appeals are tracked separately for denials and appeals related to medical necessity.

Tracking of Prior Authorization versus Concurrent Review

Prior authorization is tracked separately from concurrent authorizations.

Sentara uses the terms “concurrent review” and “concurrent service authorization” synonymously. Concurrent review is conducted within 72 hours of receiving the request provided that Sentara receives the request at least 24 hours prior to expiration of the previously approved time period or number of treatments. If the prior authorization has expired, the request is treated as a new request for prior authorization.

Extent of Medical Records Required

Sentara may request medical records for review. Listed below are the current medical record standards:

- Comprehensive history and physical, including the history of present illness and relevant psychiatric history
- Documentation of allergies and adverse reactions to medications
- Problem list
- Medications management and reconciliation
- Clinical findings and evaluations documented for each visit
- Preventive services and risk screenings
- Diagnoses, including documentation for behavioral health
- Substance use assessment
- Mental status examination
- Treatment planning
- Evidence of continuity of care

The standards above apply equally to M/S and MH/SUD.

Appeal Rights

The timeframes to review appeals are compliant with NCQA standards and identical for M/S and MH/SUD appeal of authorization denials. Providers and members have 180 days from notice of an adverse benefits determination to request an appeal. For pre-service appeals, Sentara must respond within 30 days. Following one level of internal appeal, a request for an external appeal is available.

External review appeal rights apply to both M/S and MH/SUD benefits. There is no difference in application of an external review. A member or provider can appeal any decision (whether M/S or MH/SUD) regardless of whether the member accepts and receives a lower level of care.

In the context of the internal appeal process, any denial or reduction of benefits and/or nonpayment based upon a determination of medical necessity is treated as an Adverse Benefit Determination and subject to the appeal process outlined in the plans. Written notice of Adverse Benefit Determinations is required except for Urgent Claims, where notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notice of an Adverse Benefit Determination includes the following:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.

Any member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination. For denials due to Medical Necessity, members are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances.

After notification of an Adverse Benefit Determination, a member has 180 days to request an appeal. Upon appeal, all comments, documents, records, and other information submitted is reviewed. Additional information may be provided. The clinical peer reviewer reviewing the appeal will not have participated in the original coverage decision. Should a member disagree with the Final Benefit Determination, an external appeal is available.

Vendor Involvement

Information related to Sentara's UM vendors is below. Notably, no vendor relationship exists for utilization management for MH/SUD services. Further, Sentara reviews and adjudicates all appeals for all M/S and MH/SUD services.

A third-party vendor ("UM Vendor 1") conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a master services agreement. UM Vendor 2 is URAC and NCQA accredited. UM Vendor 2 provides access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a vendor services agreement.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. The clinical guidelines are available at https://www1.radmd.com/all-health-plans/sentara-health-plans. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Separate Operating Departments or Divisions

There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Urgent Care Requests

Urgent request/expedited review is appropriate when application of time frame for making routine or non-life threatening care determinations that:

- Could seriously jeopardize the life or health of the member or the members ability to regain maximum function, or
- Could seriously jeopardize the life, health or safety of the member or others due to the members psychological state, or
- In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested.

One factor of the definition of urgent requests contemplates: "In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested." That opinion is not questioned in terms of the 72 hour review time for the request. Said another way, Sentara does not question the urgency requested for the 72 hour review time if presented by a treating physician.

An urgent request is not different than an expedited review. An expedited review is defined in the Provider Manual as "a request for medical care or services where application of time frame for making routine or non-life threatening care determinations that:

- Could seriously jeopardize the life or health of the member or the members ability to regain maximum function, or
- Could seriously jeopardize the life, health or safety of the member or others due to the members psychological state, or

• In the opinion of a practitioner with knowledge of the member's medical or behavioral condition, would subject the member to adverse health consequences without the care or treatment requested.

Sentara utilizes the same process for urgent requests for M/S and MH/SUD benefit.

Step 5: Demonstration of comparability and stringency in operation.

See **45 CFR 146.137(c)(5).** The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional

safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Data:

The data provided herein is for Virginia fully-insured plans in 2023 and 2024. Specifically, the following products were analyzed:

Sentara Direct M Silver 6600 Ded, Sentara Direct M Bronze 7200 Ded, Sentara Direct Vantage Silver 4000 Ded 250 Rx Ded, Sentara Direct Vantage Gold 2000 Ded, BAE Systems - POS 200/15/20% LG 2017, UVA Consortium - VANT EQUIT 3200/10% LG, Sentara Direct Plus Gold 2000 Ded, Sentara Direct Plus Gold 500 Ded 200 Rx Ded, Hampton Roads Transit EQUITY PLUS 3500/10% LG, UVA Consortium PLUS EQUITY 3200/10% LG

Sentara will supplement this analysis with 2025 data when it becomes available.

UM Program Audits:

Sentara audits monthly its utilization management processes. Sentara audit its monthly and quarterly utilization report that includes for example:

o Days/1000, Admissions/1000

o Average length of stay (ALOS)

o Observation days/1000

o Readmission rate for both medical and behavioral health services

o Outpatient surgeries/1000

o Outpatient visits/1000

o Milliman Benchmarking

o High-Dollar claims

o Complex medical conditions

o Authorizations provided to non-participating providers

Sentara conducts an annual evaluation, which includes an evaluation of vendors performing utilization management services for Sentara.

In addition, Sentara conducts an annual evaluation of its utilization management program, which also includes an evaluation of vendors performing utilization management services for Sentara.

Sentara follows NCQA mandates regarding the tracking of approvals and denials. If a requested service (level of care) is requested and denied, it is tracked as a denial, even if a lower level of care was authorized. This is accurate for both M/S and MH/SUD services.

For authorization requests, Sentara tracks authorization volume by decision, including approvals, denials, and partial denials. For example:

- 2023: 58,786 requests for authorization; 54,841 approvals; 3,970 denials; and 119 partial denials. Of these authorization requests, 328 (306 approved) were for outpatient behavioral health services and 53,197 (49,626 approved) were for outpatient M/S services. See UM Exhibit.

- 2024: 76,871 requests for authorization; 68,618 approvals; 8,409 denials; and 176 partial denials. Of these requests for authorization, 496 (462 approved) were for outpatient behavioral health services and 69,079 (61,484 approved) were for outpatient M/S services. See UM Exhibit.

Sentara also tracks the denial rate by episode type:

- 2023: grand total denial rate 6.95%; 7.99% inpatient M/S; 6.3% inpatient behavioral health; 6.87% outpatient M/S; 6.71% outpatient behavioral health

- 2024: grand total denial rate 11.16%; 10.06% inpatient M/S; 6.28% inpatient behavioral health; 11.34% outpatient M/S; 6.85% outpatient behavioral health

In Summary, as it relates to outpatient services:

2023 Analysis

Total Auths: 58,786

- M/S OP: 53,197
    - Approved: 49,626
    - Denied: 3,537
        - Administrative denial, lack of member eligibility: 302
        - Administrative denial, mandated paperwork not provided: 1
        - Administrative denial, non-covered service: 495
        - Administrative denial, benefit exhausted: 9
        - Denied, member coverage: 2
        - Denied, non-participating provider: 116
        - Denied, not a covered benefit: 51
        - Denied, not medically necessary: 2412
        - Denied on appeal: 3
        - Denied peer to peer: 25
    - Partial denial: 118
    - MD referral rate: 3.4%
    - Denial rate: 6.87%

- MH/SUD OP: 328
    - Approved: 306
    - Denied: 21

        - Administrative denial, non-covered service: 11
        - Administrative denial, lack of member eligibility: 4
        - Denied, non-participating provider: 6
    - Partial denial: 1
    - MD referral rate: 14.6%
    - Denial rate: 6.71%

2024 Analysis

Total Auths: 76,871

- M/S OP: 69,079
    - Approved: 61.484
    - Denied: 7,666
        - Administrative denial, lack of member eligibility: 304
        - Administrative denial, mandated paperwork not provided: 3
        - Administrative denial, non-covered service: 390
        - Administrative denial, benefit exhausted:
        - Denied, member coverage: 2
        - Denied, non-participating provider: 160
        - Denied, not a covered benefit: 58
        - Denied, not medically necessary: 1187
        - Denied, on appeal: 2
        - Denied, peer to peer: 22
    - Partial denial: 174
    - MD referral rate: 3.1%
    - Denial rate: 11.34%

- MH/SUD OP: 496
    - Approved: 462
    - Denied: 32
        - Administrative denial, non-covered service: 19
        - Administrative denial, lack of member eligibility: 8
        - Denied, non-participating provider: 2
        - Denied, not medically necessary: 3
    - Partial denial: 2
    - MD referral rate: 21.2%
    - Denial rate: 6.85%

Appeals Data:

2023: Current Appeals Data is included herewith in the UM Exhibit.

2024: Current Appeals Data is included herewith in the UM Exhibit.

For outpatient services, the authorization volume by review can be reported as follows:

2023: Outpatient MH/SUD

328 Requests for Authorization: 212 Non-urgent preservice; 111 expedited; 5 post-service.

2023: Outpatient M/S

53,197 Requests for Authorization: 39,106 Nonurgent Preservice; 9861 Urgent Preservice; 3,987 Post-service; and 473 standard.

2024: Outpatient MH/SUD

496 Requests for Authorization: 211 Expedited; 196 Non-urgent preservice; 72 Non-Urgent preservice 12 standard

2024: Outpatient M/S

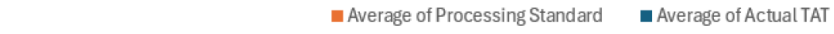
69,072 Requests for Authorization: 43,513 Non-urgent preservice; 15,682 Non-urgent preservice; 5,414 Urgent Preservice; 2,982 Post-service.

UM Exhibit.

Turnaround Times: Data concerning turnaround times is discussed extensively in the Commercial and Exchange Utilization Management Annual Evaluations. As a snapshot for outpatient services from 2024 annual evaluation:

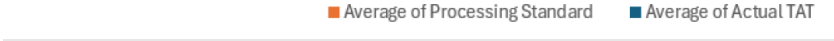
2024 Outpatient MH/SUD NCQA Performance:

	Expedited	Nonurgent Pre-Service	Post Service	Urgent Concurrent: 72 hours
	Days	Days	Days	Days
Average of Processing Standard	3	15	30	3
Average of Actual TAT	1.1	2.4	10.8	0.1



2024 Outpatient M/S NCQA Performance:

	Expedited	Nonurgent Pre-Service	Post Service	Urgent Concurrent: 24 hours	Urgent Pre-Service
	Days	Days	Days	Days	Days
Average of Processing Standard	3	15	30	1	3
Average of Actual TAT	0.7	5.0	8.5	1.0	0.4



No denials occurred for MH or SUD services for any commercial plan in 2024.

Sentara collected authorization data as requested for 2023 and 2024 to determine if denials were disproportionate for MH/SUD outpatient services as compared to M/S outpatient services.

In 2023, for outpatient services, there were a total of 55,525 requests for authorizations. Of these requests for authorization, 53,197 were for outpatient M/S services and 328 were for MH/SUD outpatient services. As for outpatient M/S services, 49,626 were approved and 3,537 were denied. The denial rate was 6.87% for M/S services. Of the 3,537 denials, 2,537 were denied for medical necessity or 71.72%. As it relates to MH/SUD outpatient services, 306 were approved and 21 were denied. The denial rate was 6.71%, slightly lower than the denial rate for M/S outpatient services. Of the 21 denials, 1 was partially denied and none were denied for medical necessity, representing 0%. With this data, Sentara does not see disparity in the application of its utilization management program, as the denial rate is below that for M/S services. Insight into the reasons for denial of requests for outpatient services support this conclusion, as not one of the 21 denials for MH/SUD were for medical necessity, as compared to 71.72% for M/S.

Similar trends occurred in 2024, for outpatient services, there were a total of 69,575 requests for authorizations. Of these authorizations, 69,079 were for outpatient M/S services and 496 were for MH/SUD services. As for outpatient M/S services, 61,484 were approved and 7,666 were denied. The denial rate was 11.34% for M/S services. As it relates to MH/SUD outpatient services, 462 were approved and 32 were denied. The denial rate was 6.85%, substantially lower than the denial rate for M/S outpatient services. Of the 32 denials, 3 were denied for medical necessity. With this data, Sentara does not see disparity in the application of its utilization management program, as the denial rate is well below that for M/S services. Insight into the reasons for denial support this conclusion, as only 7.9% of the denials for MH/SUD were for medical necessity.

Physician review – In analyzing physician review, Sentara's main objective was to determine if the MH/SUD physician reviewers were applying discretion in a way that was more stringent or arbitrary than how M/S physicians applied discretion and to determine if they were adhering to criteria in a fashion that was no more stringent than M/S physicians' adherence to criteria. Sentara further studied MD (Medical Director) referral rates and discovered that percentages of requests for authorizations referred for Medical Director review are significantly higher in MH/SUD outpatient services. In 2023, 3.4% of M/S outpatient requests for authorization were referred to MD review, as compared to 14.6% of MH/SUD outpatient requests for authorization. In 2024, 3.1% of M/S outpatient requests for authorizations were referred to MD Review as compared to 21.2% for MH/SUD outpatient services. Given that only a fraction of the denials for MH/SUD services were denied for medical necessity, MD referrals appear to be a positive review protocol and physician review is not causing any disparate impact.

In reviewing peer-to-peer review data, the objectives were largely the same. While significantly more M/S outpatient services are subject to peer review than MH/SUD

outpatient services, the denial rates are much lower for MH/SUD outpatient services. With such few instances of peer-to-peer review, 1 total in 2023, it is difficult to determine any trends, however, denial rates indicate that utilization review is not being more stringently applied to MH/SUD outpatient services.

Appeal data further confirms that no disparity exists as to utilization review. In 2023, for MH/SUD services, 7appeals occurred throughout the commercial line of business and none of the 7 appeals were medical necessity appeals. In 2024, there were 5 appeals for MH/SUD services and only 1 appeal concerned medical necessity.

Sentara further compared TAT and noticed an area of improvement. The TAT for MH/SUD outpatient services, while still better than the NCQA standard, was 1.1 days for expedited review, as compared to 0.7 days for M/S.

Step 6: Findings and conclusions.

See **45 CFR 146.137(c)(6).** The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the

design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the FAQ 45 guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara provided a definition of Preauthorization NQTL and identified the outpatient services subject to preauthorization, referencing the documents which specify those services, including the Prior Authorization List. For Step 1, Sentara provided information as to all vendors that provide utilization review services and produced the contractual documents related to those services. Sentara provided the factors and sources considered when requiring certain outpatient services be subject to preauthorization. Sentara noted that for MH/SUD outpatient services, the applicable factor is industry standards, including CMS, DMAS, LCDs, NCDs, and Milliman Clinical Guidelines. Sentara provided data including, but not limited to, authorization and denials, authorization by priority, MD referral rates, peer-to-peer reviews, audit results and appeals. Sentara completed the comparative analysis, set forth in Step Four above.

The analysis establishes Sentara is compliant with MHPAEA.

This analysis was completed in September 2026 by the following Sentara Departments: Utilization Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

CONCURRENT REVIEW: INPATIENT, IN-NETWORK

(CONCURRENT REVIEW DOES NOT APPLY TO EMERGENCY SERVICES)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See **45 CFR 146.137(c)(1).** Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also **FAQ 45** (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

***Non-clinical Review**:* Some carriers require requests for continued coverage that are reviewed and approved by non-clinical personnel according to predetermined criteria, which is also referred to by multiple carriers as "fast certification." Sentara does not use this form of concurrent review. Therefore, this analysis will focus solely on clinical review as that is the only form of concurrent review Sentara uses.

***Clinical Review**:* Sentara defines the clinical review form of concurrent review as ongoing medical necessity review of a member's care during a course of treatment.

The Provider Manual states: "If Sentara Health Plans decides to reduce or end coverage of a particular service, Sentara Health Plans will notify the Member/Provider before the coverage is reduced and early enough to allow for an appeal of the decision. Sentara Health Plans providers must follow certain procedures to make sure that if a previously authorized course of treatment or Hospital stay needs to be extended, the extension is requested in time to minimize disruption of needed services. Sentara Health Plans will notify the member of a coverage decision within 72 hours of receipt of the request. Notification will include information on how to appeal an adverse benefit determination prior to services being discontinued. Requests for extensions of therapy or rehabilitative treatment plans must be made seven (7) days prior to the end of the authorized timeframe to avoid disruption of care or services."

Sentara's process for concurrent review is largely identical to the process for prior authorization except for the timing of the review. Throughout this analysis, Sentara highlights the few aspects of concurrent review that differ from prior authorization.

List of Services Subject to NQTL

The same services subject to prior authorization are subject to concurrent review. Specifically, all inpatient services (M/S and MH/SUD) are subject to the two NQTLs. Services defined in the Plan documents as covered outpatient services (M/S and MH/SUD) are subject to the two NQTLs. Office visits and emergency services are never subject to the two NQTLs. Please see Sentara's Prior Authorization Submission for a more compressive description of the MH/SUD and M/S services subject to prior authorization (and, by extension, concurrent review).

Vendor Involvement

A third-party vendor ("UM Vendor 1") conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate third-party vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a services agreement. UM Vendor 2 is URAC and NCQA accredited. Under the services agreement provides, UM Vendor 2 providers access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a services agreement.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Separate Operating Departments or Divisions

There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See **45 CFR 146.137(c)(2).** Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:
- (A) A detailed description of the factor;
- (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
- (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also **FAQ 45** guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Clinical Review:

Sentara uses the following factors to determine the basis for requiring prior authorization and concurrent review for certain services:

- Industry standards in conformance with Centers for Medicare & Medicaid Services (CMS), Department of Medical Assistance Services (DMAS), Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and Milliman Care Guidelines (which incorporate American Society for Addiction Medicine (ASAM) Criteria)

- Excessive (high volume) variability in utilization. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization and concurrent review.

- High-Cost/High variability in cost. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization and concurrent review.

Weight of Factors

Industry standards in conformance with an internal utilization management determinations hierarchy determine which services are subject to prior authorization and concurrent review. Specifically, Sentara has implemented a policy outlining a determinations hierarchy for

commercial utilization management decisions which is used for reviewing and processing requests for authorization. Specifically, the following hierarchy is used: Federal Regulations; State Regulations; Sentara Medical Policies; MCG CareWeb ("MCG"); and review of association guidelines, specialty and subspeciality associations, and peer reviewed literature.

Sentara follows first the industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine which services are subject to prior authorization and concurrent review. As described in detail in the response to the Medical Necessity NQTL, Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed. The development of MCG or internal policies renders a service subject to prior authorization and concurrent review. There is little to no variation in the industry as to the services which require prior authorization. As described below in Step 3, Sentara does analyze and trend utilization review data and make determinations based upon that data. In operation, these trends impact M/S services more directly than MH/SUD because utilization of M/S outpatient services is greater, and more M/S outpatient services require prior authorization and, therefore, concurrent review. Sentara utilizes this trending and benchmarking data but does not have any policy that defines when that data requires a change to prior authorization or concurrent review status.

Step 3: Description of how factors are used in the design and application of the NQTL.

See **45 CFR 146.137(c)(3).** Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

- Industry standards in conformance with CMS, DMAS, LCDs, NCDs, and Milliman Care Guidelines (which incorporate ASAM): Sentara follows first industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine which services are subject to prior authorization and concurrent review. Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed (see Sentara's Medical Necessity NQTL Analysis). The development of MCG or internal policies renders a service subject to prior authorization and concurrent review. There is little to no variation in the industry as to the services which require prior authorization.

- Excessive (high volume)/variability in utilization: excessive utilization is measured by a number of metrics including authorization volume; denial volume, denial rates; days or admissions/100; average length of stay; observation days/1000, outpatient surgeries/1000, outpatient visits/1000. Trend analysis is considered, which includes: annualized cases/1,000; % change in annualized cases/1,000; annualized units/1,000; % change in annualized units; and Cost/Case for prior period and current period. Examples of these metrics are found in Commercial and Exchange Utilization Management Annual Evaluations and Trend Analysis Reports. Sentara also tracks utilization by authorization volume by CPT Code. Sentara is not aware of utilization rates as a factor for determining whether MH/SUD services require prior authorization or concurrent review. While utilization is tracked and trend analysis exists, utilization has not factored into any known decision to require prior authorization or concurrent review for any MH/SUD services.

- High-cost/High variability in cost: Sentara tracks allowed Per Member/Per Month ("PMPM") Data for outpatient categories of service. These PMPM are then benchmarked for comparison. Sentara is not aware of high cost or variability in cost as a factor for determining whether MH/SUD services require prior authorization or concurrent review. While utilization benchmarking exists, cost variability or high cost has not factored into any known decision to require prior authorization or concurrent review for any MH/SUD services.

Factors like utilization and cost, while tracked, trended and reviewed as compared to benchmarks, in operation, are not factors for determinations of whether MH/SUD services are subject to prior authorization or concurrent review. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization and, therefore, concurrent review.

The Prior Authorization List, available on Sentara's website, identifies all services subject to prior authorization (and, by extension, concurrent review). These services are subject to clinical review, and, as explained above, non-clinical review is not implicated. These services identified on the PAL are not categorized by classification or subclassification. As noted, all inpatient services require preauthorization and concurrent review. The factors related to the services identified in the PAL are identified above.

Medical Policy Committee

The Medical Policy Committee makes determinations concerning which services are subject to preauthorization and concurrent review. The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties.

One objective of the MPC is to recommend, review, and approve authorization requirements for Health Plan services through collaboration with the Integrated Benefits Management Team

("IBMT") to ensure codes are configured in compliance with federal and state regulations and medical policies. The IBMT is a multi-department team that ensures decisions rendered by the MPC can be implemented operationally with any changes in configuration and coding. The UM Program Plan is reviewed and revised as necessary, but at least annually. The UM Program evaluation is conducted by the Clinical Care Services Vice-President, the UM Director, and the Commercial Lead Medical Director. The UM Program review is completed within 120 days of the fiscal year end (March 30). The workplan is presented and approved by the SHP Quality Improvement Committee. All changes to the UM Program are finalized by the MPC.

The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties. Specifically, voting members for recommendations of coverage decisions consist of the following: Health Plan Medical Directors, including the Behavioral Health Medical Directors, the Chief Medical Officer, VPs CCS (or proxy), and Director of Pharmacy (or designee) (for pharmaceutical items).

VPs CCS means the Vice President(s) of Clinical Care Services or his or her proxy for voting purposes on the MPC. VP Pharmacy means the Vice President of Pharmacy or his or her designee for pharmaceutical items.

The Medical Policy is comprised of 28 individuals with varying clinical or other specialties. Of the members of the Medical Policy Committee, 9 are considered MH/SUD experts and 13 are considered M/S experts in various specialties.

Step 4: Demonstration of comparability and stringency as written.

See **45 CFR 146.137(c)(4).** The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold

identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent

to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Regarding the factors, definitions, evidentiary standards, sources, and strategies described in Step Two and Step Three, Sentara provides the following information:

Documentation of Each Factor Identified and Defined in Step Two:

The following factors are implicated in determining whether concurrent review applies to certain services:

Service	Factors
All outpatient, M/S services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, M/S services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, MH/SUD services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria
All outpatient, MH/SUD services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria

Comparison of Existing Written Documents:

All plan terms and Sentara policies regarding utilization management, including concurrent review, are equally designed and applied to M/S and MH/SUD services with no variations.

The Concurrent Review Process is defined in the Provider Manual and Sentara utilization management policies. As it pertains to concurrent review, the MPC requires concurrent review for any service for which clinical criteria is established by MCG (inclusive of ASAM) and/or any internal clinical policy.

There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

How Factors Are Comparably Applied:

Sentara applies applicable industry standards (MCG for M/S and ASAM for MH/SUD) equally to all services in the respective classifications. Industry standards are applied without discretion, regardless of whether the particular service is M/S or MH/SUD. For services (either M/S or MH/SUD) for which there is no applicable industry standard, the Sentara MPC evaluates and reviews the requested service.

Reasons for Any Deviations or Variations:

There are no variations or deviations in the design or application of prior authorization between M/S and MH/SUD benefits.

Prior Authorization Similarities and Differences

There is no difference in the clinical utilization review process except for the timing in which the process takes place.

Initiation of Concurrent Review

For many outpatient services, determinations are made for initial authorizations, based upon clinical guidelines, to include a specific number of visits or units. If additional visits or units are required, the provider submits a request for the additional units or visits. The request is reviewed based on the clinical data presented at the time of the additional request for determination. If the initial authorization expires prior to concurrent authorization,[1] the authorization is considered a new authorization. This applies to both M/S and MH/SUD services.

Providers are made aware of obligations to initiate a concurrent review via the Provider Manual and Sentara's utilization management policies and procedures.

Initial Authorization

There is no difference in the clinical utilization review process except for the timing in which the process takes place.

Clinical Review

Clinical Review Processes

[1] Concurrent authorization and concurrent review are used interchangeably throughout this analysis.

Any processes and policies related to Utilization Management, including the role of the Medical Policy Committee, apply equally to both prior authorization and concurrent review. However, Peer to Peer review does apply to non-hospital services. Please see Sentara's Prior Authorization Analysis.

Case Management

Healthcare service teams (case management services) are comprised of clinical professional staff, behavioral health clinicians, and nonclinical staff. These teams are integrated around populations of members in specified managed care products. This allows for a complete plan of care for the patient encompassing case management, behavioral health, and disease management services. Types of issues which may be referred to healthcare services:

- members with complex medical issues who utilize multiple services
- members who are nonadherent with treatment plans
- members who frequently utilize services without consulting PCP or specialist • members who frequently utilize the ER
- members who could benefit from disease management of heart failure, metabolic cardiovascular disease, asthma, COPD, or obesity
- neonatal care for premature and medically complex newborns (partnership with ProgenyHealth)

Requests for services (written or verbal) may be initiated by:

- provider
- member
- Sentara

A member's participation in case management services is optional and cost-sharing is not impacted.

Case management is a not a NQTL and does not impact prior authorization, concurrent review, or coverage determinations. Sentara confirms that a decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time.

Case management is provided by a licensed Registered Nurse (RN) or Masters in Social Worker (MSW). Case managers work with hospital review teams and primary care physicians to assist with coordination and transition of care, and community resources. Case managers do not have the

ability to "override" a treating physician's recommended course of treatment or deny any request for authorization. Only Medical Directors can issue adverse benefit determinations.

As explained above, any decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time. Further, case managers cannot overturn treatment recommendation or issue adverse benefit determinations. Case management is optional and designed for care coordination. Activities are aimed at improving member health through risk reduction and minimizing complications through education.

Examples of levels of care to which case management applies include severe behavioral health risk or chronic condition with co-morbidities (medical or behavioral). Sentara's case management policy complies with the most current NCQA standards. CCS Leadership (Director and VP) review the policy annually, which mirrors NCQA accreditation requirements. The policy is reviewed and approved by the overarching SHP Policy and Procedure Committee.

Discharge Planning

"Discharge planning" begins during pre-admission or admission to transition to a lower outpatient level of care. The medical necessity of any inpatient service including inpatient MH/SUD and M/S services is determined by the applicable clinical criteria. Sentara utilizes MGC (which incorporate ASAM) for all MH/SUD and M/S inpatient services. Sentara is not aware of any denials for entire inpatient stays for a member leaving the facility and is not aware of a denial of inpatient MH/SUD services based upon a "lack of improvement."

Tracking of Denials

Sentara tracks turnaround times and reports all claim denials and closed internal and external appeals and complaints. Claim denials are tracked for services were not medically necessary and services not authorized concurrently.

For appeals, Sentara tracks whether the denials were upheld, partially upheld or overturned in closed internal appeals and closed external reviews.

Sentara follows NCQA mandates regarding the tracking of approvals and denials. If a requested service (level of care) is requested and denied, it is tracked as a denial, even if a lower level of care was authorized. This is accurate for both M/S and MH/SUD services.

For prior and concurrent authorization requests, Sentara tracks authorization volume by decision, including approvals, denials, and partial denials. Sentara also tracks the denial rate by episode type (i.e., inpatient M/S, inpatient MH/SUD, outpatient M/S, and outpatient MH/SUD).

Sentara follows a standard process for administrative denials. Specifically, Sentara processes administrative denials in the following circumstances: (i) services are not a covered member benefit or (ii) member is not eligible under the Plan. This policy applies to both M/S and MH/SUD services. As shown in the data included herewith, administrative denials are subject to appeals but such denials and appeals are tracked separately for denials and appeals related to medical necessity.

Tracking of Prior Authorization versus Concurrent Review

Prior authorization is tracked separately from concurrent authorizations.

Sentara uses the terms "concurrent review" and "concurrent service authorization" synonymously. Concurrent review is conducted within 72 hours of receiving the request provided that Sentara receives the request at least 24 hours prior to expiration of the previously approved time period or number of treatments. If the prior authorization has expired, the request is treated as a new request for prior authorization.

On-Site Audits

Except for the M/S utilization management vendors described in Step One of this Analysis, utilization review is performed by Sentara on-site. The process is also described throughout the Sentara's Prior Authorization Submission. All utilization review for MH/SUD is performed by Sentara.

Extent of Medical Records Required

Sentara may request medical records for review. Listed below are the current medical record standards:

- Comprehensive history and physical, including the history of present illness and relevant psychiatric history
- Documentation of allergies and adverse reactions to medications
- Problem list
- Medications management and reconciliation
- Clinical findings and evaluations documented for each visit
- Preventive services and risk screenings
- Diagnoses, including documentation for behavioral health
- Substance use assessment
- Mental status examination
- Treatment planning
- Evidence of continuity of care

The standards above apply equally to M/S and MH/SUD.

Appeal Rights

The appeals process for concurrent review decisions are identical to the process for prior authorization decisions. Specifically, the timeframes to review appeals are compliant with NCQA standards and identical for M/S and MH/SUD appeal of authorization denials. Providers and members have 180 days from notice of an adverse benefits determination to request an appeal. For pre-service appeals, Sentara must respond within 30 days. Following one level of internal appeal, a request for an external appeal is available.

External review appeal rights apply to both M/S and MH/SUD benefits. There is no difference in application of an external review. A member or provider can appeal any decision (whether M/S or MH/SUD) regardless of whether the member accepts and receives a lower level of care.

In the context of the internal appeal process, any denial or reduction of benefits and/or nonpayment based upon a determination of medical necessity is treated as an Adverse Benefit Determination and subject to the appeal process outlined in the plans. Written notice of Adverse Benefit Determinations is required except for Urgent Claims, where notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notice of an Adverse Benefit Determination includes the following:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.

Any member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination. For denials due to Medical Necessity, members are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances.

After notification of an Adverse Benefit Determination, a member has 180 days to request an appeal. Upon appeal, all comments, documents, records, and other information submitted is reviewed. Additional information may be provided. The clinical peer reviewer reviewing the appeal will not have participated in the original coverage decision. Should a member disagree with the Final Benefit Determination, an external appeal is available.

Alternative Levels of Care

Prior and initial authorizations are tracked separately from concurrent reviews. The provider is responsible for obtaining concurrent authorization prior to expiration of the initial authorization. Should the initial authorization expire before a concurrent review occurs, the authorization typically is considered a new authorization for both M/S and MH/SUD outpatient benefits.

Step 5: Demonstration of comparability and stringency in operation.

See 45 CFR 146.137(c)(5). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Please see the analysis in Step 5 of Sentara's Prior Authorization Submission and data attached thereto as it applies to both prior authorization and concurrent review.

Step 6: Findings and conclusions.

See **45 CFR 146.137(c)(6).** The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section

146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the **FAQ 45** guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara defined the Concurrent Review NQTL and clarified that the only type of preauthorization/concurrent review is clinical review. For Step 1, Sentara identified that all inpatient services are subject to preauthorization/concurrent review. Sentara referred to its Prior Authorization Analysis, including the information provided as to all vendors that provide utilization review. Sentara provided the factors and sources considered when requiring certain outpatient services be subject to preauthorization. Sentara noted that for MH/SUD outpatient services, the applicable factor is industry standards, including CMS, DMAS, LCDs, NCDs, and Milliman Clinical Guidelines. In Step 4 (both as written and in-operation), Sentara provided and analyzed policies and processes applicable to preauthorization and concurrent review for

inpatient services and provided data including, but not limited to, authorization and denials, authorization by priority, MD referral rates, peer-to-peer reviews, audit results and appeals. Sentara completed the comparative analysis, set forth in Steps 4 and 5 above.

Analysis establishes Sentara is compliant with MHPAEA.

This analysis was completed in September 2026 by the following Sentara departments: Utilization Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

CONCURRENT REVIEW: INPATIENT, OUT-OF-NETWORK

(CONCURRENT REVIEW DOES NOT APPLY TO EMERGENCY SERVICES)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See **45 CFR 146.137(c)(1).** Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also **FAQ 45** (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

***Non-clinical Review**:* Some carriers require requests for continued coverage that are reviewed and approved by non-clinical personnel according to predetermined criteria, which is also referred to by multiple carriers as "fast certification." Sentara does not use this form of concurrent review. Therefore, this analysis will focus solely on clinical review as that is the only form of concurrent review Sentara uses.

***Clinical Review**:* Sentara defines the clinical review form of concurrent review as ongoing medical necessity review of a member's care during a course of treatment.

The Provider Manual states: "If Sentara Health Plans decides to reduce or end coverage of a particular service, Sentara Health Plans will notify the Member/Provider before the coverage is reduced and early enough to allow for an appeal of the decision. Sentara Health Plans providers must follow certain procedures to make sure that if a previously authorized course of treatment or Hospital stay needs to be extended, the extension is requested in time to minimize disruption of needed services. Sentara Health Plans will notify the member of a coverage decision within 72 hours of receipt of the request. Notification will include information on how to appeal an adverse benefit determination prior to services being discontinued. Requests for extensions of therapy or rehabilitative treatment plans must be made seven (7) days prior to the end of the authorized timeframe to avoid disruption of care or services."

Sentara's process for concurrent review is largely identical to the process for prior authorization except for the timing of the review. Throughout this analysis, Sentara highlights the few aspects of concurrent review that differ from prior authorization.

List of Services Subject to NQTL

The same services subject to prior authorization are subject to concurrent review. Specifically, all inpatient services (M/S and MH/SUD) are subject to the two NQTLs. Services defined in the Plan documents as covered outpatient services (M/S and MH/SUD) are subject to the two NQTLs. Office visits and emergency services are never subject to the two NQTLs. Please see Sentara's Prior Authorization Submission for a more compressive description of the MH/SUD and M/S services subject to prior authorization (and, by extension, concurrent review).

Vendor Involvement

A third-party vendor ("UM Vendor 1") conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate third-party vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a services agreement. UM Vendor 2 is URAC and NCQA accredited. Under the services agreement provides, UM Vendor 2 providers access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a services agreement.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Separate Operating Departments or Divisions

There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See **45 CFR 146.137(c)(2).** Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:
- (A) A detailed description of the factor;
- (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
- (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also **FAQ 45** guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Clinical Review:

Sentara uses the following factors to determine the basis for requiring prior authorization and concurrent review for certain services:

- Industry standards in conformance with Centers for Medicare & Medicaid Services (CMS), Department of Medical Assistance Services (DMAS), Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and Milliman Care Guidelines (which incorporate American Society for Addiction Medicine (ASAM) Criteria)

- Excessive (high volume) variability in utilization. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization and concurrent review.

- High-Cost/High variability in cost. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization and concurrent review.

Weight of Factors

Industry standards in conformance with an internal utilization management determinations hierarchy determine which services are subject to prior authorization and concurrent review. Specifically, Sentara has implemented a policy outlining a determinations hierarchy for

commercial utilization management decisions which is used for reviewing and processing requests for authorization. Specifically, the following hierarchy is used: Federal Regulations; State Regulations; Sentara Medical Policies; MCG CareWeb ("MCG"); and review of association guidelines, specialty and subspeciality associations, and peer reviewed literature.

Sentara follows first the industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine which services are subject to prior authorization and concurrent review. As described in detail in the response to the Medical Necessity NQTL, Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed. The development of MCG or internal policies renders a service subject to prior authorization and concurrent review. There is little to no variation in the industry as to the services which require prior authorization. As described below in Step 3, Sentara does analyze and trend utilization review data and make determinations based upon that data. In operation, these trends impact M/S services more directly than MH/SUD because utilization of M/S outpatient services is greater, and more M/S outpatient services require prior authorization and, therefore, concurrent review. Sentara utilizes this trending and benchmarking data but does not have any policy that defines when that data requires a change to prior authorization or concurrent review status.

Step 3: Description of how factors are used in the design and application of the NQTL.

See **45 CFR 146.137(c)(3).** Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

- Industry standards in conformance with CMS, DMAS, LCDs, NCDs, and Milliman Care Guidelines (which incorporate ASAM): Sentara follows first industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine which services are subject to prior authorization and concurrent review. Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed (see Sentara's Medical Necessity NQTL Analysis). The development of MCG or internal policies renders a service subject to prior authorization and concurrent review. There is little to no variation in the industry as to the services which require prior authorization.

- Excessive (high volume)/variability in utilization: excessive utilization is measured by a number of metrics including authorization volume; denial volume, denial rates; days or admissions/100; average length of stay; observation days/1000, outpatient surgeries/1000, outpatient visits/1000. Trend analysis is considered, which includes: annualized cases/1,000; % change in annualized cases/1,000; annualized units/1,000; % change in annualized units; and Cost/Case for prior period and current period. Examples of these metrics are found in Commercial and Exchange Utilization Management Annual Evaluations and Trend Analysis Reports. Sentara also tracks utilization by authorization volume by CPT Code. Sentara is not aware of utilization rates as a factor for determining whether MH/SUD services require prior authorization or concurrent review. While utilization is tracked and trend analysis exists, utilization has not factored into any known decision to require prior authorization or concurrent review for any MH/SUD services.

- High-cost/High variability in cost: Sentara tracks allowed Per Member/Per Month ("PMPM") Data for outpatient categories of service. These PMPM are then benchmarked for comparison. Sentara is not aware of high cost or variability in cost as a factor for determining whether MH/SUD services require prior authorization or concurrent review. While utilization benchmarking exists, cost variability or high cost has not factored into any known decision to require prior authorization or concurrent review for any MH/SUD services.

Factors like utilization and cost, while tracked, trended and reviewed as compared to benchmarks, in operation, are not factors for determinations of whether MH/SUD services are subject to prior authorization or concurrent review. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization and, therefore, concurrent review.

The Prior Authorization List, available on Sentara's website, identifies all services subject to prior authorization (and, by extension, concurrent review). These services are subject to clinical review, and, as explained above, non-clinical review is not implicated. These services identified on the PAL are not categorized by classification or subclassification. As noted, all inpatient services require preauthorization and concurrent review. The factors related to the services identified in the PAL are identified above.

Medical Policy Committee

The Medical Policy Committee makes determinations concerning which services are subject to preauthorization and concurrent review. The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties.

One objective of the MPC is to recommend, review, and approve authorization requirements for Health Plan services through collaboration with the Integrated Benefits Management Team

("IBMT") to ensure codes are configured in compliance with federal and state regulations and medical policies. The IBMT is a multi-department team that ensures decisions rendered by the MPC can be implemented operationally with any changes in configuration and coding. The UM Program Plan is reviewed and revised as necessary, but at least annually. The UM Program evaluation is conducted by the Clinical Care Services Vice-President, the UM Director, and the Commercial Lead Medical Director. The UM Program review is completed within 120 days of the fiscal year end (March 30). The workplan is presented and approved by the SHP Quality Improvement Committee. All changes to the UM Program are finalized by the MPC.

The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties. Specifically, voting members for recommendations of coverage decisions consist of the following: Health Plan Medical Directors, including the Behavioral Health Medical Directors, the Chief Medical Officer, VPs CCS (or proxy), and Director of Pharmacy (or designee) (for pharmaceutical items).

VPs CCS means the Vice President(s) of Clinical Care Services or his or her proxy for voting purposes on the MPC. VP Pharmacy means the Vice President of Pharmacy or his or her designee for pharmaceutical items.

The Medical Policy is comprised of 28 individuals with varying clinical or other specialties. Of the members of the Medical Policy Committee, 9 are considered MH/SUD experts and 13 are considered M/S experts in various specialties.

Step 4: Demonstration of comparability and stringency as written.

See **45 CFR 146.137(c)(4).** The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold

identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent

to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Regarding the factors, definitions, evidentiary standards, sources, and strategies described in Step Two and Step Three, Sentara provides the following information:

Documentation of Each Factor Identified and Defined in Step Two:

The following factors are implicated in determining whether concurrent review applies to certain services:

Service	Factors
All outpatient, M/S services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, M/S services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, MH/SUD services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria
All outpatient, MH/SUD services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria

Comparison of Existing Written Documents:

All plan terms and Sentara policies regarding utilization management, including concurrent review, are equally designed and applied to M/S and MH/SUD services with no variations.

The Concurrent Review Process is defined in the Provider Manual and Sentara utilization management policies. As it pertains to concurrent review, the MPC requires concurrent review for any service for which clinical criteria is established by MCG (inclusive of ASAM) and/or any internal clinical policy.

There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

How Factors Are Comparably Applied:

Sentara applies applicable industry standards (MCG for M/S and ASAM for MH/SUD) equally to all services in the respective classifications. Industry standards are applied without discretion, regardless of whether the particular service is M/S or MH/SUD. For services (either M/S or MH/SUD) for which there is no applicable industry standard, the Sentara MPC evaluates and reviews the requested service.

Reasons for Any Deviations or Variations:

There are no variations or deviations in the design or application of prior authorization between M/S and MH/SUD benefits.

Prior Authorization Similarities and Differences

There is no difference in the clinical utilization review process except for the timing in which the process takes place.

Initiation of Concurrent Review

For many outpatient services, determinations are made for initial authorizations, based upon clinical guidelines, to include a specific number of visits or units. If additional visits or units are required, the provider submits a request for the additional units or visits. The request is reviewed based on the clinical data presented at the time of the additional request for determination. If the initial authorization expires prior to concurrent authorization,[1] the authorization is considered a new authorization. This applies to both M/S and MH/SUD services.

Providers are made aware of obligations to initiate a concurrent review via the Provider Manual and Sentara's utilization management policies and procedures.

Initial Authorization

There is no difference in the clinical utilization review process except for the timing in which the process takes place.

Clinical Review

Clinical Review Processes

[1] Concurrent authorization and concurrent review are used interchangeably throughout this analysis.

Any processes and policies related to Utilization Management, including the role of the Medical Policy Committee, apply equally to both prior authorization and concurrent review. However, Peer to Peer review does apply to non-hospital services. Please see Sentara's Prior Authorization Analysis.

Case Management

Healthcare service teams (case management services) are comprised of clinical professional staff, behavioral health clinicians, and nonclinical staff. These teams are integrated around populations of members in specified managed care products. This allows for a complete plan of care for the patient encompassing case management, behavioral health, and disease management services. Types of issues which may be referred to healthcare services:

- members with complex medical issues who utilize multiple services
- members who are nonadherent with treatment plans
- members who frequently utilize services without consulting PCP or specialist • members who frequently utilize the ER
- members who could benefit from disease management of heart failure, metabolic cardiovascular disease, asthma, COPD, or obesity
- neonatal care for premature and medically complex newborns (partnership with ProgenyHealth)

Requests for services (written or verbal) may be initiated by:

- provider
- member
- Sentara

A member's participation in case management services is optional and cost-sharing is not impacted.

Case management is a not a NQTL and does not impact prior authorization, concurrent review, or coverage determinations. Sentara confirms that a decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time.

Case management is provided by a licensed Registered Nurse (RN) or Masters in Social Worker (MSW). Case managers work with hospital review teams and primary care physicians to assist with coordination and transition of care, and community resources. Case managers do not have the

ability to "override" a treating physician's recommended course of treatment or deny any request for authorization. Only Medical Directors can issue adverse benefit determinations.

As explained above, any decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time. Further, case managers cannot overturn treatment recommendation or issue adverse benefit determinations. Case management is optional and designed for care coordination. Activities are aimed at improving member health through risk reduction and minimizing complications through education.

Examples of levels of care to which case management applies include severe behavioral health risk or chronic condition with co-morbidities (medical or behavioral). Sentara's case management policy complies with the most current NCQA standards. CCS Leadership (Director and VP) review the policy annually, which mirrors NCQA accreditation requirements. The policy is reviewed and approved by the overarching SHP Policy and Procedure Committee.

Discharge Planning

"Discharge planning" begins during pre-admission or admission to transition to a lower outpatient level of care. The medical necessity of any inpatient service including inpatient MH/SUD and M/S services is determined by the applicable clinical criteria. Sentara utilizes MGC (which incorporate ASAM) for all MH/SUD and M/S inpatient services. Sentara is not aware of any denials for entire inpatient stays for a member leaving the facility and is not aware of a denial of inpatient MH/SUD services based upon a "lack of improvement."

Tracking of Denials

Sentara tracks turnaround times and reports all claim denials and closed internal and external appeals and complaints. Claim denials are tracked for services were not medically necessary and services not authorized concurrently.

For appeals, Sentara tracks whether the denials were upheld, partially upheld or overturned in closed internal appeals and closed external reviews.

Sentara follows NCQA mandates regarding the tracking of approvals and denials. If a requested service (level of care) is requested and denied, it is tracked as a denial, even if a lower level of care was authorized. This is accurate for both M/S and MH/SUD services.

For prior and concurrent authorization requests, Sentara tracks authorization volume by decision, including approvals, denials, and partial denials. Sentara also tracks the denial rate by episode type (i.e., inpatient M/S, inpatient MH/SUD, outpatient M/S, and outpatient MH/SUD).

Sentara follows a standard process for administrative denials. Specifically, Sentara processes administrative denials in the following circumstances: (i) services are not a covered member benefit or (ii) member is not eligible under the Plan. This policy applies to both M/S and MH/SUD services. As shown in the data included herewith, administrative denials are subject to appeals but such denials and appeals are tracked separately for denials and appeals related to medical necessity.

Tracking of Prior Authorization versus Concurrent Review

Prior authorization is tracked separately from concurrent authorizations.

Sentara uses the terms "concurrent review" and "concurrent service authorization" synonymously. Concurrent review is conducted within 72 hours of receiving the request provided that Sentara receives the request at least 24 hours prior to expiration of the previously approved time period or number of treatments. If the prior authorization has expired, the request is treated as a new request for prior authorization.

On-Site Audits

Except for the M/S utilization management vendors described in Step One of this Analysis, utilization review is performed by Sentara on-site. The process is also described throughout the Sentara's Prior Authorization Submission. All utilization review for MH/SUD is performed by Sentara.

Extent of Medical Records Required

Sentara may request medical records for review. Listed below are the current medical record standards:

- Comprehensive history and physical, including the history of present illness and relevant psychiatric history
- Documentation of allergies and adverse reactions to medications
- Problem list
- Medications management and reconciliation
- Clinical findings and evaluations documented for each visit
- Preventive services and risk screenings
- Diagnoses, including documentation for behavioral health
- Substance use assessment
- Mental status examination
- Treatment planning
- Evidence of continuity of care

The standards above apply equally to M/S and MH/SUD.

Appeal Rights

The appeals process for concurrent review decisions are identical to the process for prior authorization decisions. Specifically, the timeframes to review appeals are compliant with NCQA standards and identical for M/S and MH/SUD appeal of authorization denials. Providers and members have 180 days from notice of an adverse benefits determination to request an appeal. For pre-service appeals, Sentara must respond within 30 days. Following one level of internal appeal, a request for an external appeal is available.

External review appeal rights apply to both M/S and MH/SUD benefits. There is no difference in application of an external review. A member or provider can appeal any decision (whether M/S or MH/SUD) regardless of whether the member accepts and receives a lower level of care.

In the context of the internal appeal process, any denial or reduction of benefits and/or nonpayment based upon a determination of medical necessity is treated as an Adverse Benefit Determination and subject to the appeal process outlined in the plans. Written notice of Adverse Benefit Determinations is required except for Urgent Claims, where notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notice of an Adverse Benefit Determination includes the following:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.

Any member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination. For denials due to Medical Necessity, members are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances.

After notification of an Adverse Benefit Determination, a member has 180 days to request an appeal. Upon appeal, all comments, documents, records, and other information submitted is reviewed. Additional information may be provided. The clinical peer reviewer reviewing the appeal will not have participated in the original coverage decision. Should a member disagree with the Final Benefit Determination, an external appeal is available.

Alternative Levels of Care

Prior and initial authorizations are tracked separately from concurrent reviews. The provider is responsible for obtaining concurrent authorization prior to expiration of the initial authorization. Should the initial authorization expire before a concurrent review occurs, the authorization typically is considered a new authorization for both M/S and MH/SUD outpatient benefits.

Step 5: Demonstration of comparability and stringency in operation.

See 45 CFR 146.137(c)(5). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Please see the analysis in Step 5 of Sentara's Prior Authorization Submission and data attached thereto as it applies to both prior authorization and concurrent review.

Step 6: Findings and conclusions.

See **45 CFR 146.137(c)(6).** The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section

146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the **FAQ 45** guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara defined the Concurrent Review NQTL and clarified that the only type of preauthorization/concurrent review is clinical review. For Step 1, Sentara identified that all inpatient services are subject to preauthorization/concurrent review. Sentara referred to its Prior Authorization Analysis, including the information provided as to all vendors that provide utilization review. Sentara provided the factors and sources considered when requiring certain outpatient services be subject to preauthorization. Sentara noted that for MH/SUD outpatient services, the applicable factor is industry standards, including CMS, DMAS, LCDs, NCDs, and Milliman Clinical Guidelines. In Step 4 (both as written and in-operation), Sentara provided and analyzed policies and processes applicable to preauthorization and concurrent review for

inpatient services and provided data including, but not limited to, authorization and denials, authorization by priority, MD referral rates, peer-to-peer reviews, audit results and appeals. Sentara completed the comparative analysis, set forth in Steps 4 and 5 above.

Analysis establishes Sentara is compliant with MHPAEA.

This analysis was completed in September 2026 by the following Sentara departments: Utilization Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

CONCURRENT REVIEW: OUTPATIENT, IN-NETWORK

(CONCURRENT REVIEW DOES NOT APPLY TO EMERGENCY SERVICES)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See **45 CFR 146.137(c)(1).** Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also **FAQ 45** (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

***Non-clinical Review**:* Some carriers require requests for continued coverage that are reviewed and approved by non-clinical personnel according to predetermined criteria, which is also referred to by multiple carriers as "fast certification." Sentara does not use this form of concurrent review. Therefore, this analysis will focus solely on clinical review as that is the only form of concurrent review Sentara uses.

***Clinical Review**:* Sentara defines the clinical review form of concurrent review as ongoing medical necessity review of a member's care during a course of treatment.

The Provider Manual states: "If Sentara Health Plans decides to reduce or end coverage of a particular service, Sentara Health Plans will notify the Member/Provider before the coverage is reduced and early enough to allow for an appeal of the decision. Sentara Health Plans providers must follow certain procedures to make sure that if a previously authorized course of treatment or Hospital stay needs to be extended, the extension is requested in time to minimize disruption of needed services. Sentara Health Plans will notify the member of a coverage decision within 72 hours of receipt of the request. Notification will include information on how to appeal an adverse benefit determination prior to services being discontinued. Requests for extensions of therapy or rehabilitative treatment plans must be made seven (7) days prior to the end of the authorized timeframe to avoid disruption of care or services."

Sentara's process for concurrent review is largely identical to the process for prior authorization except for the timing of the review. Throughout this analysis, Sentara highlights the few aspects of concurrent review that differ from prior authorization.

List of Services Subject to NQTL

The same services subject to prior authorization are subject to concurrent review. Specifically, all inpatient services (M/S and MH/SUD) are subject to the two NQTLs. Services defined in the Plan documents as covered outpatient services (M/S and MH/SUD) are subject to the two NQTLs. Office visits and emergency services are never subject to the two NQTLs. Please see Sentara's Prior Authorization Submission for a more compressive description of the MH/SUD and M/S services subject to prior authorization (and, by extension, concurrent review).

Vendor Involvement

A third-party vendor ("UM Vendor 1") conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate third-party vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a services agreement. UM Vendor 2 is URAC and NCQA accredited. Under the services agreement provides, UM Vendor 2 providers access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a services agreement.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Separate Operating Departments or Divisions

There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See **45 CFR 146.137(c)(2).** Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:
- (A) A detailed description of the factor;
- (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
- (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also **FAQ 45** guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Clinical Review:

Sentara uses the following factors to determine the basis for requiring prior authorization and concurrent review for certain services:

- Industry standards in conformance with Centers for Medicare & Medicaid Services (CMS), Department of Medical Assistance Services (DMAS), Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and Milliman Care Guidelines (which incorporate American Society for Addiction Medicine (ASAM) Criteria)

- Excessive (high volume) variability in utilization. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization and concurrent review.

- High-Cost/High variability in cost. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization and concurrent review.

Weight of Factors

Industry standards in conformance with an internal utilization management determinations hierarchy determine which services are subject to prior authorization and concurrent review. Specifically, Sentara has implemented a policy outlining a determinations hierarchy for

commercial utilization management decisions which is used for reviewing and processing requests for authorization. Specifically, the following hierarchy is used: Federal Regulations; State Regulations; Sentara Medical Policies; MCG CareWeb ("MCG"); and review of association guidelines, specialty and subspeciality associations, and peer reviewed literature.

Sentara follows first the industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine which services are subject to prior authorization and concurrent review. As described in detail in the response to the Medical Necessity NQTL, Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed. The development of MCG or internal policies renders a service subject to prior authorization and concurrent review. There is little to no variation in the industry as to the services which require prior authorization. As described below in Step 3, Sentara does analyze and trend utilization review data and make determinations based upon that data. In operation, these trends impact M/S services more directly than MH/SUD because utilization of M/S outpatient services is greater, and more M/S outpatient services require prior authorization and, therefore, concurrent review. Sentara utilizes this trending and benchmarking data but does not have any policy that defines when that data requires a change to prior authorization or concurrent review status.

Step 3: Description of how factors are used in the design and application of the NQTL.

See **45 CFR 146.137(c)(3).** Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

- Industry standards in conformance with CMS, DMAS, LCDs, NCDs, and Milliman Care Guidelines (which incorporate ASAM): Sentara follows first industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine which services are subject to prior authorization and concurrent review. Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed (see Sentara's Medical Necessity NQTL Analysis). The development of MCG or internal policies renders a service subject to prior authorization and concurrent review. There is little to no variation in the industry as to the services which require prior authorization.

- Excessive (high volume)/variability in utilization: excessive utilization is measured by a number of metrics including authorization volume; denial volume, denial rates; days or admissions/100; average length of stay; observation days/1000, outpatient surgeries/1000, outpatient visits/1000. Trend analysis is considered, which includes: annualized cases/1,000; % change in annualized cases/1,000; annualized units/1,000; % change in annualized units; and Cost/Case for prior period and current period. Examples of these metrics are found in Commercial and Exchange Utilization Management Annual Evaluations and Trend Analysis Reports. Sentara also tracks utilization by authorization volume by CPT Code. Sentara is not aware of utilization rates as a factor for determining whether MH/SUD services require prior authorization or concurrent review. While utilization is tracked and trend analysis exists, utilization has not factored into any known decision to require prior authorization or concurrent review for any MH/SUD services.

- High-cost/High variability in cost: Sentara tracks allowed Per Member/Per Month ("PMPM") Data for outpatient categories of service. These PMPM are then benchmarked for comparison. Sentara is not aware of high cost or variability in cost as a factor for determining whether MH/SUD services require prior authorization or concurrent review. While utilization benchmarking exists, cost variability or high cost has not factored into any known decision to require prior authorization or concurrent review for any MH/SUD services.

Factors like utilization and cost, while tracked, trended and reviewed as compared to benchmarks, in operation, are not factors for determinations of whether MH/SUD services are subject to prior authorization or concurrent review. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization and, therefore, concurrent review.

The Prior Authorization List, available on Sentara's website, identifies all services subject to prior authorization (and, by extension, concurrent review). These services are subject to clinical review, and, as explained above, non-clinical review is not implicated. These services identified on the PAL are not categorized by classification or subclassification. As noted, all inpatient services require preauthorization and concurrent review. The factors related to the services identified in the PAL are identified above.

Medical Policy Committee

The Medical Policy Committee makes determinations concerning which services are subject to preauthorization and concurrent review. The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties.

One objective of the MPC is to recommend, review, and approve authorization requirements for Health Plan services through collaboration with the Integrated Benefits Management Team

("IBMT") to ensure codes are configured in compliance with federal and state regulations and medical policies. The IBMT is a multi-department team that ensures decisions rendered by the MPC can be implemented operationally with any changes in configuration and coding. The UM Program Plan is reviewed and revised as necessary, but at least annually. The UM Program evaluation is conducted by the Clinical Care Services Vice-President, the UM Director, and the Commercial Lead Medical Director. The UM Program review is completed within 120 days of the fiscal year end (March 30). The workplan is presented and approved by the SHP Quality Improvement Committee. All changes to the UM Program are finalized by the MPC.

The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties. Specifically, voting members for recommendations of coverage decisions consist of the following: Health Plan Medical Directors, including the Behavioral Health Medical Directors, the Chief Medical Officer, VPs CCS (or proxy), and Director of Pharmacy (or designee) (for pharmaceutical items).

VPs CCS means the Vice President(s) of Clinical Care Services or his or her proxy for voting purposes on the MPC. VP Pharmacy means the Vice President of Pharmacy or his or her designee for pharmaceutical items.

The Medical Policy is comprised of 28 individuals with varying clinical or other specialties. Of the members of the Medical Policy Committee, 9 are considered MH/SUD experts and 13 are considered M/S experts in various specialties.

Step 4: Demonstration of comparability and stringency as written.

See **45 CFR 146.137(c)(4).** The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold

identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent

to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Regarding the factors, definitions, evidentiary standards, sources, and strategies described in Step Two and Step Three, Sentara provides the following information:

Documentation of Each Factor Identified and Defined in Step Two:

The following factors are implicated in determining whether concurrent review applies to certain services:

Service	Factors
All outpatient, M/S services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, M/S services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, MH/SUD services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria
All outpatient, MH/SUD services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria

Comparison of Existing Written Documents:

All plan terms and Sentara policies regarding utilization management, including concurrent review, are equally designed and applied to M/S and MH/SUD services with no variations.

The Concurrent Review Process is defined in the Provider Manual and Sentara utilization management policies. As it pertains to concurrent review, the MPC requires concurrent review for any service for which clinical criteria is established by MCG (inclusive of ASAM) and/or any internal clinical policy.

There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

How Factors Are Comparably Applied:

Sentara applies applicable industry standards (MCG for M/S and ASAM for MH/SUD) equally to all services in the respective classifications. Industry standards are applied without discretion, regardless of whether the particular service is M/S or MH/SUD. For services (either M/S or MH/SUD) for which there is no applicable industry standard, the Sentara MPC evaluates and reviews the requested service.

Reasons for Any Deviations or Variations:

There are no variations or deviations in the design or application of prior authorization between M/S and MH/SUD benefits.

Prior Authorization Similarities and Differences

There is no difference in the clinical utilization review process except for the timing in which the process takes place.

Initiation of Concurrent Review

For many outpatient services, determinations are made for initial authorizations, based upon clinical guidelines, to include a specific number of visits or units. If additional visits or units are required, the provider submits a request for the additional units or visits. The request is reviewed based on the clinical data presented at the time of the additional request for determination. If the initial authorization expires prior to concurrent authorization,[1] the authorization is considered a new authorization. This applies to both M/S and MH/SUD services.

Providers are made aware of obligations to initiate a concurrent review via the Provider Manual and Sentara's utilization management policies and procedures.

Initial Authorization

There is no difference in the clinical utilization review process except for the timing in which the process takes place.

Clinical Review

Clinical Review Processes

[1] Concurrent authorization and concurrent review are used interchangeably throughout this analysis.

Any processes and policies related to Utilization Management, including the role of the Medical Policy Committee, apply equally to both prior authorization and concurrent review. However, Peer to Peer review does apply to non-hospital services. Please see Sentara's Prior Authorization Analysis.

Case Management

Healthcare service teams (case management services) are comprised of clinical professional staff, behavioral health clinicians, and nonclinical staff. These teams are integrated around populations of members in specified managed care products. This allows for a complete plan of care for the patient encompassing case management, behavioral health, and disease management services. Types of issues which may be referred to healthcare services:

- members with complex medical issues who utilize multiple services
- members who are nonadherent with treatment plans
- members who frequently utilize services without consulting PCP or specialist • members who frequently utilize the ER
- members who could benefit from disease management of heart failure, metabolic cardiovascular disease, asthma, COPD, or obesity
- neonatal care for premature and medically complex newborns (partnership with ProgenyHealth)

Requests for services (written or verbal) may be initiated by:

- provider
- member
- Sentara

A member's participation in case management services is optional and cost-sharing is not impacted.

Case management is a not a NQTL and does not impact prior authorization, concurrent review, or coverage determinations. Sentara confirms that a decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time.

Case management is provided by a licensed Registered Nurse (RN) or Masters in Social Worker (MSW). Case managers work with hospital review teams and primary care physicians to assist with coordination and transition of care, and community resources. Case managers do not have the

ability to "override" a treating physician's recommended course of treatment or deny any request for authorization. Only Medical Directors can issue adverse benefit determinations.

As explained above, any decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time. Further, case managers cannot overturn treatment recommendation or issue adverse benefit determinations. Case management is optional and designed for care coordination. Activities are aimed at improving member health through risk reduction and minimizing complications through education.

Examples of levels of care to which case management applies include severe behavioral health risk or chronic condition with co-morbidities (medical or behavioral). Sentara's case management policy complies with the most current NCQA standards. CCS Leadership (Director and VP) review the policy annually, which mirrors NCQA accreditation requirements. The policy is reviewed and approved by the overarching SHP Policy and Procedure Committee.

Discharge Planning

"Discharge planning" begins during pre-admission or admission to transition to a lower outpatient level of care. The medical necessity of any inpatient service including inpatient MH/SUD and M/S services is determined by the applicable clinical criteria. Sentara utilizes MGC (which incorporate ASAM) for all MH/SUD and M/S inpatient services. Sentara is not aware of any denials for entire inpatient stays for a member leaving the facility and is not aware of a denial of inpatient MH/SUD services based upon a "lack of improvement."

Tracking of Denials

Sentara tracks turnaround times and reports all claim denials and closed internal and external appeals and complaints. Claim denials are tracked for services were not medically necessary and services not authorized concurrently.

For appeals, Sentara tracks whether the denials were upheld, partially upheld or overturned in closed internal appeals and closed external reviews.

Sentara follows NCQA mandates regarding the tracking of approvals and denials. If a requested service (level of care) is requested and denied, it is tracked as a denial, even if a lower level of care was authorized. This is accurate for both M/S and MH/SUD services.

For prior and concurrent authorization requests, Sentara tracks authorization volume by decision, including approvals, denials, and partial denials. Sentara also tracks the denial rate by episode type (i.e., inpatient M/S, inpatient MH/SUD, outpatient M/S, and outpatient MH/SUD).

Sentara follows a standard process for administrative denials. Specifically, Sentara processes administrative denials in the following circumstances: (i) services are not a covered member benefit or (ii) member is not eligible under the Plan. This policy applies to both M/S and MH/SUD services. As shown in the data included herewith, administrative denials are subject to appeals but such denials and appeals are tracked separately for denials and appeals related to medical necessity.

Tracking of Prior Authorization versus Concurrent Review

Prior authorization is tracked separately from concurrent authorizations.

Sentara uses the terms "concurrent review" and "concurrent service authorization" synonymously. Concurrent review is conducted within 72 hours of receiving the request provided that Sentara receives the request at least 24 hours prior to expiration of the previously approved time period or number of treatments. If the prior authorization has expired, the request is treated as a new request for prior authorization.

On-Site Audits

Except for the M/S utilization management vendors described in Step One of this Analysis, utilization review is performed by Sentara on-site. The process is also described throughout the Sentara's Prior Authorization Submission. All utilization review for MH/SUD is performed by Sentara.

Extent of Medical Records Required

Sentara may request medical records for review. Listed below are the current medical record standards:

- Comprehensive history and physical, including the history of present illness and relevant psychiatric history
- Documentation of allergies and adverse reactions to medications
- Problem list
- Medications management and reconciliation
- Clinical findings and evaluations documented for each visit
- Preventive services and risk screenings
- Diagnoses, including documentation for behavioral health
- Substance use assessment
- Mental status examination
- Treatment planning
- Evidence of continuity of care

The standards above apply equally to M/S and MH/SUD.

Appeal Rights

The appeals process for concurrent review decisions are identical to the process for prior authorization decisions. Specifically, the timeframes to review appeals are compliant with NCQA standards and identical for M/S and MH/SUD appeal of authorization denials. Providers and members have 180 days from notice of an adverse benefits determination to request an appeal. For pre-service appeals, Sentara must respond within 30 days. Following one level of internal appeal, a request for an external appeal is available.

External review appeal rights apply to both M/S and MH/SUD benefits. There is no difference in application of an external review. A member or provider can appeal any decision (whether M/S or MH/SUD) regardless of whether the member accepts and receives a lower level of care.

In the context of the internal appeal process, any denial or reduction of benefits and/or nonpayment based upon a determination of medical necessity is treated as an Adverse Benefit Determination and subject to the appeal process outlined in the plans. Written notice of Adverse Benefit Determinations is required except for Urgent Claims, where notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notice of an Adverse Benefit Determination includes the following:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.

Any member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination. For denials due to Medical Necessity, members are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances.

After notification of an Adverse Benefit Determination, a member has 180 days to request an appeal. Upon appeal, all comments, documents, records, and other information submitted is reviewed. Additional information may be provided. The clinical peer reviewer reviewing the appeal will not have participated in the original coverage decision. Should a member disagree with the Final Benefit Determination, an external appeal is available.

Alternative Levels of Care

Prior and initial authorizations are tracked separately from concurrent reviews. The provider is responsible for obtaining concurrent authorization prior to expiration of the initial authorization. Should the initial authorization expire before a concurrent review occurs, the authorization typically is considered a new authorization for both M/S and MH/SUD outpatient benefits.

Step 5: Demonstration of comparability and stringency in operation.

See 45 CFR 146.137(c)(5). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Please see the analysis in Step 5 of Sentara's Prior Authorization Submission and data attached thereto as it applies to both prior authorization and concurrent review.

Step 6: Findings and conclusions.

See **45 CFR 146.137(c)(6).** The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section

146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the **FAQ 45** guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara defined the Concurrent Review NQTL and clarified that the only type of preauthorization/concurrent review is clinical review. For Step 1, Sentara identified that all inpatient services are subject to preauthorization/concurrent review. Sentara referred to its Prior Authorization Analysis, including the information provided as to all vendors that provide utilization review. Sentara provided the factors and sources considered when requiring certain outpatient services be subject to preauthorization. Sentara noted that for MH/SUD outpatient services, the applicable factor is industry standards, including CMS, DMAS, LCDs, NCDs, and Milliman Clinical Guidelines. In Step 4 (both as written and in-operation), Sentara provided and analyzed policies and processes applicable to preauthorization and concurrent review for

inpatient services and provided data including, but not limited to, authorization and denials, authorization by priority, MD referral rates, peer-to-peer reviews, audit results and appeals. Sentara completed the comparative analysis, set forth in Steps 4 and 5 above.

Analysis establishes Sentara is compliant with MHPAEA.

This analysis was completed in September 2026 by the following Sentara departments: Utilization Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

CONCURRENT REVIEW: OUTPATIENT, OUT-OF-NETWORK

(CONCURRENT REVIEW DOES NOT APPLY TO EMERGENCY SERVICES)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See **45 CFR 146.137(c)(1).** Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also **FAQ 45** (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

***Non-clinical Review**:* Some carriers require requests for continued coverage that are reviewed and approved by non-clinical personnel according to predetermined criteria, which is also referred to by multiple carriers as "fast certification." Sentara does not use this form of concurrent review. Therefore, this analysis will focus solely on clinical review as that is the only form of concurrent review Sentara uses.

***Clinical Review**:* Sentara defines the clinical review form of concurrent review as ongoing medical necessity review of a member's care during a course of treatment.

The Provider Manual states: "If Sentara Health Plans decides to reduce or end coverage of a particular service, Sentara Health Plans will notify the Member/Provider before the coverage is reduced and early enough to allow for an appeal of the decision. Sentara Health Plans providers must follow certain procedures to make sure that if a previously authorized course of treatment or Hospital stay needs to be extended, the extension is requested in time to minimize disruption of needed services. Sentara Health Plans will notify the member of a coverage decision within 72 hours of receipt of the request. Notification will include information on how to appeal an adverse benefit determination prior to services being discontinued. Requests for extensions of therapy or rehabilitative treatment plans must be made seven (7) days prior to the end of the authorized timeframe to avoid disruption of care or services."

Sentara's process for concurrent review is largely identical to the process for prior authorization except for the timing of the review. Throughout this analysis, Sentara highlights the few aspects of concurrent review that differ from prior authorization.

List of Services Subject to NQTL

The same services subject to prior authorization are subject to concurrent review. Specifically, all inpatient services (M/S and MH/SUD) are subject to the two NQTLs. Services defined in the Plan documents as covered outpatient services (M/S and MH/SUD) are subject to the two NQTLs. Office visits and emergency services are never subject to the two NQTLs. Please see Sentara's Prior Authorization Submission for a more compressive description of the MH/SUD and M/S services subject to prior authorization (and, by extension, concurrent review).

Vendor Involvement

A third-party vendor ("UM Vendor 1") conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate third-party vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a services agreement. UM Vendor 2 is URAC and NCQA accredited. Under the services agreement provides, UM Vendor 2 providers access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a services agreement.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Separate Operating Departments or Divisions

There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See **45 CFR 146.137(c)(2).** Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:
- (A) A detailed description of the factor;
- (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
- (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also **FAQ 45** guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Clinical Review:

Sentara uses the following factors to determine the basis for requiring prior authorization and concurrent review for certain services:

- Industry standards in conformance with Centers for Medicare & Medicaid Services (CMS), Department of Medical Assistance Services (DMAS), Local Coverage Determinations (LCDs), National Coverage Determinations (NCDs), and Milliman Care Guidelines (which incorporate American Society for Addiction Medicine (ASAM) Criteria)

- Excessive (high volume) variability in utilization. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization and concurrent review.

- High-Cost/High variability in cost. This factor, while tracked, trended and reviewed as compared to benchmarks, in operation, is not a factor for determinations of whether MH/SUD services are subject to prior authorization. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization and concurrent review.

Weight of Factors

Industry standards in conformance with an internal utilization management determinations hierarchy determine which services are subject to prior authorization and concurrent review. Specifically, Sentara has implemented a policy outlining a determinations hierarchy for

commercial utilization management decisions which is used for reviewing and processing requests for authorization. Specifically, the following hierarchy is used: Federal Regulations; State Regulations; Sentara Medical Policies; MCG CareWeb ("MCG"); and review of association guidelines, specialty and subspeciality associations, and peer reviewed literature.

Sentara follows first the industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine which services are subject to prior authorization and concurrent review. As described in detail in the response to the Medical Necessity NQTL, Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed. The development of MCG or internal policies renders a service subject to prior authorization and concurrent review. There is little to no variation in the industry as to the services which require prior authorization. As described below in Step 3, Sentara does analyze and trend utilization review data and make determinations based upon that data. In operation, these trends impact M/S services more directly than MH/SUD because utilization of M/S outpatient services is greater, and more M/S outpatient services require prior authorization and, therefore, concurrent review. Sentara utilizes this trending and benchmarking data but does not have any policy that defines when that data requires a change to prior authorization or concurrent review status.

Step 3: Description of how factors are used in the design and application of the NQTL.

See **45 CFR 146.137(c)(3).** Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

- Industry standards in conformance with CMS, DMAS, LCDs, NCDs, and Milliman Care Guidelines (which incorporate ASAM): Sentara follows first industry standards and the policies of CMS, DMAS, LCDs, NCDs, and published clinical guidelines to determine which services are subject to prior authorization and concurrent review. Sentara utilizes MCG for medical necessity determinations unless an internal clinical policy is developed (see Sentara's Medical Necessity NQTL Analysis). The development of MCG or internal policies renders a service subject to prior authorization and concurrent review. There is little to no variation in the industry as to the services which require prior authorization.

- Excessive (high volume)/variability in utilization: excessive utilization is measured by a number of metrics including authorization volume; denial volume, denial rates; days or admissions/100; average length of stay; observation days/1000, outpatient surgeries/1000, outpatient visits/1000. Trend analysis is considered, which includes: annualized cases/1,000; % change in annualized cases/1,000; annualized units/1,000; % change in annualized units; and Cost/Case for prior period and current period. Examples of these metrics are found in Commercial and Exchange Utilization Management Annual Evaluations and Trend Analysis Reports. Sentara also tracks utilization by authorization volume by CPT Code. Sentara is not aware of utilization rates as a factor for determining whether MH/SUD services require prior authorization or concurrent review. While utilization is tracked and trend analysis exists, utilization has not factored into any known decision to require prior authorization or concurrent review for any MH/SUD services.

- High-cost/High variability in cost: Sentara tracks allowed Per Member/Per Month ("PMPM") Data for outpatient categories of service. These PMPM are then benchmarked for comparison. Sentara is not aware of high cost or variability in cost as a factor for determining whether MH/SUD services require prior authorization or concurrent review. While utilization benchmarking exists, cost variability or high cost has not factored into any known decision to require prior authorization or concurrent review for any MH/SUD services.

Factors like utilization and cost, while tracked, trended and reviewed as compared to benchmarks, in operation, are not factors for determinations of whether MH/SUD services are subject to prior authorization or concurrent review. Sentara relies upon industry standards and practices for identifying which services are subject to prior authorization and, therefore, concurrent review.

The Prior Authorization List, available on Sentara's website, identifies all services subject to prior authorization (and, by extension, concurrent review). These services are subject to clinical review, and, as explained above, non-clinical review is not implicated. These services identified on the PAL are not categorized by classification or subclassification. As noted, all inpatient services require preauthorization and concurrent review. The factors related to the services identified in the PAL are identified above.

Medical Policy Committee

The Medical Policy Committee makes determinations concerning which services are subject to preauthorization and concurrent review. The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties.

One objective of the MPC is to recommend, review, and approve authorization requirements for Health Plan services through collaboration with the Integrated Benefits Management Team

("IBMT") to ensure codes are configured in compliance with federal and state regulations and medical policies. The IBMT is a multi-department team that ensures decisions rendered by the MPC can be implemented operationally with any changes in configuration and coding. The UM Program Plan is reviewed and revised as necessary, but at least annually. The UM Program evaluation is conducted by the Clinical Care Services Vice-President, the UM Director, and the Commercial Lead Medical Director. The UM Program review is completed within 120 days of the fiscal year end (March 30). The workplan is presented and approved by the SHP Quality Improvement Committee. All changes to the UM Program are finalized by the MPC.

The Medical Policy Committee is comprised of medical directors and specialists from medical/surgical, behavioral health, and substance use disorder specialties. Specifically, voting members for recommendations of coverage decisions consist of the following: Health Plan Medical Directors, including the Behavioral Health Medical Directors, the Chief Medical Officer, VPs CCS (or proxy), and Director of Pharmacy (or designee) (for pharmaceutical items).

VPs CCS means the Vice President(s) of Clinical Care Services or his or her proxy for voting purposes on the MPC. VP Pharmacy means the Vice President of Pharmacy or his or her designee for pharmaceutical items.

The Medical Policy is comprised of 28 individuals with varying clinical or other specialties. Of the members of the Medical Policy Committee, 9 are considered MH/SUD experts and 13 are considered M/S experts in various specialties.

Step 4: Demonstration of comparability and stringency as written.

See **45 CFR 146.137(c)(4).** The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold

identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent

to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Regarding the factors, definitions, evidentiary standards, sources, and strategies described in Step Two and Step Three, Sentara provides the following information:

Documentation of Each Factor Identified and Defined in Step Two:

The following factors are implicated in determining whether concurrent review applies to certain services:

Service	Factors
All outpatient, M/S services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, M/S services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, MH/SUD services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria
All outpatient, MH/SUD services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria

Comparison of Existing Written Documents:

All plan terms and Sentara policies regarding utilization management, including concurrent review, are equally designed and applied to M/S and MH/SUD services with no variations.

The Concurrent Review Process is defined in the Provider Manual and Sentara utilization management policies. As it pertains to concurrent review, the MPC requires concurrent review for any service for which clinical criteria is established by MCG (inclusive of ASAM) and/or any internal clinical policy.

There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

How Factors Are Comparably Applied:

Sentara applies applicable industry standards (MCG for M/S and ASAM for MH/SUD) equally to all services in the respective classifications. Industry standards are applied without discretion, regardless of whether the particular service is M/S or MH/SUD. For services (either M/S or MH/SUD) for which there is no applicable industry standard, the Sentara MPC evaluates and reviews the requested service.

Reasons for Any Deviations or Variations:

There are no variations or deviations in the design or application of prior authorization between M/S and MH/SUD benefits.

Prior Authorization Similarities and Differences

There is no difference in the clinical utilization review process except for the timing in which the process takes place.

Initiation of Concurrent Review

For many outpatient services, determinations are made for initial authorizations, based upon clinical guidelines, to include a specific number of visits or units. If additional visits or units are required, the provider submits a request for the additional units or visits. The request is reviewed based on the clinical data presented at the time of the additional request for determination. If the initial authorization expires prior to concurrent authorization,[1] the authorization is considered a new authorization. This applies to both M/S and MH/SUD services.

Providers are made aware of obligations to initiate a concurrent review via the Provider Manual and Sentara's utilization management policies and procedures.

Initial Authorization

There is no difference in the clinical utilization review process except for the timing in which the process takes place.

Clinical Review

Clinical Review Processes

[1] Concurrent authorization and concurrent review are used interchangeably throughout this analysis.

Any processes and policies related to Utilization Management, including the role of the Medical Policy Committee, apply equally to both prior authorization and concurrent review. However, Peer to Peer review does apply to non-hospital services. Please see Sentara's Prior Authorization Analysis.

Case Management

Healthcare service teams (case management services) are comprised of clinical professional staff, behavioral health clinicians, and nonclinical staff. These teams are integrated around populations of members in specified managed care products. This allows for a complete plan of care for the patient encompassing case management, behavioral health, and disease management services. Types of issues which may be referred to healthcare services:

- members with complex medical issues who utilize multiple services
- members who are nonadherent with treatment plans
- members who frequently utilize services without consulting PCP or specialist • members who frequently utilize the ER
- members who could benefit from disease management of heart failure, metabolic cardiovascular disease, asthma, COPD, or obesity
- neonatal care for premature and medically complex newborns (partnership with ProgenyHealth)

Requests for services (written or verbal) may be initiated by:

- provider
- member
- Sentara

A member's participation in case management services is optional and cost-sharing is not impacted.

Case management is a not a NQTL and does not impact prior authorization, concurrent review, or coverage determinations. Sentara confirms that a decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time.

Case management is provided by a licensed Registered Nurse (RN) or Masters in Social Worker (MSW). Case managers work with hospital review teams and primary care physicians to assist with coordination and transition of care, and community resources. Case managers do not have the

ability to "override" a treating physician's recommended course of treatment or deny any request for authorization. Only Medical Directors can issue adverse benefit determinations.

As explained above, any decision to decline case management by a member does not result in any adverse action, including the lowering of reimbursement or the limitation of future treatment. Members have a right to terminate case management services at any time. Further, case managers cannot overturn treatment recommendation or issue adverse benefit determinations. Case management is optional and designed for care coordination. Activities are aimed at improving member health through risk reduction and minimizing complications through education.

Examples of levels of care to which case management applies include severe behavioral health risk or chronic condition with co-morbidities (medical or behavioral). Sentara's case management policy complies with the most current NCQA standards. CCS Leadership (Director and VP) review the policy annually, which mirrors NCQA accreditation requirements. The policy is reviewed and approved by the overarching SHP Policy and Procedure Committee.

Discharge Planning

"Discharge planning" begins during pre-admission or admission to transition to a lower outpatient level of care. The medical necessity of any inpatient service including inpatient MH/SUD and M/S services is determined by the applicable clinical criteria. Sentara utilizes MGC (which incorporate ASAM) for all MH/SUD and M/S inpatient services. Sentara is not aware of any denials for entire inpatient stays for a member leaving the facility and is not aware of a denial of inpatient MH/SUD services based upon a "lack of improvement."

Tracking of Denials

Sentara tracks turnaround times and reports all claim denials and closed internal and external appeals and complaints. Claim denials are tracked for services were not medically necessary and services not authorized concurrently.

For appeals, Sentara tracks whether the denials were upheld, partially upheld or overturned in closed internal appeals and closed external reviews.

Sentara follows NCQA mandates regarding the tracking of approvals and denials. If a requested service (level of care) is requested and denied, it is tracked as a denial, even if a lower level of care was authorized. This is accurate for both M/S and MH/SUD services.

For prior and concurrent authorization requests, Sentara tracks authorization volume by decision, including approvals, denials, and partial denials. Sentara also tracks the denial rate by episode type (i.e., inpatient M/S, inpatient MH/SUD, outpatient M/S, and outpatient MH/SUD).

Sentara follows a standard process for administrative denials. Specifically, Sentara processes administrative denials in the following circumstances: (i) services are not a covered member benefit or (ii) member is not eligible under the Plan. This policy applies to both M/S and MH/SUD services. As shown in the data included herewith, administrative denials are subject to appeals but such denials and appeals are tracked separately for denials and appeals related to medical necessity.

Tracking of Prior Authorization versus Concurrent Review

Prior authorization is tracked separately from concurrent authorizations.

Sentara uses the terms "concurrent review" and "concurrent service authorization" synonymously. Concurrent review is conducted within 72 hours of receiving the request provided that Sentara receives the request at least 24 hours prior to expiration of the previously approved time period or number of treatments. If the prior authorization has expired, the request is treated as a new request for prior authorization.

On-Site Audits

Except for the M/S utilization management vendors described in Step One of this Analysis, utilization review is performed by Sentara on-site. The process is also described throughout the Sentara's Prior Authorization Submission. All utilization review for MH/SUD is performed by Sentara.

Extent of Medical Records Required

Sentara may request medical records for review. Listed below are the current medical record standards:

- Comprehensive history and physical, including the history of present illness and relevant psychiatric history
- Documentation of allergies and adverse reactions to medications
- Problem list
- Medications management and reconciliation
- Clinical findings and evaluations documented for each visit
- Preventive services and risk screenings
- Diagnoses, including documentation for behavioral health
- Substance use assessment
- Mental status examination
- Treatment planning
- Evidence of continuity of care

The standards above apply equally to M/S and MH/SUD.

Appeal Rights

The appeals process for concurrent review decisions are identical to the process for prior authorization decisions. Specifically, the timeframes to review appeals are compliant with NCQA standards and identical for M/S and MH/SUD appeal of authorization denials. Providers and members have 180 days from notice of an adverse benefits determination to request an appeal. For pre-service appeals, Sentara must respond within 30 days. Following one level of internal appeal, a request for an external appeal is available.

External review appeal rights apply to both M/S and MH/SUD benefits. There is no difference in application of an external review. A member or provider can appeal any decision (whether M/S or MH/SUD) regardless of whether the member accepts and receives a lower level of care.

In the context of the internal appeal process, any denial or reduction of benefits and/or nonpayment based upon a determination of medical necessity is treated as an Adverse Benefit Determination and subject to the appeal process outlined in the plans. Written notice of Adverse Benefit Determinations is required except for Urgent Claims, where notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notice of an Adverse Benefit Determination includes the following:

- The specific reason or reasons for the Adverse Benefit Determination;
- Reference to the specific Plan provisions on which the determination is based;
- A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.

Any member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination. For denials due to Medical Necessity, members are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances.

After notification of an Adverse Benefit Determination, a member has 180 days to request an appeal. Upon appeal, all comments, documents, records, and other information submitted is reviewed. Additional information may be provided. The clinical peer reviewer reviewing the appeal will not have participated in the original coverage decision. Should a member disagree with the Final Benefit Determination, an external appeal is available.

Alternative Levels of Care

Prior and initial authorizations are tracked separately from concurrent reviews. The provider is responsible for obtaining concurrent authorization prior to expiration of the initial authorization. Should the initial authorization expire before a concurrent review occurs, the authorization typically is considered a new authorization for both M/S and MH/SUD outpatient benefits.

Step 5: Demonstration of comparability and stringency in operation.

See 45 CFR 146.137(c)(5). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Please see the analysis in Step 5 of Sentara's Prior Authorization Submission and data attached thereto as it applies to both prior authorization and concurrent review.

Step 6: Findings and conclusions.

See **45 CFR 146.137(c)(6).** The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section

146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the **FAQ 45** guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara defined the Concurrent Review NQTL and clarified that the only type of preauthorization/concurrent review is clinical review. For Step 1, Sentara identified that all inpatient services are subject to preauthorization/concurrent review. Sentara referred to its Prior Authorization Analysis, including the information provided as to all vendors that provide utilization review. Sentara provided the factors and sources considered when requiring certain outpatient services be subject to preauthorization. Sentara noted that for MH/SUD outpatient services, the applicable factor is industry standards, including CMS, DMAS, LCDs, NCDs, and Milliman Clinical Guidelines. In Step 4 (both as written and in-operation), Sentara provided and analyzed policies and processes applicable to preauthorization and concurrent review for

inpatient services and provided data including, but not limited to, authorization and denials, authorization by priority, MD referral rates, peer-to-peer reviews, audit results and appeals. Sentara completed the comparative analysis, set forth in Steps 4 and 5 above.

Analysis establishes Sentara is compliant with MHPAEA.

This analysis was completed in September 2026 by the following Sentara departments: Utilization Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

RETROSPECTIVE REVIEW: INPATIENT, IN-NETWORK

(NOT APPLICABLE TO EMERGENCY SERVICES

EXCEPT AS TO CODING EDITS)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See 45 CFR 146.137(c)(1). Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also FAQ 45 (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

Definitions

Pre-Payment Review: Sentara does not conduct any pre-payment review of providers. While corrective actions plans are utilized as outcomes for FWA audits and investigations, those corrective plans do not include pre-payment review.

Pre-Payment FWA: Sentara does not conduct any pre-payment FWA audits or investigations of providers. While the Provider Manual permits Sentara to conduct pre-payment FWA audits or investigations, Sentara does not currently conduct any pre-payment FWA review for M/S or MH/SUD services.

Coding Edits: Sentara does not conduct any pre-payment coding edits.

NOTE: *The remainder of this analysis will focus solely on pre-claim retrospective review and post-claim retrospective review (each defined below) because Sentara does not use pre-payment reviews, pre-payment FWA, coding edits, or any other form of retrospective review.*

Pre-Claim Retrospective Review: Pre-claim retrospective review means the review of the member's medical records and other supporting documentation by the Plan after services have been rendered to determine the Plan's liability for payment. Pre-claim retrospective review pertains to the time period post-service, but pre-claim submission. Specifically, pre-claim retrospective review only applies to services which required a prior authorization, and one was not obtained before the service was rendered. Post-service, pre-claim retrospective review does not apply if authorization was requested and denied. Pre-claim retrospective review also does not apply once a claim has been submitted. Pre-claim retrospective review applies to both M/S and MH/SUD services.

Post-Claim/Post-Denial Retrospective Review ("Post-Claim"): Post-claim retrospective review means the review of the member's medical records and other supporting documentation by the Plan after services have been rendered to determine the Plan's liability for payment. Post-claim retrospective review pertains to the time period post-service, post-claim submission. Services are eligible for post-claim retrospective review only upon request for reconsideration by a provider. Providers may request reconsideration of claims for services which require prior authorization that are submitted without an authorization having been granted by Sentara and later denied. Claims for services which require authorization will deny provider responsible if authorization is not obtained and no payment will be issued. Reconsideration focuses on the processing of the claim and does not allow for modification of the claim. It applies equally to both M/S and MH/SUD claims. For a first-level review, the reconsideration request must be received within 365 days from the date of service. If timely received, a medical necessity review is conducted. If medical necessity is met, the claim is authorized. If medical necessity is not satisfied, a subsequent review is conducted by a Medical Director and either approved or denied. A second-level reconsideration review occurs if requested within 60 days of the notification of the first-level claim reconsideration. For medical necessity denials, the second-level reconsideration review is conducted by a Medical Director not originally involved with the review.

Vendors:

Pre-Claim Retrospective Review: As set forth in its Prior Authorization and Concurrent Review Analyses, Sentara utilizes vendors for utilization review of certain M/S services. These vendors

perform utilization review for their respective services (as described below) for pre-claim retrospective review. Sentara does not utilize vendors for medical necessity reviews for MH/SUD services regardless of the timing of those reviews.

Post-Claim Retrospective Review: As it pertains to post-claim retrospective reviews, these reviews are conducted only if initiated by a provider under Sentara reconsideration processes. Once initiated, Sentara, through its Utilization Management Department, internally will review for medical necessity. With the exception of chiropractic services, Sentara does not utilize vendors for post-claim retrospective review for M/S or MH/SUD services. With the exception of chiropractic services, post-claim medical necessity reviews are performed internally by the Utilization Management Department using Sentara's definition of medical necessity.

With respect to chiropractic services, a vendor ("UM Vendor 1")conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate third-party vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a services agreement. UM Vendor 2 is URAC and NCQA accredited. Under the services agreement provides, UM Vendor 2 providers access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a services agreement.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Separate Operating Departments or Divisions:

Pre-Claim Retrospective Review: There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Post-Claim Retrospective Review: There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Supporting Documentation

Sentara maintains an organizational chart of positions with the Utilization Management department. Moreover, Sentara maintains policies and procedures relating to retrospective review including a Utilization Management Program Description, an Annual Commercial and Exchange Utilization Management Evaluation, Provider Claim Reconsideration Procedure, Technology Assessment and Coverage Decision Policy, Administrative Denial Policy, and Medical Policy Committee Charter.

Traditional Retrospective Review

Sentara defines the traditional retrospective review as a medical necessity review that takes place after services have been rendered. Traditional retrospective review includes both pre-claim and post-claim retrospective review.

Pre-Claim Retrospective Review: All services which require an authorization are eligible for pre-claim retrospective review if a request for authorization is submitted post-service, but pre-claim. Services are not eligible for pre-claim retrospective review if the service does not require authorization or if authorization was already requested. Pre-claim retrospective review does not apply if a claim has been submitted for the requested service. A provider is responsible for initiating or requesting a pre-claim retrospective review. Sentara does not initiate requests for pre-claim retrospective review. The process mirrors that of prior authorization or concurrent review (with limited differences discussed in the analysis below). The pre-claim retrospective review process does not vary between M/S and MH/SUD services.

Post-Claim Retrospective Review: Services are eligible for post-claim retrospective review upon a reconsideration request by a provider under the Sentara reconsideration process. A provider is responsible for initiating or requesting a post-claim reconsideration. Sentara does not initiate post-claim retrospective reviews. At claim submission, if a service requiring prior authorization was not authorized the claim will be administratively denied provider responsible for no authorization. A provider may then initiate a request for post-claim retrospective review of medical records. That process is considered a reconsideration or member appeal of an adverse benefit determination and is described in Sentara's Post-Payment Retrospective Review Analysis. The reconsideration or member appeal process does not vary between MH/SUD and M/S benefits.

Services to Which NQTL Applies:

The M/S and MH/SUD services to which the preauthorization NQTL applies are those services to which the retrospective review (both pre-claim and post-claim) NQTL applies. Specifically, retrospective review applies to all inpatient services, both M/S and MH/SUD.

Specific Medical/Surgical Benefits to Which NQTL Applies

Specifically, retrospective review applies to all inpatient services, both M/S and MH/SUD.

Specific MH/SUD Benefits to Which Prior Authorization Applies

Specifically, retrospective review applies to all inpatient services, both M/S and MH/SUD.

There are a number of ways Sentara identifies which services are subject to prior authorization for clinical review (and thus may be subject to retrospective review). Specifically:

Plan Documents:

The HMO and PPO plan documents state the following:
"Some Covered Services under this Plan require Pre-Authorization to be Covered. Please read the entire section on Pre-Authorization in the EOC."

Defines Pre-Authorization as "an evaluation process which assesses the medical necessity of proposed treatment and checks to see that the treatment is being provided at the appropriate level of care."

Describes preauthorization and states: "On Your Schedule of Benefits, We tell You what services require pre-authorization before You receive them. You can also look in the What is Covered Section of this document or call Member Services to find out about Pre-Authorization."

Describes generally the types of services which require preauthorization, including: Inpatient hospitalization services; Partial hospitalization services; Residential treatment services; Non-emergency ambulance transport; Inpatient and outpatient surgery; Surgery in a physician's office; Single items of durable medical equipment and orthopedic and prosthetic appliances over [$750]; Rental of durable medical equipment and orthopedic and prosthetic appliances; Repair and replacement items of durable medical equipment and orthopedic and prosthetic appliances; Artificial prosthetic limbs; Prenatal maternity services (excluding recommended preventive care services, screenings, and one breast pump per pregnancy); Home health care; Skilled Nursing Facility care; Physical, occupational, and speech therapy; Cardiac, pulmonary, and vascular rehabilitation; IV therapy with medications; Inhalation therapy; Early intervention services; Clinical trials for treatment studies on cancer; Hospice services; Oral surgery; TMJ services; Tubal ligation; Hospitalization and anesthesia for dental procedures; Treatment of lymphedema; Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiography (MRA); Positron Emission Tomography (PET) scans; Computerized Axial Tomography (CT) scans; Computerized Axial Tomography Angiogram (CTA) scans; Sleep studies; transplant services; Injectable and infused medications, biologics, and IV therapy medications defined by Our Pharmacy Committee; Intensive outpatient programs (IOP); Medical, psychological and neuro psychological diagnostic procedures and testing; Electro-convulsive therapy (ECT); Telemedicine service; Transcranial Magnetic Stimulation (TMS); Insulin pumps and insulin pump infusion sets and supplies; Chemotherapy and Chemotherapy Drugs; Radiation Therapy; Dialysis Services; Genetic Testing and Counseling. If Your plan includes any riders generally those services will require Pre-Authorization listed in the rider.

Define Covered Services and designate those which require prior authorization. These Services and others are then further defined.

Schedule of Benefits

States “Some benefits require Pre-Authorization before You receive them. These services ae marked with an * in this document.”

The Schedules of Benefits designate the following service types as requiring preauthorization: outpatient therapies and services; outpatient dialysis; outpatient surgery; outpatient lab, diagnostic, imaging, and testing; outpatient advanced imaging, testing and scans; injectable and infused medications; maternity care; inpatient M/S services including inpatient hospital services, transplants, skilled nursing facility services; non-emergency transport; inpatient MH/SUD services including hospital services, residential treatment services, partial hospitalization, intensive outpatient program services, transcranial magnetic stimulation, electro-convulsive therapy, autism spectrum disorder, other outpatient services; diabetes treatment including insulin pumps, pump infusion sets and supplies, talking blood glucose meters, insulin, and needles and syringes for injection; prosthetic devices and components, repair, fitting, replacement and adjustment; durable medical equipment for items over $750, repair, replacement, and rental items; wigs following cancer treatment; early invention services including speech and language therapy, occupational therapy, physical therapy, assistance technology services and devices; home health care; private duty nursing; hospice care; reconstructive breast surgery for members who have had a mastectomy; infertility services including endometrial biopsies, semen analysis, hysterosalpingography, Sims-Huhner test, diagnostic laparoscopy; clinical trial services; allergy testing and serum; telemedicine services; chiropractic services; hearing aids and related services for children 18 and younger

Provider Manual

The Provider Manual states:

“Except in the case of emergency treatment, prior authorization will be required for: all inpatient hospitalizations, all partial hospitalizations (mental health or substance abuse), all outpatient surgeries/short stays/observations and IV therapy and drug infusions, all skilled nursing facility admissions, all acute rehabilitation, all intensive outpatient programs, all out-of-area services or referrals to nonparticipating providers (prior to scheduling) for members that do not have out-of-network benefits included in their plan. All the following services require prior authorization regardless of the place of service: Commercial plan DME single purchased items greater than $750 and all rentals, orthotics/prosthetics, single purchased items greater than $750 and all rentals, repair, replacement, and duplicates, home health, hospice, IV infusions, plastic surgery, all rehabilitation programs (cardiac, vascular, vestibular, pulmonary, etc.), therapies (PT, OT, ST), applied behavioral analysis, early intervention services (part H certificate required), OB global notification, transplant services, human and synthetic tissue, oral surgery and related services, advanced imaging studies (PET, CT, CTA, MRI, MRA, MR-CT), sleep studies, hyperbaric therapy, electronic bone stimulator, any surgical or diagnostic procedure for which anesthesiology or conscious sedation is billed, injectable drugs indicated on the online prior-authorization forms, genetic testing (if covered by group/plan), bone densitometry if less than 24 months since last study.”

Prior Authorization List: (accessible at http://pal.sentarahealthplans.com/)

Tool allows anyone to access and search for procedure code or description to determination whether prior authorization is required.

Procedure and Revenue Codes:

As previously stated, all inpatient services require prior authorization.

Certain services such as PT, OT, and ST, can be used for both MH/SUD and M/S conditions. Specific to these therapies, Sentara ensures MHPAEA compliance through benefit structure. Currently, no numerical visit limitations are placed on PT, OT, and ST for MH/SUD, unlike the annual visit limits for M/S. For other services such as non-emergency transport, Sentara does not preauthorize services strictly by diagnosis. If a medical necessity review is required for the service, it will include all pertinent clinical information required to make a determination based on the appropriate necessity criteria used whether that be internal medical policies or MCG (which incorporate ASAM). For example, Sentara tracks transportation authorizations but does not track whether authorization for non-emergency transportation was reviewed for an underlying M/S or MH/SUD condition.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See 45 CFR 146.137(c)(2). Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:
  (A) A detailed description of the factor;
  (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
  (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining

which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Sentara incorporates by reference its Analyses for Prior Authorization and Concurrent Authorization. The only factor and standard that differs between Prior Authorization and Retrospective Review is that Retrospective Review applies when prior or concurrent authorization was required but not obtained.

Step 3: Description of how factors are used in the design and application of the NQTL.

See **45 CFR 146.137(c)(3).** Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Sentara incorporates by reference its Analyses for Prior Authorization and Concurrent Authorization.

Step 4: Demonstration of comparability and stringency as written.

See 45 CFR 146.137(c)(4). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S

benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Documentation of Each Factor Identified as Defined in Step Two:

The following factors are implicated in determining whether Prior Authorization applies to certain services:

Service	Factors
All outpatient, M/S services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, M/S services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, MH/SUD services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria
All outpatient, MH/SUD services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria

As explained above, the only factor that determines whether retrospective review (pre-claim or post-claim) applies is whether the claim is for a service requiring prior authorization or concurrent authorization when the provider failed to obtain one.

How Factors are Comparably Applied:

Sentara applies applicable industry standards (MCG for M/S and ASAM for MH/SUD) equally to all services in the respective classifications. Industry standards are applied without discretion, regardless of whether the particular service is M/S or MH/SUD. For services (either M/S or MH/SUD) for which there is no applicable industry standard, the Sentara MPC evaluates and reviews the requested service.

Reasons for Any Deviations or Variations:

There are no variations or deviations in the design or application of prior authorization between M/S and MH/SUD benefits.

Comparison of Existing Written Documents:

The policies and procedures identified and defined in the preauthorization NQTL apply to the retrospective review NQTL. There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

Prior Authorization, Concurrent Review, and Retrospective Review

Pre-Claim Retrospective Review: Policies and procedures for pre-claim retrospective review are identical to those for preauthorization and concurrent review except for two aspects. First, the timing of the review is different. For pre-claim retrospective review, the timing consists of post-service, pre-claim services. Second, and relatedly, discussions of lower levels of care are not applicable since the service has been provided. Reviewing Medical Directors do use the same

peer-to-peer process when reviewing medical necessity pre-claim, post-service as they do when reviewing medical necessity pre-claim, pre-service. This process applies to both M/S and MH/SUD services.

Post-Claim Retrospective Review: Sentara's policies and procedures for retrospective review are identical" to those for preauthorization and concurrent review except for a few key differences described herein. The first difference is the timing of the review. For post-claim retrospective review, a reconsideration request occurs from the provider post-claim and after the claim has denied. There are differences in the process for clinical review when conducted post-claim at the request for reconsideration by the provider. One difference is that UM Vendor 1 is the only vendor used to conduct medical necessity reviews in the reconsideration process. While vendors never conduct utilization review for MH/SUD services, as described in Sentara's Medical Necessity Analysis, vendors are used for certain M/S services. With the exception of UM Vendor 1, these vendors are not used when the clinical review is conducted retrospectively through the post-service reconsideration process. Also, Sentara does not conduct peer-to-peer reviews and does not negotiate lower levels of care because the service has been rendered the claim submitted. This process applies to both M/S and MH/SUD services.

Traditional Retrospective Review:

Clinical Review Processes

Pre-Claim Retrospective Review: All clinical review requests are assessed based on approved clinical criteria and guidelines (as explained in Sentara's Medical Necessity Analysis for commercial lines of business, when no internal medical policies exist for any MH/SUD or M/S service, MCG is utilized without incorporation or supplementation of any internal guidelines or policies.). For pre-claim retrospective review, reviews and decisions will be completed within 30 days of received the request. If an authorization request results in an adverse determination, providers and members are notified of post-service decisions via adverse benefit determinations which contain appeal instructions. Providers or members have 180 days from notice of an adverse benefit determination to ask for an appeal. When Sentara reviews an appeal, Sentara looks at all comments, documents, records, and other information submitted to Sentara. Appeals involving medical necessity will be reviewed by a clinical peer reviewer, with the same qualification as described in Sentara's Prior Authorization Analysis, who did not participate in the first coverage decision. When Sentara completes the appeal, Sentara will send written notification of the decision. If Sentara Health Plans doesn't change the initial decision the notice will include:

1. The specific reason for the decision;

2. The specific plan provisions Sentara Health Plans based the decision on; and

3. Information on any independent external appeal rights. In general, the internal appeal process must be exhausted prior to filing an independent external appeal. An exception exists for the treatment of cancer.

The levels of review include a request for authorization which is handled by clinicians, including "Registered Nurses, Licensed Practical Nurses, Clinical Pharmacists, Clinical Psychologists, and Board certified Medical and Behavioral Health Physicians (Medical Directors)." The process does include access to Board Certified Physicians to serve as physician specialty advisors. At the discretion of the medical director or for appeals and grievances, cases are referred to these physicians to review for medical necessity or appropriateness. If a request for authorization

results in an adverse benefit determination, providers and members have 180 days to request an appeal. Providers may also request a peer review or reconsideration, which is not considered part of the appeal. There is one level of internal appeals. Registered and practical nurses can authorize, but not deny a service. Any denials of medical necessity must be conducted by a Medical or Behavioral Health Physician (Medical Director) depending on the service type. Post-claim retrospective clinical review upon a request by a provider for reconsideration does not include peer-to-peer review.

Post-Claim Retrospective Review: All clinical review requests are assessed based on approved clinical criteria and guidelines (as explained in Sentara's Medical Necessity Analysis, for commercial lines of business, when no internal medical policies exist for any MH or M/S service, MCG is utilized without incorporation or supplementation of any internal guidelines or policies.). For a first-level review post-claim provider reconsideration requests, the reconsideration request must be received within 365 days from the date of service. If timely received, a review is conducted to determine medical necessity. If medical necessity is not satisfied, a subsequent review is conducted by a Medical Director and either approved or denied. A second-level reconsideration review occurs if requested within 60 days of the notification of the first-level claim reconsideration. For medical necessity denials, the second-level reconsideration review is conducted by a Medical Director not originally involved with the review. A post-service, pre-claim request for authorization is handled by clinicians, including "Registered Nurses, Licensed Practical Nurses, Clinical Pharmacists, Clinical Psychologists, and Board certified Medical and Behavioral Health Physicians (Medical Directors)." The process does include access to Board Certified Physicians to serve as physician specialty advisors. At the discretion of the medical director or for appeals and grievances, cases are referred to these physicians to review for medical necessity or appropriateness. If a request for authorization results in an adverse benefit determination, providers and members have 180 days to request an appeal. There is one level of internal appeals. Registered and practical nurses can authorize, but not deny a service. Any denials of medical necessity must be conducted by a Medical or Behavioral Health Physician (Medical Director) depending on the service type. Post-claim retrospective clinical review upon a request by a provider for reconsideration does not include peer-to-peer review.

Tracking of Denials

Sentara tracks and reports all claim denials and closed internal and external appeals and complaints. Sentara tracks administrative denials as compared to denials for medical necessity. For appeals, Sentara tracks whether the denials were upheld, partially upheld or overturned in closed internal appeals and closed external reviews.

Pre-Claim Retrospective Review:

2023: M/S IP

702 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 663 were initiated by in-network providers and 39 from out-of-network providers for a 5.56% of out-of-network providers. The denial rate of the 702 requests was 19.37%, and 20.8% of the requests were referred to MD.

2023: MH/SUD IP

24 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 20 were initiated by in-network providers and 4 from out-of-network providers for a 16.67% of out-of-network providers. Of the 24 requests, 20 were approved for a 16.67% denial rate. 16.7% of the requests were referred to MD. Only 1 of the 4 denials constituted a medical necessity denial.

2023: M/S OP

4083 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 3760 were initiated by in-network providers and 323 from out-of-network providers for a 7.91% of out-of-network providers. The denial rate of the 4083 requests was 7.89%, and 8.3% of the requests were referred to MD.

2023: MH/SUD OP

5 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 4 were initiated by in-network providers and 1 from out-of-network providers for a 20% of out-of-network providers. Of the 5 requests, 5 were approved for a 0% denial rate. 0% of the requests were referred to MD.

2024: M/S IP

450 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 433 were initiated by in-network providers and 17 from out-of-network providers for a 3.78% of out-of-network providers. Of the 450 requests, 352 were approved for a 22% denial rate. 22% of the requests were referred to MD.

2024: MH/SUD IP

24 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 20 were initiated by in-network providers and 4 from out-of-network providers for a 16.67% of out-of-network providers. Of the 24 requests, 23 were approved for a 4.17% denial rate. 8.3% of the requests were referred to MD.

2024: M/S OP

3025 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 2869 were initiated by in-network providers and 156 from out-of-network providers for a 5.16% of out-of-network providers. The denial rate of the 3025 requests was 5.65%, and 4.9% of the requests were referred to MD.

2024: MH/SUD OP

7 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 5 were initiated by in-network providers and 2 from out-of-network providers for a 28.57% of out-of-network providers. Of the 7 requests, 7 were approved for a 0% denial rate. 28.6% of the requests were referred to MD.

Post-Claim Retrospective Review: For post-service, post-claim requests for reconsideration, the authorization volume by review can be reported as follows:

2023: M/S

503 Total Requests for Post-Claim Retrospective Review. Of these requests 484 were initiated by in-network providers and 19 by out-of-network providers for a 3.78% of out-of-network providers. Of the 503 requests, 21 were for inpatient services and 482 were for outpatient services. All requests for inpatient services were approved. Of the 482 requests for outpatient services, 28 were denied for a denial rate of 5.57%. Of the 5.57%, 5.12% denied for medical necessity. The MD referral rate was 4.1%.

2023: MH/SUD

5 Total Requests for Retrospective Review (Post-Service). Of these requests, 4 were initiated by in-network providers and 1 from an out-of-network provider for a 20% of out-of-network providers. Of the 5 requests, all were for inpatient services and all were approved for a 0% denial rate. None of the 5 requests were referred to Medical Directors. There were no MH/SUD Requests for Retrospective Review for outpatient services in 2023.

2024: M/S

2056 Total Requests for Retrospective Review (Post-Service). Of these requests,1974 were initiated by in-network providers and 82 from out-of-network providers for a 3.99% of out-of-network providers. Of the 2056 total requests, 1926 were approved, 131 were denied and 1 claim was partially denied for a denial rate of 6.42%. Of the 2056 claims, 180 were for inpatient services. Of these 180 claims, the denial rate was 1.67%. The MD Referral Rate for inpatient services was 0 .6%. Of the 2056 claims, 1876 were for outpatient services. Of these 1876 claims, the denial rate was 6.88%. The MD Referral Rate for outpatient services was 4.5%. Of the total 131 denials and 1 partial denial, 110 were denied as not being medically necessary and 21 were administratively denied for non-covered service or benefit exhaustion. The Medical Director referral rate was 4.1%.

2024: MH/SUD

21 Total Requests for Retrospective Review (Post-Service). Of these requests, 19 were initiated by in-network providers and 2 from out-of-network providers for a 9.52% of out-of-network providers. Of the 21 total requests, all 21 were approved for a 0% denial rate. Of the 21 claims, 11 were for inpatient services. Of these 11 claims, the denial rate was 0%. Of the 21 claims, 10 were for outpatient services. Of these 10 claims, the denial rate was 0%.

Appeals Data:

2023: In 2023 there were 0 MH/SUD provider medical necessity appeals, compared with 19 M/S medical necessity appeals.

2024: In 2024, there was 1 MH/SUD medical necessity provider appeal, compared with 34 M/S provider medical necessity appeals.

Extent of Medical Records Required

The policies related to medical records are identified in the preauthorization NQTL. Any additional medical records establishing medical necessity are pertinent to any traditional retrospective review.

Appeal Rights

In the context of the internal appeal process, any denial or reduction of benefits and/or nonpayment based upon a determination of medical necessity is treated as an Adverse Benefit Determination and subject to the appeal process outlined in the plans. Written notice of Adverse Benefit Determinations is required except for Urgent Claims, where notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notice of an Adverse Benefit Determination includes the following:

• The specific reason or reasons for the Adverse Benefit Determination;

• Reference to the specific Plan provisions on which the determination is based;

• A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.

Any member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination.

For denials due to Medical Necessity, Experimental treatment, or similar exclusion or limit, members are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances.

After notification of an Adverse Benefit Determination, a member has 180 days to request an appeal. Upon appeal, all comments, documents, records, and other information submitted is reviewed. Additional information may be provided. The clinical peer reviewer reviewing the appeal will not have participated in the original coverage decision. Should a member disagree with the Final Benefit Determination, an external appeal is available. There are no differences in the process for appeals of retrospective reviews as it relates to MH/SUD and M/S benefits.

Lower levels of care are not authorized in retrospective reviews because the services have already been provided. As a general matter, for requests for prior or concurrent authorizations, a member or provider can appeal any decision (whether M/S or MH/SUD) regardless of whether the member accepts and receives a lower level of care.

Approvals of Lower Levels of Care

Discussions of lower levels of care are not applicable during pre-claim retrospective reviews since the service has been provided or during post-claim retrospective reviews because the claim has already been submitted. This applies to both M/S and MH/SUD services.

Initiation of Clinical Review

Pre-Claim Retrospective Review: The provider must initiate a request for pre-claim retrospective review. Sentara will not initiate any request for retrospective review. A pre-claim request for retrospective review will be conducted, upon request of the provider, for any requested service which a prior authorization was required but not obtained. This is true for M/S and MH/SUD services. A provider is made aware of this process through the Provider Manual which is available to both in-network and out-of-network providers. If an authorization was required and

not obtained, the provider is required to hold the member harmless. Extensions for additional time and requested documents are consistent with M/S and MH/SUD services. The data establishes the operation of pre-claim retrospective review as being inherently consistent, in that no denials for MH/SUD outpatient services occurred in 2023 or 2024 on pre-claim retrospective review. As for inpatient MH/SUD services, denials on pre-claim retrospective review totaled 16.67% in 2023 (compared to 19.37% for M/S services) and 4.17% in 2024 (compared to 22% for M/S).

Post-Claim Retrospective Review: The provider must initiate a request for reconsideration for post-claim retrospective review. Sentara will not initiate any request for retrospective review. A post-service retrospective review will be conducted, upon request of the provider, for any requested service which a prior authorization was required but not obtained. This is true for M/S and MH/SUD services. A provider is made aware of this process through the Provider Manual which is available to both in-network and out-of-network providers. If an authorization was required and not obtained, the provider is required to hold the member harmless. Extensions for additional time and requested documents are consistent with M/S and MH/SUD services. The data establishes the operation of post-claim retrospective review as being inherently consistent, in that no denials for MH/SUD services occurred upon post-claim retrospective review in 2023 and 2024.

Initial Authorization

The type of initial authorization does not have any impact on retrospective review. In the event of an inpatient admission, once notification or a request for authorization occurs, a medical necessity review is conducted.

Step 5: Demonstration of comparability and stringency in operation.

See 45 CFR 146.137(c)(5). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies,

evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

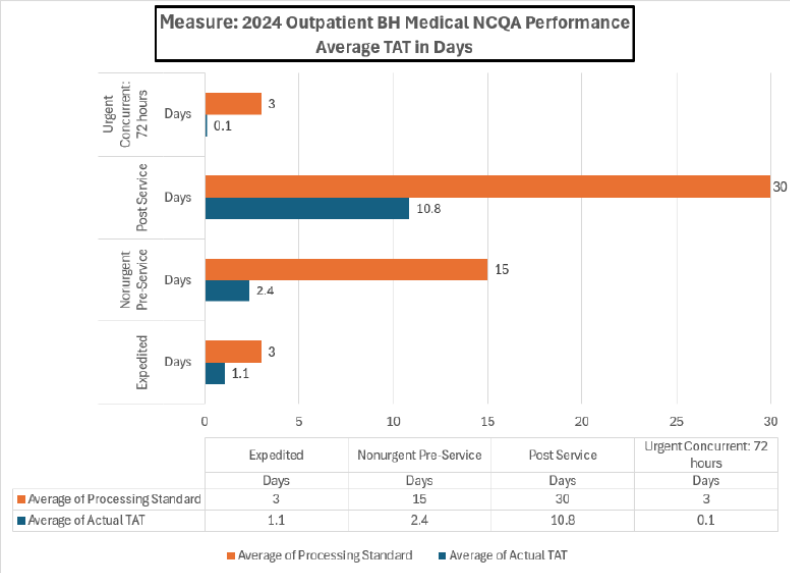
- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

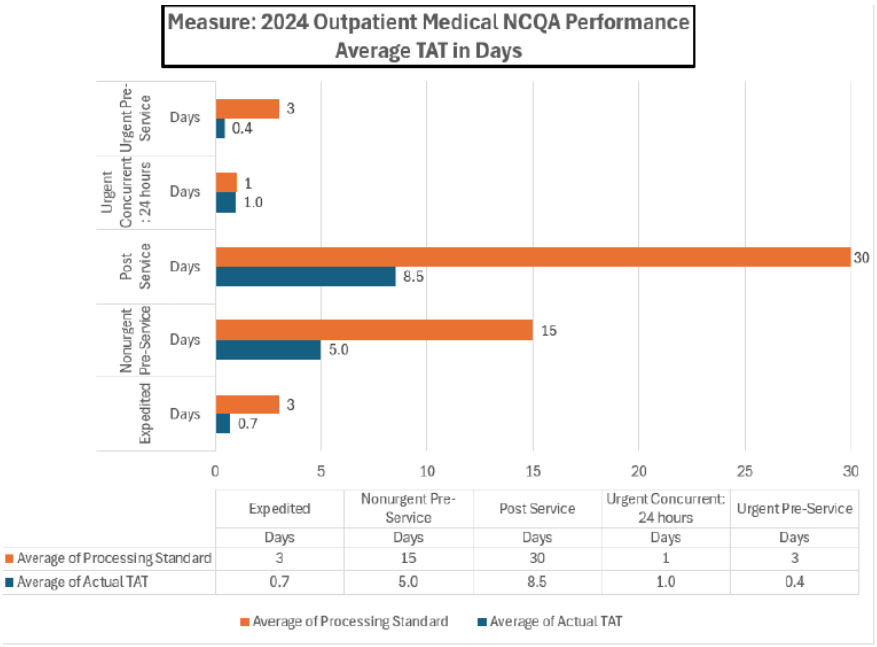
Data provided herein is for 2024 Virginia fully-insured plans. This analysis will be supplemented with 2025 data when it becomes available. See denial rates and peer-to-peer reviews for pre-claim retrospective reviews above. See denial rates for post-claim retrospective reviews above.

Pre-Claim Retrospective Review— Turnaround Times: The charts below specify pre-claim, post-service data.

2024 Outpatient MH/SUD NCQA Performance:



2024 Outpatient M/S NCQA Performance:



IRR Testing:

Sentara performs IRR testing as described below:

o Required score to pass: 80%

o How participants are evaluated: Test is developed by Sentara's utilization management leadership and educators. It consists of a variety of scenarios (inpatient, outpatient, behavioral health and medical). The same test is administered to all clinical staff who review requests for authorization determination.

o Results: 100% MH/SUD pass rate for 2022 and 2023 and M/S 97.9% for 2022 and 96% for 2023

o Separate testing occurs for MH/SUD reviewers and M/S reviewers: There are separate scenarios/questions addressing M/S or MH/SUD. The utilization team is separated by M/S and MH/SUD. If the clinical staff is on the MH/SUD team, they will take the MH/SUD test and the same is accurate for M/S.

Pre- and Post-Claim Retrospective Review: Sentara has implemented a policy regarding Measuring Staff Consistency Including Inter-rater Reliability. Testing is scored individually. The results of each individual tested should be at least 80% accurate. A report will be given to each manager/team coordinator for staff who make UM decisions and to the Chief Medical Officer (CMO) for Medical Directors. UM Staff and Medical Directors will have ongoing education regarding the use of criteria. Training will be completed with staff and Medical Directors who do not achieve at least an 80% test score.

Sentara audits monthly its utilization management processes. Sentara audit its Monthly and Quarterly Utilization report that includes for example:

o Days/1000, Admissions/1000

o Average length of stay (ALOS)

o Observation days/1000

o Readmission rate for both medical and behavioral health services

o Outpatient surgeries/1000

o Outpatient visits/1000

o Milliman Benchmarking

o High-Dollar claims

o Complex medical conditions

o Authorizations provided to non-participating providers

Sentara conducts an annual evaluation of its utilization management program, which includes an evaluation of vendors performing utilization management services for Sentara.

In Operation Data

Post-Service, Pre-Claim Retrospective Review

Sentara collected post-service, pre-claim retrospective requests for authorization data as requested for 2023 and 2024 to determine if denials were disproportionate for MH/SUD outpatient services as compared to M/S outpatient services.

In 2023, for outpatient services, there were a total of 4088 post-service, pre-claim requests for authorizations. Of these post-service, pre-claim requests for authorization, 4083 were for outpatient M/S services and 5 were for outpatient MH/SUD services. As for outpatient M/S services, the denial rate was 7.89% for outpatient M/S services. Of the 7.89% of denials, 5.57% denied for medical necessity. As it relates to MH/SUD requests for outpatient services, of the 5 requests, all 5 were approved. The denial rate was 0%. With this data, Sentara does not see disparity in the application of its utilization management program, for post-service, pre-claim retrospective review for outpatient claims.

The same trend occurred in 2024. For outpatient services, there were a total of 3032 post-service, pre-claim requests for authorization. Of these post-service, pre-claim requests for authorizations, 3025 were for outpatient M/S services and 7 were for outpatient MH/SUD services. As for inpatient M/S services, the denial rate was 5.65% for M/S services. Of the 5.65% of denials, 2.67% denied for medical necessity. As it relates to MH/SUD outpatient services, of the 7 requests, all 7 were approved. The denial rate was 0%. With this data,

Sentara does not see disparity in the application of its utilization management program, for post-service, pre-claim retrospective review.

Physician review – In analyzing physician review, Sentara's main objective was to determine if the MH/SUD physician reviewers were applying discretion in a way that was more stringent or arbitrary than how M/S physicians applied discretion and to determine if they were adhering to criteria in a fashion that was no more stringent than M/S physicians' adherence to criteria. Sentara further studied MD (Medical Director) referral rates. In 2023, Sentara discovered that percentages of requests for authorizations referred for Medical Director review was higher in M/S than MH/SUD inpatient services. In 2023, 8.3% of M/S outpatient requests for authorization were referred to MD review, as compared to 0% of MH/SUD outpatient requests for authorization. This trend reversed in 2024, 4.9% of M/S outpatient requests for authorizations were referred to MD Review as compared to 28.6% for MH/SUD outpatient services. Given that 0 denials occurred for medical necessity for MH/SUD services in 2023 and 2024, MD referrals appear to be a positive review protocol and physician review is not causing any disparate impact.

In reviewing peer-to-peer review data, the objectives were largely the same. While significantly more M/S inpatient services are subject to peer review than MH/SUD inpatient services, the denial rates are much lower for MH/SUD inpatient services. In fact, no MH/SUD services (inpatient or outpatient) were referred to peer-to-peer in 2023 and 2024. With such few instances of peer to peer review, 10 total in 2023 and 2024 combined, it is difficult to determine any trends, however, denial rates indicate that utilization review is not being more stringently applied to MH/SUD inpatient services.

Appeal data further confirms that no disparity exists as to utilization review. In 2023, for MH/SUD services, 7 appeals occurred throughout the commercial line of business and none of the 7 appeals were medical necessity appeals. In 2024, there were 5 appeals for MH/SUD services and only 1 appeal concerned medical necessity.

Sentara further compared turnaround time (TAT) and noticed an area of improvement. The TAT for MH/SUD outpatient services, while still better than the NCQA standard, was 10.8 days for post-service, pre-claim review, as compared to 8.5 days for M/S.

Post-claim Retrospective Review:

Sentara collected post-service, post-claim retrospective requests for authorization data for 2023 and 2024 to determine if denials on provider requests for reconsideration were disproportionate for MH/SUD outpatient services as compared to M/S outpatient services.

In 2023, for outpatient M/S services, there were a total of 482 post-service, post-claim requests for authorization. Of these 482 post-service, post-claim requests for authorization, 28 were denied for a denial rate of 5.81%. Of the 5.81% denied, 5.12% denied for medical necessity. There were no post-service, post-claim requests for MH/SUD outpatient services in 2023. With this data, Sentara does not see disparity in the application of its utilization management program, for post-service, post-claim retrospective review.

The same trend occurred in 2024. For outpatient services, there were a total of 1876 post-service, post-claim requests for authorization. Of these authorizations, the denial rate was 6.88% with a MD Referral Rate of 4.5%. As it relates to MH/SUD outpatient services, there were a total of 21 post-service, post-claim requests for authorization. Of the 21 post-service, post-claim requests for authorization, 10 were for outpatient MH/SUD services. Of these 10, all were approved and the denial rate was 0%. With this data, Sentara does not see disparity in the application of its post-service, post-claim retrospective review.

Physician review – In analyzing physician review, Sentara's main objective was to determine if the MH/SUD physician reviewers were applying discretion in a way that was more stringent or arbitrary than how M/S physicians applied discretion and to determine if they were adhering to criteria in a fashion that was no more stringent than M/S physicians' adherence to criteria. Sentara further studied MD (Medical Director) referral rates. Given that there were no denials for MH/SUD outpatient services upon post-service, post-claim retrospective review, Sentara finds no disparity.

Peer to Peer Data does not apply to post-service, post-claim retrospective review.

Appeal data further confirms that no disparity exists as to utilization review. In 2023, for MH/SUD services, 7 appeals occurred throughout the commercial line of business and none of the 7 appeals were medical necessity appeals. In 2024, there were 5 appeals for MH/SUD services and only 1 appeal concerned medical necessity.

Step 6: Findings and conclusions.

See **45 CFR 146.137(c)(6).** The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the **FAQ 45** guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara defined Retrospective Review NQTL as a clinical review following the provision of M/S or MH/SUD services. Sentara noted that retrospective reviews can occur either pre-claim or post-claim. Sentara identified the processes for seeking retrospective review. Retrospective clinical review is consistently applied to both M/S and MH/SUD services. Sentara identified the Medical Policy Committee as the body that determines medical policies and clinical guidelines, which apply regardless of whether the clinical review occurs pre- or post-service. Sentara explained its process for reviewing services for medical necessity post-service and the process for appeal. Sentara detailed its process for tracking retrospective reviews, which is consistently applied for both M/S and MH/SUD services.

Data collected includes:

- No denials occurred for MH or SUD services for any Plan in 2024.

- IRR testing descriptions and results, demonstrating passing scores and 100% pass rate for clinicians in MH/SUD.

Analysis establishes Sentara is compliant with MHPAEA. This analysis was completed in September 2026 by the following Sentara departments: Utilization Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

RETROSPECTIVE REVIEW: INPATIENT, OUT-OF-NETWORK

(NOT APPLICABLE TO EMERGENCY SERVICES

EXCEPT AS TO CODING EDITS)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See 45 CFR 146.137(c)(1). Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also FAQ 45 (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

Definitions

Pre-Payment Review: Sentara does not conduct any pre-payment review of providers. While corrective actions plans are utilized as outcomes for FWA audits and investigations, those corrective plans do not include pre-payment review.

Pre-Payment FWA: Sentara does not conduct any pre-payment FWA audits or investigations of providers. While the Provider Manual permits Sentara to conduct pre-payment FWA audits or investigations, Sentara does not currently conduct any pre-payment FWA review for M/S or MH/SUD services.

Coding Edits: Sentara does not conduct any pre-payment coding edits.

NOTE: *The remainder of this analysis will focus solely on pre-claim retrospective review and post-claim retrospective review (each defined below) because Sentara does not use pre-payment reviews, pre-payment FWA, coding edits, or any other form of retrospective review.*

Pre-Claim Retrospective Review: Pre-claim retrospective review means the review of the member's medical records and other supporting documentation by the Plan after services have been rendered to determine the Plan's liability for payment. Pre-claim retrospective review pertains to the time period post-service, but pre-claim submission. Specifically, pre-claim retrospective review only applies to services which required a prior authorization, and one was not obtained before the service was rendered. Post-service, pre-claim retrospective review does not apply if authorization was requested and denied. Pre-claim retrospective review also does not apply once a claim has been submitted. Pre-claim retrospective review applies to both M/S and MH/SUD services.

Post-Claim/Post-Denial Retrospective Review ("Post-Claim"): Post-claim retrospective review means the review of the member's medical records and other supporting documentation by the Plan after services have been rendered to determine the Plan's liability for payment. Post-claim retrospective review pertains to the time period post-service, post-claim submission. Services are eligible for post-claim retrospective review only upon request for reconsideration by a provider. Providers may request reconsideration of claims for services which require prior authorization that are submitted without an authorization having been granted by Sentara and later denied. Claims for services which require authorization will deny provider responsible if authorization is not obtained and no payment will be issued. Reconsideration focuses on the processing of the claim and does not allow for modification of the claim. It applies equally to both M/S and MH/SUD claims. For a first-level review, the reconsideration request must be received within 365 days from the date of service. If timely received, a medical necessity review is conducted. If medical necessity is met, the claim is authorized. If medical necessity is not satisfied, a subsequent review is conducted by a Medical Director and either approved or denied. A second-level reconsideration review occurs if requested within 60 days of the notification of the first-level claim reconsideration. For medical necessity denials, the second-level reconsideration review is conducted by a Medical Director not originally involved with the review.

Vendors:

Pre-Claim Retrospective Review: As set forth in its Prior Authorization and Concurrent Review Analyses, Sentara utilizes vendors for utilization review of certain M/S services. These vendors

perform utilization review for their respective services (as described below) for pre-claim retrospective review. Sentara does not utilize vendors for medical necessity reviews for MH/SUD services regardless of the timing of those reviews.

Post-Claim Retrospective Review: As it pertains to post-claim retrospective reviews, these reviews are conducted only if initiated by a provider under Sentara reconsideration processes. Once initiated, Sentara, through its Utilization Management Department, internally will review for medical necessity. With the exception of chiropractic services, Sentara does not utilize vendors for post-claim retrospective review for M/S or MH/SUD services. With the exception of chiropractic services, post-claim medical necessity reviews are performed internally by the Utilization Management Department using Sentara's definition of medical necessity.

With respect to chiropractic services, a vendor ("UM Vendor 1")conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate third-party vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a services agreement. UM Vendor 2 is URAC and NCQA accredited. Under the services agreement provides, UM Vendor 2 providers access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a services agreement.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Separate Operating Departments or Divisions:

Pre-Claim Retrospective Review: There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Post-Claim Retrospective Review: There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Supporting Documentation

Sentara maintains an organizational chart of positions with the Utilization Management department. Moreover, Sentara maintains policies and procedures relating to retrospective review including a Utilization Management Program Description, an Annual Commercial and Exchange Utilization Management Evaluation, Provider Claim Reconsideration Procedure, Technology Assessment and Coverage Decision Policy, Administrative Denial Policy, and Medical Policy Committee Charter.

Traditional Retrospective Review

Sentara defines the traditional retrospective review as a medical necessity review that takes place after services have been rendered. Traditional retrospective review includes both pre-claim and post-claim retrospective review.

Pre-Claim Retrospective Review: All services which require an authorization are eligible for pre-claim retrospective review if a request for authorization is submitted post-service, but pre-claim. Services are not eligible for pre-claim retrospective review if the service does not require authorization or if authorization was already requested. Pre-claim retrospective review does not apply if a claim has been submitted for the requested service. A provider is responsible for initiating or requesting a pre-claim retrospective review. Sentara does not initiate requests for pre-claim retrospective review. The process mirrors that of prior authorization or concurrent review (with limited differences discussed in the analysis below). The pre-claim retrospective review process does not vary between M/S and MH/SUD services.

Post-Claim Retrospective Review: Services are eligible for post-claim retrospective review upon a reconsideration request by a provider under the Sentara reconsideration process. A provider is responsible for initiating or requesting a post-claim reconsideration. Sentara does not initiate post-claim retrospective reviews. At claim submission, if a service requiring prior authorization was not authorized the claim will be administratively denied provider responsible for no authorization. A provider may then initiate a request for post-claim retrospective review of medical records. That process is considered a reconsideration or member appeal of an adverse benefit determination and is described in Sentara's Post-Payment Retrospective Review Analysis. The reconsideration or member appeal process does not vary between MH/SUD and M/S benefits.

Services to Which NQTL Applies:

The M/S and MH/SUD services to which the preauthorization NQTL applies are those services to which the retrospective review (both pre-claim and post-claim) NQTL applies. Specifically, retrospective review applies to all inpatient services, both M/S and MH/SUD.

Specific Medical/Surgical Benefits to Which NQTL Applies

Specifically, retrospective review applies to all inpatient services, both M/S and MH/SUD.

Specific MH/SUD Benefits to Which Prior Authorization Applies

Specifically, retrospective review applies to all inpatient services, both M/S and MH/SUD.

There are a number of ways Sentara identifies which services are subject to prior authorization for clinical review (and thus may be subject to retrospective review). Specifically:

Plan Documents:

The HMO and PPO plan documents state the following:
"Some Covered Services under this Plan require Pre-Authorization to be Covered. Please read the entire section on Pre-Authorization in the EOC."

Defines Pre-Authorization as "an evaluation process which assesses the medical necessity of proposed treatment and checks to see that the treatment is being provided at the appropriate level of care."

Describes preauthorization and states: "On Your Schedule of Benefits, We tell You what services require pre-authorization before You receive them. You can also look in the What is Covered Section of this document or call Member Services to find out about Pre-Authorization."

Describes generally the types of services which require preauthorization, including: Inpatient hospitalization services; Partial hospitalization services; Residential treatment services; Non-emergency ambulance transport; Inpatient and outpatient surgery; Surgery in a physician's office; Single items of durable medical equipment and orthopedic and prosthetic appliances over [$750]; Rental of durable medical equipment and orthopedic and prosthetic appliances; Repair and replacement items of durable medical equipment and orthopedic and prosthetic appliances; Artificial prosthetic limbs; Prenatal maternity services (excluding recommended preventive care services, screenings, and one breast pump per pregnancy); Home health care; Skilled Nursing Facility care; Physical, occupational, and speech therapy; Cardiac, pulmonary, and vascular rehabilitation; IV therapy with medications; Inhalation therapy; Early intervention services; Clinical trials for treatment studies on cancer; Hospice services; Oral surgery; TMJ services; Tubal ligation; Hospitalization and anesthesia for dental procedures; Treatment of lymphedema; Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiography (MRA); Positron Emission Tomography (PET) scans; Computerized Axial Tomography (CT) scans; Computerized Axial Tomography Angiogram (CTA) scans; Sleep studies; transplant services; Injectable and infused medications, biologics, and IV therapy medications defined by Our Pharmacy Committee; Intensive outpatient programs (IOP); Medical, psychological and neuro psychological diagnostic procedures and testing; Electro-convulsive therapy (ECT); Telemedicine service; Transcranial Magnetic Stimulation (TMS); Insulin pumps and insulin pump infusion sets and supplies; Chemotherapy and Chemotherapy Drugs; Radiation Therapy; Dialysis Services; Genetic Testing and Counseling. If Your plan includes any riders generally those services will require Pre-Authorization listed in the rider.

Define Covered Services and designate those which require prior authorization. These Services and others are then further defined.

Schedule of Benefits

States “Some benefits require Pre-Authorization before You receive them. These services ae marked with an * in this document.”

The Schedules of Benefits designate the following service types as requiring preauthorization: outpatient therapies and services; outpatient dialysis; outpatient surgery; outpatient lab, diagnostic, imaging, and testing; outpatient advanced imaging, testing and scans; injectable and infused medications; maternity care; inpatient M/S services including inpatient hospital services, transplants, skilled nursing facility services; non-emergency transport; inpatient MH/SUD services including hospital services, residential treatment services, partial hospitalization, intensive outpatient program services, transcranial magnetic stimulation, electro-convulsive therapy, autism spectrum disorder, other outpatient services; diabetes treatment including insulin pumps, pump infusion sets and supplies, talking blood glucose meters, insulin, and needles and syringes for injection; prosthetic devices and components, repair, fitting, replacement and adjustment; durable medical equipment for items over $750, repair, replacement, and rental items; wigs following cancer treatment; early invention services including speech and language therapy, occupational therapy, physical therapy, assistance technology services and devices; home health care; private duty nursing; hospice care; reconstructive breast surgery for members who have had a mastectomy; infertility services including endometrial biopsies, semen analysis, hysterosalpingography, Sims-Huhner test, diagnostic laparoscopy; clinical trial services; allergy testing and serum; telemedicine services; chiropractic services; hearing aids and related services for children 18 and younger

Provider Manual

The Provider Manual states:

“Except in the case of emergency treatment, prior authorization will be required for: all inpatient hospitalizations, all partial hospitalizations (mental health or substance abuse), all outpatient surgeries/short stays/observations and IV therapy and drug infusions, all skilled nursing facility admissions, all acute rehabilitation, all intensive outpatient programs, all out-of-area services or referrals to nonparticipating providers (prior to scheduling) for members that do not have out-of-network benefits included in their plan. All the following services require prior authorization regardless of the place of service: Commercial plan DME single purchased items greater than $750 and all rentals, orthotics/prosthetics, single purchased items greater than $750 and all rentals, repair, replacement, and duplicates, home health, hospice, IV infusions, plastic surgery, all rehabilitation programs (cardiac, vascular, vestibular, pulmonary, etc.), therapies (PT, OT, ST), applied behavioral analysis, early intervention services (part H certificate required), OB global notification, transplant services, human and synthetic tissue, oral surgery and related services, advanced imaging studies (PET, CT, CTA, MRI, MRA, MR-CT), sleep studies, hyperbaric therapy, electronic bone stimulator, any surgical or diagnostic procedure for which anesthesiology or conscious sedation is billed, injectable drugs indicated on the online prior-authorization forms, genetic testing (if covered by group/plan), bone densitometry if less than 24 months since last study.”

Prior Authorization List: (accessible at http://pal.sentarahealthplans.com/)

Tool allows anyone to access and search for procedure code or description to determination whether prior authorization is required.

Procedure and Revenue Codes:

As previously stated, all inpatient services require prior authorization.

Certain services such as PT, OT, and ST, can be used for both MH/SUD and M/S conditions. Specific to these therapies, Sentara ensures MHPAEA compliance through benefit structure. Currently, no numerical visit limitations are placed on PT, OT, and ST for MH/SUD, unlike the annual visit limits for M/S. For other services such as non-emergency transport, Sentara does not preauthorize services strictly by diagnosis. If a medical necessity review is required for the service, it will include all pertinent clinical information required to make a determination based on the appropriate necessity criteria used whether that be internal medical policies or MCG (which incorporate ASAM). For example, Sentara tracks transportation authorizations but does not track whether authorization for non-emergency transportation was reviewed for an underlying M/S or MH/SUD condition.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See 45 CFR 146.137(c)(2). Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:
  (A) A detailed description of the factor;
  (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
  (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining

which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Sentara incorporates by reference its Analyses for Prior Authorization and Concurrent Authorization. The only factor and standard that differs between Prior Authorization and Retrospective Review is that Retrospective Review applies when prior or concurrent authorization was required but not obtained.

Step 3: Description of how factors are used in the design and application of the NQTL.

See **45 CFR 146.137(c)(3).** Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Sentara incorporates by reference its Analyses for Prior Authorization and Concurrent Authorization.

Step 4: Demonstration of comparability and stringency as written.

See 45 CFR 146.137(c)(4). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S

benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Documentation of Each Factor Identified as Defined in Step Two:

The following factors are implicated in determining whether Prior Authorization applies to certain services:

Service	Factors
All outpatient, M/S services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, M/S services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, MH/SUD services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria
All outpatient, MH/SUD services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria

As explained above, the only factor that determines whether retrospective review (pre-claim or post-claim) applies is whether the claim is for a service requiring prior authorization or concurrent authorization when the provider failed to obtain one.

How Factors are Comparably Applied:

Sentara applies applicable industry standards (MCG for M/S and ASAM for MH/SUD) equally to all services in the respective classifications. Industry standards are applied without discretion, regardless of whether the particular service is M/S or MH/SUD. For services (either M/S or MH/SUD) for which there is no applicable industry standard, the Sentara MPC evaluates and reviews the requested service.

Reasons for Any Deviations or Variations:

There are no variations or deviations in the design or application of prior authorization between M/S and MH/SUD benefits.

Comparison of Existing Written Documents:

The policies and procedures identified and defined in the preauthorization NQTL apply to the retrospective review NQTL. There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

Prior Authorization, Concurrent Review, and Retrospective Review

Pre-Claim Retrospective Review: Policies and procedures for pre-claim retrospective review are identical to those for preauthorization and concurrent review except for two aspects. First, the timing of the review is different. For pre-claim retrospective review, the timing consists of post-service, pre-claim services. Second, and relatedly, discussions of lower levels of care are not applicable since the service has been provided. Reviewing Medical Directors do use the same

peer-to-peer process when reviewing medical necessity pre-claim, post-service as they do when reviewing medical necessity pre-claim, pre-service. This process applies to both M/S and MH/SUD services.

Post-Claim Retrospective Review: Sentara's policies and procedures for retrospective review are identical" to those for preauthorization and concurrent review except for a few key differences described herein. The first difference is the timing of the review. For post-claim retrospective review, a reconsideration request occurs from the provider post-claim and after the claim has denied. There are differences in the process for clinical review when conducted post-claim at the request for reconsideration by the provider. One difference is that UM Vendor 1 is the only vendor used to conduct medical necessity reviews in the reconsideration process. While vendors never conduct utilization review for MH/SUD services, as described in Sentara's Medical Necessity Analysis, vendors are used for certain M/S services. With the exception of UM Vendor 1, these vendors are not used when the clinical review is conducted retrospectively through the post-service reconsideration process. Also, Sentara does not conduct peer-to-peer reviews and does not negotiate lower levels of care because the service has been rendered the claim submitted. This process applies to both M/S and MH/SUD services.

Traditional Retrospective Review:

Clinical Review Processes

Pre-Claim Retrospective Review: All clinical review requests are assessed based on approved clinical criteria and guidelines (as explained in Sentara's Medical Necessity Analysis for commercial lines of business, when no internal medical policies exist for any MH/SUD or M/S service, MCG is utilized without incorporation or supplementation of any internal guidelines or policies.). For pre-claim retrospective review, reviews and decisions will be completed within 30 days of received the request. If an authorization request results in an adverse determination, providers and members are notified of post-service decisions via adverse benefit determinations which contain appeal instructions. Providers or members have 180 days from notice of an adverse benefit determination to ask for an appeal. When Sentara reviews an appeal, Sentara looks at all comments, documents, records, and other information submitted to Sentara. Appeals involving medical necessity will be reviewed by a clinical peer reviewer, with the same qualification as described in Sentara's Prior Authorization Analysis, who did not participate in the first coverage decision. When Sentara completes the appeal, Sentara will send written notification of the decision. If Sentara Health Plans doesn't change the initial decision the notice will include:

1. The specific reason for the decision;

2. The specific plan provisions Sentara Health Plans based the decision on; and

3. Information on any independent external appeal rights. In general, the internal appeal process must be exhausted prior to filing an independent external appeal. An exception exists for the treatment of cancer.

The levels of review include a request for authorization which is handled by clinicians, including "Registered Nurses, Licensed Practical Nurses, Clinical Pharmacists, Clinical Psychologists, and Board certified Medical and Behavioral Health Physicians (Medical Directors)." The process does include access to Board Certified Physicians to serve as physician specialty advisors. At the discretion of the medical director or for appeals and grievances, cases are referred to these physicians to review for medical necessity or appropriateness. If a request for authorization

results in an adverse benefit determination, providers and members have 180 days to request an appeal. Providers may also request a peer review or reconsideration, which is not considered part of the appeal. There is one level of internal appeals. Registered and practical nurses can authorize, but not deny a service. Any denials of medical necessity must be conducted by a Medical or Behavioral Health Physician (Medical Director) depending on the service type. Post-claim retrospective clinical review upon a request by a provider for reconsideration does not include peer-to-peer review.

Post-Claim Retrospective Review: All clinical review requests are assessed based on approved clinical criteria and guidelines (as explained in Sentara's Medical Necessity Analysis, for commercial lines of business, when no internal medical policies exist for any MH or M/S service, MCG is utilized without incorporation or supplementation of any internal guidelines or policies.). For a first-level review post-claim provider reconsideration requests, the reconsideration request must be received within 365 days from the date of service. If timely received, a review is conducted to determine medical necessity. If medical necessity is not satisfied, a subsequent review is conducted by a Medical Director and either approved or denied. A second-level reconsideration review occurs if requested within 60 days of the notification of the first-level claim reconsideration. For medical necessity denials, the second-level reconsideration review is conducted by a Medical Director not originally involved with the review. A post-service, pre-claim request for authorization is handled by clinicians, including "Registered Nurses, Licensed Practical Nurses, Clinical Pharmacists, Clinical Psychologists, and Board certified Medical and Behavioral Health Physicians (Medical Directors)." The process does include access to Board Certified Physicians to serve as physician specialty advisors. At the discretion of the medical director or for appeals and grievances, cases are referred to these physicians to review for medical necessity or appropriateness. If a request for authorization results in an adverse benefit determination, providers and members have 180 days to request an appeal. There is one level of internal appeals. Registered and practical nurses can authorize, but not deny a service. Any denials of medical necessity must be conducted by a Medical or Behavioral Health Physician (Medical Director) depending on the service type. Post-claim retrospective clinical review upon a request by a provider for reconsideration does not include peer-to-peer review.

Tracking of Denials

Sentara tracks and reports all claim denials and closed internal and external appeals and complaints. Sentara tracks administrative denials as compared to denials for medical necessity. For appeals, Sentara tracks whether the denials were upheld, partially upheld or overturned in closed internal appeals and closed external reviews.

Pre-Claim Retrospective Review:

2023: M/S IP

702 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 663 were initiated by in-network providers and 39 from out-of-network providers for a 5.56% of out-of-network providers. The denial rate of the 702 requests was 19.37%, and 20.8% of the requests were referred to MD.

2023: MH/SUD IP

24 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 20 were initiated by in-network providers and 4 from out-of-network providers for a 16.67% of out-of-network providers. Of the 24 requests, 20 were approved for a 16.67% denial rate. 16.7% of the requests were referred to MD. Only 1 of the 4 denials constituted a medical necessity denial.

2023: M/S OP

4083 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 3760 were initiated by in-network providers and 323 from out-of-network providers for a 7.91% of out-of-network providers. The denial rate of the 4083 requests was 7.89%, and 8.3% of the requests were referred to MD.

2023: MH/SUD OP

5 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 4 were initiated by in-network providers and 1 from out-of-network providers for a 20% of out-of-network providers. Of the 5 requests, 5 were approved for a 0% denial rate. 0% of the requests were referred to MD.

2024: M/S IP

450 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 433 were initiated by in-network providers and 17 from out-of-network providers for a 3.78% of out-of-network providers. Of the 450 requests, 352 were approved for a 22% denial rate. 22% of the requests were referred to MD.

2024: MH/SUD IP

24 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 20 were initiated by in-network providers and 4 from out-of-network providers for a 16.67% of out-of-network providers. Of the 24 requests, 23 were approved for a 4.17% denial rate. 8.3% of the requests were referred to MD.

2024: M/S OP

3025 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 2869 were initiated by in-network providers and 156 from out-of-network providers for a 5.16% of out-of-network providers. The denial rate of the 3025 requests was 5.65%, and 4.9% of the requests were referred to MD.

2024: MH/SUD OP

7 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 5 were initiated by in-network providers and 2 from out-of-network providers for a 28.57% of out-of-network providers. Of the 7 requests, 7 were approved for a 0% denial rate. 28.6% of the requests were referred to MD.

Post-Claim Retrospective Review: For post-service, post-claim requests for reconsideration, the authorization volume by review can be reported as follows:

2023: M/S

503 Total Requests for Post-Claim Retrospective Review. Of these requests 484 were initiated by in-network providers and 19 by out-of-network providers for a 3.78% of out-of-network providers. Of the 503 requests, 21 were for inpatient services and 482 were for outpatient services. All requests for inpatient services were approved. Of the 482 requests for outpatient services, 28 were denied for a denial rate of 5.57%. Of the 5.57%, 5.12% denied for medical necessity. The MD referral rate was 4.1%.

2023: MH/SUD

5 Total Requests for Retrospective Review (Post-Service). Of these requests, 4 were initiated by in-network providers and 1 from an out-of-network provider for a 20% of out-of-network providers. Of the 5 requests, all were for inpatient services and all were approved for a 0% denial rate. None of the 5 requests were referred to Medical Directors. There were no MH/SUD Requests for Retrospective Review for outpatient services in 2023.

2024: M/S

2056 Total Requests for Retrospective Review (Post-Service). Of these requests,1974 were initiated by in-network providers and 82 from out-of-network providers for a 3.99% of out-of-network providers. Of the 2056 total requests, 1926 were approved, 131 were denied and 1 claim was partially denied for a denial rate of 6.42%. Of the 2056 claims, 180 were for inpatient services. Of these 180 claims, the denial rate was 1.67%. The MD Referral Rate for inpatient services was 0 .6%. Of the 2056 claims, 1876 were for outpatient services. Of these 1876 claims, the denial rate was 6.88%. The MD Referral Rate for outpatient services was 4.5%. Of the total 131 denials and 1 partial denial, 110 were denied as not being medically necessary and 21 were administratively denied for non-covered service or benefit exhaustion. The Medical Director referral rate was 4.1%.

2024: MH/SUD

21 Total Requests for Retrospective Review (Post-Service). Of these requests, 19 were initiated by in-network providers and 2 from out-of-network providers for a 9.52% of out-of-network providers. Of the 21 total requests, all 21 were approved for a 0% denial rate. Of the 21 claims, 11 were for inpatient services. Of these 11 claims, the denial rate was 0%. Of the 21 claims, 10 were for outpatient services. Of these 10 claims, the denial rate was 0%.

Appeals Data:

2023: In 2023 there were 0 MH/SUD provider medical necessity appeals, compared with 19 M/S medical necessity appeals.

2024: In 2024, there was 1 MH/SUD medical necessity provider appeal, compared with 34 M/S provider medical necessity appeals.

Extent of Medical Records Required

The policies related to medical records are identified in the preauthorization NQTL. Any additional medical records establishing medical necessity are pertinent to any traditional retrospective review.

Appeal Rights

In the context of the internal appeal process, any denial or reduction of benefits and/or nonpayment based upon a determination of medical necessity is treated as an Adverse Benefit Determination and subject to the appeal process outlined in the plans. Written notice of Adverse Benefit Determinations is required except for Urgent Claims, where notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notice of an Adverse Benefit Determination includes the following:

• The specific reason or reasons for the Adverse Benefit Determination;

• Reference to the specific Plan provisions on which the determination is based;

• A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.

Any member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination.

For denials due to Medical Necessity, Experimental treatment, or similar exclusion or limit, members are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances.

After notification of an Adverse Benefit Determination, a member has 180 days to request an appeal. Upon appeal, all comments, documents, records, and other information submitted is reviewed. Additional information may be provided. The clinical peer reviewer reviewing the appeal will not have participated in the original coverage decision. Should a member disagree with the Final Benefit Determination, an external appeal is available. There are no differences in the process for appeals of retrospective reviews as it relates to MH/SUD and M/S benefits.

Lower levels of care are not authorized in retrospective reviews because the services have already been provided. As a general matter, for requests for prior or concurrent authorizations, a member or provider can appeal any decision (whether M/S or MH/SUD) regardless of whether the member accepts and receives a lower level of care.

Approvals of Lower Levels of Care

Discussions of lower levels of care are not applicable during pre-claim retrospective reviews since the service has been provided or during post-claim retrospective reviews because the claim has already been submitted. This applies to both M/S and MH/SUD services.

Initiation of Clinical Review

Pre-Claim Retrospective Review: The provider must initiate a request for pre-claim retrospective review. Sentara will not initiate any request for retrospective review. A pre-claim request for retrospective review will be conducted, upon request of the provider, for any requested service which a prior authorization was required but not obtained. This is true for M/S and MH/SUD services. A provider is made aware of this process through the Provider Manual which is available to both in-network and out-of-network providers. If an authorization was required and

not obtained, the provider is required to hold the member harmless. Extensions for additional time and requested documents are consistent with M/S and MH/SUD services. The data establishes the operation of pre-claim retrospective review as being inherently consistent, in that no denials for MH/SUD outpatient services occurred in 2023 or 2024 on pre-claim retrospective review. As for inpatient MH/SUD services, denials on pre-claim retrospective review totaled 16.67% in 2023 (compared to 19.37% for M/S services) and 4.17% in 2024 (compared to 22% for M/S).

Post-Claim Retrospective Review: The provider must initiate a request for reconsideration for post-claim retrospective review. Sentara will not initiate any request for retrospective review. A post-service retrospective review will be conducted, upon request of the provider, for any requested service which a prior authorization was required but not obtained. This is true for M/S and MH/SUD services. A provider is made aware of this process through the Provider Manual which is available to both in-network and out-of-network providers. If an authorization was required and not obtained, the provider is required to hold the member harmless. Extensions for additional time and requested documents are consistent with M/S and MH/SUD services. The data establishes the operation of post-claim retrospective review as being inherently consistent, in that no denials for MH/SUD services occurred upon post-claim retrospective review in 2023 and 2024.

Initial Authorization

The type of initial authorization does not have any impact on retrospective review. In the event of an inpatient admission, once notification or a request for authorization occurs, a medical necessity review is conducted.

Step 5: Demonstration of comparability and stringency in operation.

See 45 CFR 146.137(c)(5). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies,

evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

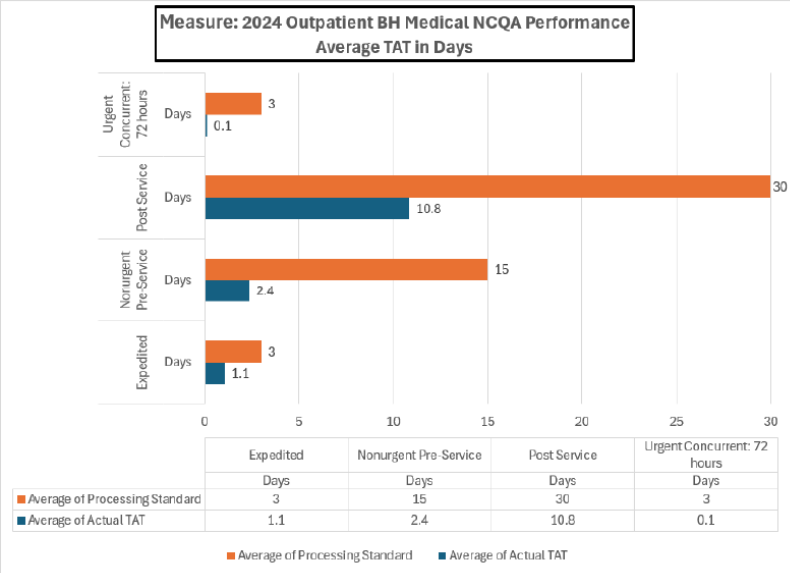
- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

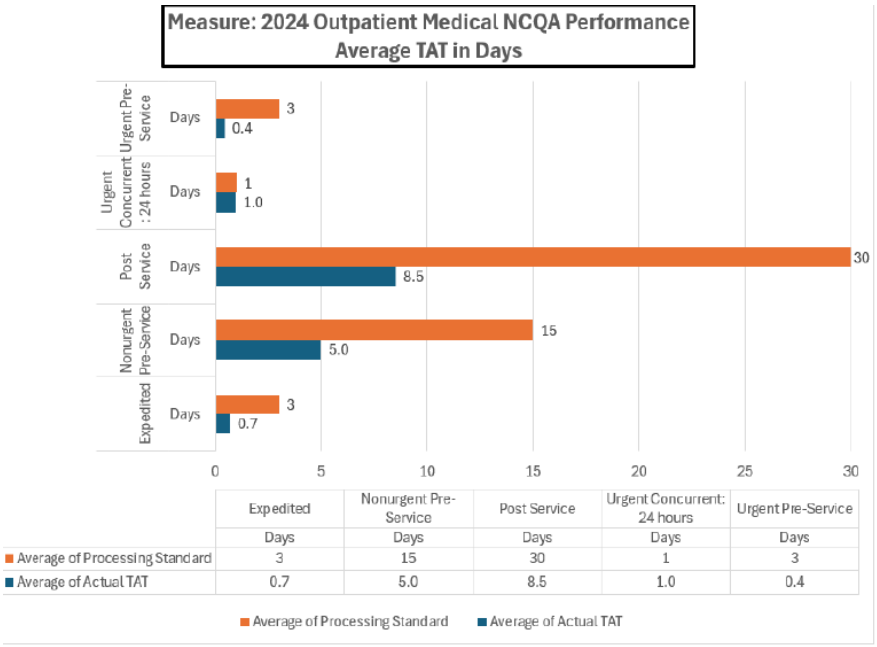
Data provided herein is for 2024 Virginia fully-insured plans. This analysis will be supplemented with 2025 data when it becomes available. See denial rates and peer-to-peer reviews for pre-claim retrospective reviews above. See denial rates for post-claim retrospective reviews above.

Pre-Claim Retrospective Review— Turnaround Times: The charts below specify pre-claim, post-service data.

2024 Outpatient MH/SUD NCQA Performance:



2024 Outpatient M/S NCQA Performance:



IRR Testing:

Sentara performs IRR testing as described below:

o Required score to pass: 80%

o How participants are evaluated: Test is developed by Sentara's utilization management leadership and educators. It consists of a variety of scenarios (inpatient, outpatient, behavioral health and medical). The same test is administered to all clinical staff who review requests for authorization determination.

o Results: 100% MH/SUD pass rate for 2022 and 2023 and M/S 97.9% for 2022 and 96% for 2023

o Separate testing occurs for MH/SUD reviewers and M/S reviewers: There are separate scenarios/questions addressing M/S or MH/SUD. The utilization team is separated by M/S and MH/SUD. If the clinical staff is on the MH/SUD team, they will take the MH/SUD test and the same is accurate for M/S.

Pre- and Post-Claim Retrospective Review: Sentara has implemented a policy regarding Measuring Staff Consistency Including Inter-rater Reliability. Testing is scored individually. The results of each individual tested should be at least 80% accurate. A report will be given to each manager/team coordinator for staff who make UM decisions and to the Chief Medical Officer (CMO) for Medical Directors. UM Staff and Medical Directors will have ongoing education regarding the use of criteria. Training will be completed with staff and Medical Directors who do not achieve at least an 80% test score.

Sentara audits monthly its utilization management processes. Sentara audit its Monthly and Quarterly Utilization report that includes for example:

o Days/1000, Admissions/1000

o Average length of stay (ALOS)

o Observation days/1000

o Readmission rate for both medical and behavioral health services

o Outpatient surgeries/1000

o Outpatient visits/1000

o Milliman Benchmarking

o High-Dollar claims

o Complex medical conditions

o Authorizations provided to non-participating providers

Sentara conducts an annual evaluation of its utilization management program, which includes an evaluation of vendors performing utilization management services for Sentara.

In Operation Data

Post-Service, Pre-Claim Retrospective Review

Sentara collected post-service, pre-claim retrospective requests for authorization data as requested for 2023 and 2024 to determine if denials were disproportionate for MH/SUD outpatient services as compared to M/S outpatient services.

In 2023, for outpatient services, there were a total of 4088 post-service, pre-claim requests for authorizations. Of these post-service, pre-claim requests for authorization, 4083 were for outpatient M/S services and 5 were for outpatient MH/SUD services. As for outpatient M/S services, the denial rate was 7.89% for outpatient M/S services. Of the 7.89% of denials, 5.57% denied for medical necessity. As it relates to MH/SUD requests for outpatient services, of the 5 requests, all 5 were approved. The denial rate was 0%. With this data, Sentara does not see disparity in the application of its utilization management program, for post-service, pre-claim retrospective review for outpatient claims.

The same trend occurred in 2024. For outpatient services, there were a total of 3032 post-service, pre-claim requests for authorization. Of these post-service, pre-claim requests for authorizations, 3025 were for outpatient M/S services and 7 were for outpatient MH/SUD services. As for inpatient M/S services, the denial rate was 5.65% for M/S services. Of the 5.65% of denials, 2.67% denied for medical necessity. As it relates to MH/SUD outpatient services, of the 7 requests, all 7 were approved. The denial rate was 0%. With this data,

Sentara does not see disparity in the application of its utilization management program, for post-service, pre-claim retrospective review.

Physician review – In analyzing physician review, Sentara's main objective was to determine if the MH/SUD physician reviewers were applying discretion in a way that was more stringent or arbitrary than how M/S physicians applied discretion and to determine if they were adhering to criteria in a fashion that was no more stringent than M/S physicians' adherence to criteria. Sentara further studied MD (Medical Director) referral rates. In 2023, Sentara discovered that percentages of requests for authorizations referred for Medical Director review was higher in M/S than MH/SUD inpatient services. In 2023, 8.3% of M/S outpatient requests for authorization were referred to MD review, as compared to 0% of MH/SUD outpatient requests for authorization. This trend reversed in 2024, 4.9% of M/S outpatient requests for authorizations were referred to MD Review as compared to 28.6% for MH/SUD outpatient services. Given that 0 denials occurred for medical necessity for MH/SUD services in 2023 and 2024, MD referrals appear to be a positive review protocol and physician review is not causing any disparate impact.

In reviewing peer-to-peer review data, the objectives were largely the same. While significantly more M/S inpatient services are subject to peer review than MH/SUD inpatient services, the denial rates are much lower for MH/SUD inpatient services. In fact, no MH/SUD services (inpatient or outpatient) were referred to peer-to-peer in 2023 and 2024. With such few instances of peer to peer review, 10 total in 2023 and 2024 combined, it is difficult to determine any trends, however, denial rates indicate that utilization review is not being more stringently applied to MH/SUD inpatient services.

Appeal data further confirms that no disparity exists as to utilization review. In 2023, for MH/SUD services, 7 appeals occurred throughout the commercial line of business and none of the 7 appeals were medical necessity appeals. In 2024, there were 5 appeals for MH/SUD services and only 1 appeal concerned medical necessity.

Sentara further compared turnaround time (TAT) and noticed an area of improvement. The TAT for MH/SUD outpatient services, while still better than the NCQA standard, was 10.8 days for post-service, pre-claim review, as compared to 8.5 days for M/S.

Post-claim Retrospective Review:

Sentara collected post-service, post-claim retrospective requests for authorization data for 2023 and 2024 to determine if denials on provider requests for reconsideration were disproportionate for MH/SUD outpatient services as compared to M/S outpatient services.

In 2023, for outpatient M/S services, there were a total of 482 post-service, post-claim requests for authorization. Of these 482 post-service, post-claim requests for authorization, 28 were denied for a denial rate of 5.81%. Of the 5.81% denied, 5.12% denied for medical necessity. There were no post-service, post-claim requests for MH/SUD outpatient services in 2023. With this data, Sentara does not see disparity in the application of its utilization management program, for post-service, post-claim retrospective review.

The same trend occurred in 2024. For outpatient services, there were a total of 1876 post-service, post-claim requests for authorization. Of these authorizations, the denial rate was 6.88% with a MD Referral Rate of 4.5%. As it relates to MH/SUD outpatient services, there were a total of 21 post-service, post-claim requests for authorization. Of the 21 post-service, post-claim requests for authorization, 10 were for outpatient MH/SUD services. Of these 10, all were approved and the denial rate was 0%. With this data, Sentara does not see disparity in the application of its post-service, post-claim retrospective review.

Physician review – In analyzing physician review, Sentara's main objective was to determine if the MH/SUD physician reviewers were applying discretion in a way that was more stringent or arbitrary than how M/S physicians applied discretion and to determine if they were adhering to criteria in a fashion that was no more stringent than M/S physicians' adherence to criteria. Sentara further studied MD (Medical Director) referral rates. Given that there were no denials for MH/SUD outpatient services upon post-service, post-claim retrospective review, Sentara finds no disparity.

Peer to Peer Data does not apply to post-service, post-claim retrospective review.

Appeal data further confirms that no disparity exists as to utilization review. In 2023, for MH/SUD services, 7 appeals occurred throughout the commercial line of business and none of the 7 appeals were medical necessity appeals. In 2024, there were 5 appeals for MH/SUD services and only 1 appeal concerned medical necessity.

Step 6: Findings and conclusions.

See **45 CFR 146.137(c)(6).** The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the **FAQ 45** guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara defined Retrospective Review NQTL as a clinical review following the provision of M/S or MH/SUD services. Sentara noted that retrospective reviews can occur either pre-claim or post-claim. Sentara identified the processes for seeking retrospective review. Retrospective clinical review is consistently applied to both M/S and MH/SUD services. Sentara identified the Medical Policy Committee as the body that determines medical policies and clinical guidelines, which apply regardless of whether the clinical review occurs pre- or post-service. Sentara explained its process for reviewing services for medical necessity post-service and the process for appeal. Sentara detailed its process for tracking retrospective reviews, which is consistently applied for both M/S and MH/SUD services.

Data collected includes:

- No denials occurred for MH or SUD services for any Plan in 2024.

- IRR testing descriptions and results, demonstrating passing scores and 100% pass rate for clinicians in MH/SUD.

Analysis establishes Sentara is compliant with MHPAEA. This analysis was completed in September 2026 by the following Sentara departments: Utilization Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

RETROSPECTIVE REVIEW: OUTPATIENT, IN-NETWORK

(NOT APPLICABLE TO EMERGENCY SERVICES

EXCEPT AS TO CODING EDITS)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See 45 CFR 146.137(c)(1). Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also FAQ 45 (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

Definitions

Pre-Payment Review: Sentara does not conduct any pre-payment review of providers. While corrective actions plans are utilized as outcomes for FWA audits and investigations, those corrective plans do not include pre-payment review.

Pre-Payment FWA: Sentara does not conduct any pre-payment FWA audits or investigations of providers. While the Provider Manual permits Sentara to conduct pre-payment FWA audits or investigations, Sentara does not currently conduct any pre-payment FWA review for M/S or MH/SUD services.

Coding Edits: Sentara does not conduct any pre-payment coding edits.

NOTE: *The remainder of this analysis will focus solely on pre-claim retrospective review and post-claim retrospective review (each defined below) because Sentara does not use pre-payment reviews, pre-payment FWA, coding edits, or any other form of retrospective review.*

Pre-Claim Retrospective Review: Pre-claim retrospective review means the review of the member's medical records and other supporting documentation by the Plan after services have been rendered to determine the Plan's liability for payment. Pre-claim retrospective review pertains to the time period post-service, but pre-claim submission. Specifically, pre-claim retrospective review only applies to services which required a prior authorization, and one was not obtained before the service was rendered. Post-service, pre-claim retrospective review does not apply if authorization was requested and denied. Pre-claim retrospective review also does not apply once a claim has been submitted. Pre-claim retrospective review applies to both M/S and MH/SUD services.

Post-Claim/Post-Denial Retrospective Review ("Post-Claim"): Post-claim retrospective review means the review of the member's medical records and other supporting documentation by the Plan after services have been rendered to determine the Plan's liability for payment. Post-claim retrospective review pertains to the time period post-service, post-claim submission. Services are eligible for post-claim retrospective review only upon request for reconsideration by a provider. Providers may request reconsideration of claims for services which require prior authorization that are submitted without an authorization having been granted by Sentara and later denied. Claims for services which require authorization will deny provider responsible if authorization is not obtained and no payment will be issued. Reconsideration focuses on the processing of the claim and does not allow for modification of the claim. It applies equally to both M/S and MH/SUD claims. For a first-level review, the reconsideration request must be received within 365 days from the date of service. If timely received, a medical necessity review is conducted. If medical necessity is met, the claim is authorized. If medical necessity is not satisfied, a subsequent review is conducted by a Medical Director and either approved or denied. A second-level reconsideration review occurs if requested within 60 days of the notification of the first-level claim reconsideration. For medical necessity denials, the second-level reconsideration review is conducted by a Medical Director not originally involved with the review.

Vendors:

Pre-Claim Retrospective Review: As set forth in its Prior Authorization and Concurrent Review Analyses, Sentara utilizes vendors for utilization review of certain M/S services. These vendors

perform utilization review for their respective services (as described below) for pre-claim retrospective review. Sentara does not utilize vendors for medical necessity reviews for MH/SUD services regardless of the timing of those reviews.

Post-Claim Retrospective Review: As it pertains to post-claim retrospective reviews, these reviews are conducted only if initiated by a provider under Sentara reconsideration processes. Once initiated, Sentara, through its Utilization Management Department, internally will review for medical necessity. With the exception of chiropractic services, Sentara does not utilize vendors for post-claim retrospective review for M/S or MH/SUD services. With the exception of chiropractic services, post-claim medical necessity reviews are performed internally by the Utilization Management Department using Sentara's definition of medical necessity.

With respect to chiropractic services, a vendor ("UM Vendor 1")conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate third-party vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a services agreement. UM Vendor 2 is URAC and NCQA accredited. Under the services agreement provides, UM Vendor 2 providers access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a services agreement.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Separate Operating Departments or Divisions:

Pre-Claim Retrospective Review: There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Post-Claim Retrospective Review: There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Supporting Documentation

Sentara maintains an organizational chart of positions with the Utilization Management department. Moreover, Sentara maintains policies and procedures relating to retrospective review including a Utilization Management Program Description, an Annual Commercial and Exchange Utilization Management Evaluation, Provider Claim Reconsideration Procedure, Technology Assessment and Coverage Decision Policy, Administrative Denial Policy, and Medical Policy Committee Charter.

Traditional Retrospective Review

Sentara defines the traditional retrospective review as a medical necessity review that takes place after services have been rendered. Traditional retrospective review includes both pre-claim and post-claim retrospective review.

Pre-Claim Retrospective Review: All services which require an authorization are eligible for pre-claim retrospective review if a request for authorization is submitted post-service, but pre-claim. Services are not eligible for pre-claim retrospective review if the service does not require authorization or if authorization was already requested. Pre-claim retrospective review does not apply if a claim has been submitted for the requested service. A provider is responsible for initiating or requesting a pre-claim retrospective review. Sentara does not initiate requests for pre-claim retrospective review. The process mirrors that of prior authorization or concurrent review (with limited differences discussed in the analysis below). The pre-claim retrospective review process does not vary between M/S and MH/SUD services.

Post-Claim Retrospective Review: Services are eligible for post-claim retrospective review upon a reconsideration request by a provider under the Sentara reconsideration process. A provider is responsible for initiating or requesting a post-claim reconsideration. Sentara does not initiate post-claim retrospective reviews. At claim submission, if a service requiring prior authorization was not authorized the claim will be administratively denied provider responsible for no authorization. A provider may then initiate a request for post-claim retrospective review of medical records. That process is considered a reconsideration or member appeal of an adverse benefit determination and is described in Sentara's Post-Payment Retrospective Review Analysis. The reconsideration or member appeal process does not vary between MH/SUD and M/S benefits.

Services to Which NQTL Applies:

The M/S and MH/SUD services to which the preauthorization NQTL applies are those services to which the retrospective review (both pre-claim and post-claim) NQTL applies. For reference, those services are listed below as well as in Sentara's Prior Authorization Analysis:

Specific Medical/Surgical Benefits to Which NQTL Applies

Retrospective review applies to services defined in the commercial plan documents as other covered outpatient services, including: surgery, testing procedures, advanced imaging (MRI,

MRA, PET, CT, etc.), hospice, rehabilitative and habilitative services, other therapy services, and home health care.

Surgery: surgical services on an outpatient or office basis. Covered Services include: (i) accepted surgical and cutting procedures; (ii) procedures to correct congenital abnormalities that cause functional impairment, newborn congenital abnormalities or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery; (iii) invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of the brain or spine; (iv) endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy; (v) treatment of fractures and dislocations; (vi) pre-operative and post-operative care; (vii) hypodermic needles, syringes, surgical dressings, splints and other surgical supplies; (viii) physician, nursing, and other support services; (ix) services and anesthesia provided by an anesthesiologist when Medically Necessary and appropriate for your condition; (x) blood and blood products and administration.

Outpatient Advanced Imaging including (i) diagnostic Radiology including X-rays, mammograms, ultrasound, doppler studies, or nuclear medicine; (ii) diagnostic Lab and pathology services or tests; (iii) diagnostic Hearing and Vision tests; (iv) diagnostic Electrocardiograms (EKGs), electroencephalograms (EEGs) and Echocardiograms; (iv) Advanced Diagnostic Imaging procedures including Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS), Positron Emission Tomography (PET Scans), Computerized Axial Tomography (CT Scans), Computerized Axial Tomography Angiogram (CTA Scans), Single Photon Emission Computed Tomography (SPECT Scans), QCT Bone Densitometry, PET/CT Fusion scans, Diagnostic CT Colonography, and nuclear cardiology; (v) professional services for test interpretation, X-ray reading, lab interpretation, and scan reading; (vi) diagnostic Sleep Testing; (vii) tests ordered before a surgery or Admission; (viii) BRCA and fetal screening; (ix) genetic testing and counseling is Covered when Medically Necessary.

Hospice means a coordinated program of home and inpatient care provided directly or under the direction of a licensed Hospice. We cover palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal Illness, whose medical prognosis is death within six months, provided by a medically directed interdisciplinary team.

Rehabilitative and Habilitative Services: including: (i) Physical therapy (PT); (ii) occupational therapy (OT); (iii) speech therapy (ST); (iv) cardiac rehabilitation; (v) pulmonary rehabilitation; (vi) chiropractic/Osteopathic Manipulation therapy.

Other Therapy Services including: (i) Radiation Therapy is treatment of an Illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy,

brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration, treatment planning, and certain other Covered Services; (ii) Respiratory Therapy includes the use of dry or moist gases in the lungs, Non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; bronco pulmonary drainage and breathing exercises; (iii) Chemotherapy includes treatment of an Illness by chemical or biological antineoplastic agents. The criteria for establishing cost sharing applicable to orally administered cancer chemotherapy drugs and cancer chemotherapy drugs that are administered intravenously or by injection will be consistently applied within the same plan; (iv) IV Infusion Therapy includes nursing, durable medical equipment and drug services that are delivered and administered to you through an IV. Also includes Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See also INFUSION SERVICES; (v) Vascular rehabilitation; (vi)Vestibular rehabilitation.

Home Health Care Skilled Services: services provided by an organization licensed by the State and operating within the scope of its license when such services provide for the care and treatment of a homebound Member in his or her home under a treatment plan established and approved in writing by his/her ordering Physician, as required for the proper treatment of the Injury or Illness, in place of inpatient treatment in a Hospital or Skilled Nursing Facility.

Home Private Duty Nurse Services: services of a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in the home when the RN or LPN is not a relative or family member.

Specific MH/SUD Benefits to Which Prior Authorization Applies

Retrospective review applies to services defined in the plan documents as covered outpatient services including: partial hospitalization, intensive outpatient therapy, electro-convulsive therapy, Applied Behavior Analysis, Transcranial Magnetic Stimulation. Partial/intensive outpatient services, partial hospitalization, and Diagnostic and Laboratory Services and Testing are specified in the EOC.

Applied Behavior Analysis: design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Partial Day/Intensive Outpatient Services: Services include an approved outpatient treatment

program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive, and multi-disciplinary treatment. Programs will provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. This also includes intensive outpatient programs for the treatment of mental health & substance use disorders which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

Partial Hospitalization: licensed or approved outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of mental health disorders or alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

There are a number of ways Sentara identifies which services are subject to prior authorization for clinical review (and thus may be subject to retrospective review). Specifically:

Plan Documents:

The HMO and PPO plan documents state the following:
"Some Covered Services under this Plan require Pre-Authorization to be Covered. Please read the entire section on Pre-Authorization in the EOC."

Defines Pre-Authorization as "an evaluation process which assesses the medical necessity of proposed treatment and checks to see that the treatment is being provided at the appropriate level of care."

Describes preauthorization and states: "On Your Schedule of Benefits, We tell You what services require pre-authorization before You receive them. You can also look in the What is Covered Section of this document or call Member Services to find out about Pre-Authorization."

Describes generally the types of services which require preauthorization, including: Inpatient hospitalization services; Partial hospitalization services; Residential treatment services; Non-emergency ambulance transport; Inpatient and outpatient surgery; Surgery in a physician's office; Single items of durable medical equipment and orthopedic and prosthetic appliances over [$750]; Rental of durable medical equipment and orthopedic and prosthetic appliances; Repair and replacement items of durable medical equipment and orthopedic and prosthetic appliances; Artificial prosthetic limbs; Prenatal maternity services (excluding recommended preventive care services, screenings, and one breast pump per pregnancy); Home health care; Skilled Nursing Facility care; Physical, occupational, and speech therapy; Cardiac, pulmonary, and vascular rehabilitation; IV

therapy with medications; Inhalation therapy; Early intervention services; Clinical trials for treatment studies on cancer; Hospice services; Oral surgery; TMJ services; Tubal ligation; Hospitalization and anesthesia for dental procedures; Treatment of lymphedema; Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiography (MRA); Positron Emission Tomography (PET) scans; Computerized Axial Tomography (CT) scans; Computerized Axial Tomography Angiogram (CTA) scans; Sleep studies; transplant services; Injectable and infused medications, biologics, and IV therapy medications defined by Our Pharmacy Committee; Intensive outpatient programs (IOP); Medical, psychological and neuro psychological diagnostic procedures and testing; Electro-convulsive therapy (ECT); Telemedicine service; Transcranial Magnetic Stimulation (TMS); Insulin pumps and insulin pump infusion sets and supplies; Chemotherapy and Chemotherapy Drugs; Radiation Therapy; Dialysis Services; Genetic Testing and Counseling. If Your plan includes any riders generally those services will require Pre-Authorization listed in the rider.

Define Covered Services and designate those which require prior authorization. These Services and others are then further defined.

Schedule of Benefits

States "Some benefits require Pre-Authorization before You receive them. These services ae marked with an * in this document."

The Schedules of Benefits designate the following service types as requiring preauthorization: outpatient therapies and services; outpatient dialysis; outpatient surgery; outpatient lab, diagnostic, imaging, and testing; outpatient advanced imaging, testing and scans; injectable and infused medications; maternity care; inpatient M/S services including inpatient hospital services, transplants, skilled nursing facility services; non-emergency transport; inpatient MH/SUD services including hospital services, residential treatment services, partial hospitalization, intensive outpatient program services, transcranial magnetic stimulation, electro-convulsive therapy, autism spectrum disorder, other outpatient services; diabetes treatment including insulin pumps, pump infusion sets and supplies, talking blood glucose meters, insulin, and needles and syringes for injection; prosthetic devices and components, repair, fitting, replacement and adjustment; durable medical equipment for items over $750, repair, replacement, and rental items; wigs following cancer treatment; early invention services including speech and language therapy, occupational therapy, physical therapy, assistance technology services and devices; home health care; private duty nursing; hospice care; reconstructive breast surgery for members who have had a mastectomy; infertility services including endometrial biopsies, semen analysis, hysterosalpingography, Sims-Huhner test, diagnostic laparoscopy; clinical trial services; allergy testing and serum; telemedicine services; chiropractic services; hearing aids and related services for children 18 and younger

Provider Manual

The Provider Manual states:

"Except in the case of emergency treatment, prior authorization will be required for: all inpatient hospitalizations, all partial hospitalizations (mental health or substance abuse), all outpatient

surgeries/short stays/observations and IV therapy and drug infusions, all skilled nursing facility admissions, all acute rehabilitation, all intensive outpatient programs, all out-of-area services or referrals to nonparticipating providers (prior to scheduling) for members that do not have out-of-network benefits included in their plan. All the following services require prior authorization regardless of the place of service: Commercial plan DME single purchased items greater than $750 and all rentals, orthotics/prosthetics, single purchased items greater than $750 and all rentals, repair, replacement, and duplicates, home health, hospice, IV infusions, plastic surgery, all rehabilitation programs (cardiac, vascular, vestibular, pulmonary, etc.), therapies (PT, OT, ST), applied behavioral analysis, early intervention services (part H certificate required), OB global notification, transplant services, human and synthetic tissue, oral surgery and related services, advanced imaging studies (PET, CT, CTA, MRI, MRA, MR-CT), sleep studies, hyperbaric therapy, electronic bone stimulator, any surgical or diagnostic procedure for which anesthesiology or conscious sedation is billed, injectable drugs indicated on the online prior-authorization forms, genetic testing (if covered by group/plan), bone densitometry if less than 24 months since last study."

Prior Authorization List: (accessible at http://pal.sentarahealthplans.com/)

Tool allows anyone to access and search for procedure code or description to determination whether prior authorization is required.

Procedure and Revenue Codes:

As previously stated, all inpatient services require prior authorization.

Certain services such as PT, OT, and ST, can be used for both MH/SUD and M/S conditions. Specific to these therapies, Sentara ensures MHPAEA compliance through benefit structure. Currently, no numerical visit limitations are placed on PT, OT, and ST for MH/SUD, unlike the annual visit limits for M/S. For other services such as non-emergency transport, Sentara does not preauthorize services strictly by diagnosis. If a medical necessity review is required for the service, it will include all pertinent clinical information required to make a determination based on the appropriate necessity criteria used whether that be internal medical policies or MCG (which incorporate ASAM). For example, Sentara tracks transportation authorizations but does not track whether authorization for non-emergency transportation was reviewed for an underlying M/S or MH/SUD condition.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See 45 CFR 146.137(c)(2). Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources

from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:

(A) A detailed description of the factor;

(B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and

(C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Sentara incorporates by reference its Analyses for Prior Authorization and Concurrent Authorization. The only factor and standard that differs between Prior Authorization and Retrospective Review is that Retrospective Review applies when prior or concurrent authorization was required but not obtained.

Step 3: Description of how factors are used in the design and application of the NQTL.

See 45 CFR 146.137(c)(3). Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s)

[Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].

- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Sentara incorporates by reference its Analyses for Prior Authorization and Concurrent Authorization.

Step 4: Demonstration of comparability and stringency as written.

See 45 CFR 146.137(c)(4). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Documentation of Each Factor Identified as Defined in Step Two:

The following factors are implicated in determining whether Prior Authorization applies to certain services:

Service	Factors
All outpatient, M/S services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, M/S services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, MH/SUD services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria
All outpatient, MH/SUD services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria

As explained above, the only factor that determines whether retrospective review (pre-claim or post-claim) applies is whether the claim is for a service requiring prior authorization or concurrent authorization when the provider failed to obtain one.

How Factors are Comparably Applied:

Sentara applies applicable industry standards (MCG for M/S and ASAM for MH/SUD) equally to all services in the respective classifications. Industry standards are applied without discretion, regardless of whether the particular service is M/S or MH/SUD. For services (either M/S or MH/SUD) for which there is no applicable industry standard, the Sentara MPC evaluates and reviews the requested service.

Reasons for Any Deviations or Variations:

There are no variations or deviations in the design or application of prior authorization between M/S and MH/SUD benefits.

Comparison of Existing Written Documents:

The policies and procedures identified and defined in the preauthorization NQTL apply to the retrospective review NQTL. There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

Prior Authorization, Concurrent Review, and Retrospective Review

Pre-Claim Retrospective Review: Policies and procedures for pre-claim retrospective review are identical to those for preauthorization and concurrent review except for two aspects. First, the timing of the review is different. For pre-claim retrospective review, the timing consists of post-service, pre-claim services. Second, and relatedly, discussions of lower levels of care are not applicable since the service has been provided. Reviewing Medical Directors do use the same peer-to-peer process when reviewing medical necessity pre-claim, post-service as they do when reviewing medical necessity pre-claim, pre-service. This process applies to both M/S and MH/SUD services.

Post-Claim Retrospective Review: Sentara's policies and procedures for retrospective review are identical" to those for preauthorization and concurrent review except for a few key differences described herein. The first difference is the timing of the review. For post-claim retrospective review, a reconsideration request occurs from the provider post-claim and after the claim has denied. There are differences in the process for clinical review when conducted post-claim at the request for reconsideration by the provider. One difference is that UM Vendor 1 is the only vendor used to conduct medical necessity reviews in the reconsideration process. While vendors never conduct utilization review for MH/SUD services, as described in Sentara's Medical Necessity Analysis, vendors are used for certain M/S services. With the exception of UM Vendor 1, these vendors are not used when the clinical review is conducted retrospectively through the post-service reconsideration process. Also, Sentara does not conduct peer-to-peer reviews and does not negotiate lower levels of care because the service has been rendered the claim submitted. This process applies to both M/S and MH/SUD services.

Traditional Retrospective Review:

Clinical Review Processes

Pre-Claim Retrospective Review: All clinical review requests are assessed based on approved clinical criteria and guidelines (as explained in Sentara's Medical Necessity Analysis for commercial lines of business, when no internal medical policies exist for any MH/SUD or M/S service, MCG is utilized without incorporation or supplementation of any internal guidelines or policies.). For pre-claim retrospective review, reviews and decisions will be completed within 30 days of received the request. If an authorization request results in an adverse determination, providers and members are notified of post-service decisions via adverse benefit determinations which contain appeal instructions. Providers or members have 180 days from notice of an adverse benefit determination to ask for an appeal. When Sentara reviews an appeal, Sentara looks at all comments, documents, records, and other information submitted to Sentara. Appeals involving medical necessity will be reviewed by a clinical peer reviewer, with the same qualification as described in Sentara's Prior Authorization Analysis, who did not participate in

the first coverage decision. When Sentara completes the appeal, Sentara will send written notification of the decision. If Sentara Health Plans doesn't change the initial decision the notice will include:

1. The specific reason for the decision;

2. The specific plan provisions Sentara Health Plans based the decision on; and

3. Information on any independent external appeal rights. In general, the internal appeal process must be exhausted prior to filing an independent external appeal. An exception exists for the treatment of cancer.

The levels of review include a request for authorization which is handled by clinicians, including "Registered Nurses, Licensed Practical Nurses, Clinical Pharmacists, Clinical Psychologists, and Board certified Medical and Behavioral Health Physicians (Medical Directors)." The process does include access to Board Certified Physicians to serve as physician specialty advisors. At the discretion of the medical director or for appeals and grievances, cases are referred to these physicians to review for medical necessity or appropriateness. If a request for authorization results in an adverse benefit determination, providers and members have 180 days to request an appeal. Providers may also request a peer review or reconsideration, which is not considered part of the appeal. There is one level of internal appeals. Registered and practical nurses can authorize, but not deny a service. Any denials of medical necessity must be conducted by a Medical or Behavioral Health Physician (Medical Director) depending on the service type. Post-claim retrospective clinical review upon a request by a provider for reconsideration does not include peer-to-peer review.

Post-Claim Retrospective Review: All clinical review requests are assessed based on approved clinical criteria and guidelines (as explained in Sentara's Medical Necessity Analysis, for commercial lines of business, when no internal medical policies exist for any MH or M/S service, MCG is utilized without incorporation or supplementation of any internal guidelines or policies.). For a first-level review post-claim provider reconsideration requests, the reconsideration request must be received within 365 days from the date of service. If timely received, a review is conducted to determine medical necessity. If medical necessity is not satisfied, a subsequent review is conducted by a Medical Director and either approved or denied. A second-level reconsideration review occurs if requested within 60 days of the notification of the first-level claim reconsideration. For medical necessity denials, the second-level reconsideration review is conducted by a Medical Director not originally involved with the review. A post-service, pre-claim request for authorization is handled by clinicians, including "Registered Nurses, Licensed Practical Nurses, Clinical Pharmacists, Clinical Psychologists, and Board certified Medical and Behavioral Health Physicians (Medical Directors)." The process does include access to Board Certified Physicians to serve as physician specialty advisors. At the discretion of the medical director or for appeals and grievances, cases are referred to these physicians to review for medical necessity or appropriateness. If a request for authorization results in an adverse benefit determination, providers and members have 180 days to request an appeal. There is one level of internal appeals. Registered and practical nurses can authorize, but not deny a service. Any denials of medical necessity must be conducted by a Medical or Behavioral Health Physician (Medical Director) depending on the service type. Post-claim retrospective clinical review upon a request by a provider for reconsideration does not include peer-to-peer review.

Tracking of Denials

Sentara tracks and reports all claim denials and closed internal and external appeals and complaints. Sentara tracks administrative denials as compared to denials for medical necessity. For appeals, Sentara tracks whether the denials were upheld, partially upheld or overturned in closed internal appeals and closed external reviews.

Pre-Claim Retrospective Review:

2023: M/S IP

702 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 663 were initiated by in-network providers and 39 from out-of-network providers for a 5.56% of out-of-network providers. The denial rate of the 702 requests was 19.37%, and 20.8% of the requests were referred to MD.

2023: MH/SUD IP

24 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 20 were initiated by in-network providers and 4 from out-of-network providers for a 16.67% of out-of-network providers. Of the 24 requests, 20 were approved for a 16.67% denial rate. 16.7% of the requests were referred to MD. Only 1 of the 4 denials constituted a medical necessity denial.

2023: M/S OP

4083 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 3760 were initiated by in-network providers and 323 from out-of-network providers for a 7.91% of out-of-network providers. The denial rate of the 4083 requests was 7.89%, and 8.3% of the requests were referred to MD.

2023: MH/SUD OP

5 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 4 were initiated by in-network providers and 1 from out-of-network providers for a 20% of out-of-network providers. Of the 5 requests, 5 were approved for a 0% denial rate. 0% of the requests were referred to MD.

2024: M/S IP

450 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 433 were initiated by in-network providers and 17 from out-of-network providers for a 3.78% of out-of-network providers. Of the 450 requests, 352 were approved for a 22% denial rate. 22% of the requests were referred to MD.

2024: MH/SUD IP

24 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 20 were initiated by in-network providers and 4 from out-of-network providers for a 16.67% of out-of-network providers. Of the 24 requests, 23 were approved for a 4.17% denial rate. 8.3% of the requests were referred to MD.

2024: M/S OP

3025 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 2869 were initiated by in-network providers and 156 from out-of-network providers for a 5.16% of out-of-network providers. The denial rate of the 3025 requests was 5.65%, and 4.9% of the requests were referred to MD.

2024: MH/SUD OP

7 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 5 were initiated by in-network providers and 2 from out-of-network providers for a 28.57% of out-of-network providers. Of the 7 requests, 7 were approved for a 0% denial rate. 28.6% of the requests were referred to MD.

Post-Claim Retrospective Review: For post-service, post-claim requests for reconsideration, the authorization volume by review can be reported as follows:

2023: M/S

503 Total Requests for Post-Claim Retrospective Review. Of these requests 484 were initiated by in-network providers and 19 by out-of-network providers for a 3.78% of out-of-network providers. Of the 503 requests, 21 were for inpatient services and 482 were for outpatient services. All requests for inpatient services were approved. Of the 482 requests for outpatient services, 28 were denied for a denial rate of 5.57%. Of the 5.57%, 5.12% denied for medical necessity. The MD referral rate was 4.1%.

2023: MH/SUD

5 Total Requests for Retrospective Review (Post-Service). Of these requests, 4 were initiated by in-network providers and 1 from an out-of-network provider for a 20% of out-of-network providers. Of the 5 requests, all were for inpatient services and all were approved for a 0% denial rate. None of the 5 requests were referred to Medical Directors. There were no MH/SUD Requests for Retrospective Review for outpatient services in 2023.

2024: M/S

2056 Total Requests for Retrospective Review (Post-Service). Of these requests,1974 were initiated by in-network providers and 82 from out-of-network providers for a 3.99% of out-of-network providers. Of the 2056 total requests, 1926 were approved, 131 were denied and 1 claim was partially denied for a denial rate of 6.42%. Of the 2056 claims, 180 were for inpatient services. Of these 180 claims, the denial rate was 1.67%. The MD Referral Rate for inpatient services was 0 .6%. Of the 2056 claims, 1876 were for outpatient services. Of these 1876 claims, the denial rate was 6.88%. The MD Referral Rate for outpatient services was 4.5%. Of the total 131 denials and 1 partial denial, 110 were denied as not being medically necessary and 21 were administratively denied for non-covered service or benefit exhaustion. The Medical Director referral rate was 4.1%.

2024: MH/SUD

21 Total Requests for Retrospective Review (Post-Service). Of these requests, 19 were initiated by in-network providers and 2 from out-of-network providers for a 9.52% of out-of-network providers. Of the 21 total requests, all 21 were approved for a 0% denial rate. Of the 21

claims, 11 were for inpatient services. Of these 11 claims, the denial rate was 0%. Of the 21 claims, 10 were for outpatient services. Of these 10 claims, the denial rate was 0%.

Appeals Data:

2023: In 2023 there were 0 MH/SUD provider medical necessity appeals, compared with 19 M/S medical necessity appeals.

2024: In 2024, there was 1 MH/SUD medical necessity provider appeal, compared with 34 M/S provider medical necessity appeals.

Extent of Medical Records Required

The policies related to medical records are identified in the preauthorization NQTL. Any additional medical records establishing medical necessity are pertinent to any traditional retrospective review.

Appeal Rights

In the context of the internal appeal process, any denial or reduction of benefits and/or nonpayment based upon a determination of medical necessity is treated as an Adverse Benefit Determination and subject to the appeal process outlined in the plans. Written notice of Adverse Benefit Determinations is required except for Urgent Claims, where notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notice of an Adverse Benefit Determination includes the following:

• The specific reason or reasons for the Adverse Benefit Determination;

• Reference to the specific Plan provisions on which the determination is based;

• A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.

Any member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination.

For denials due to Medical Necessity, Experimental treatment, or similar exclusion or limit, members are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances.

After notification of an Adverse Benefit Determination, a member has 180 days to request an appeal. Upon appeal, all comments, documents, records, and other information submitted is reviewed. Additional information may be provided. The clinical peer reviewer reviewing the appeal will not have participated in the original coverage decision. Should a member disagree with the Final Benefit Determination, an external appeal is available. There are no differences in the process for appeals of retrospective reviews as it relates to MH/SUD and M/S benefits.

Lower levels of care are not authorized in retrospective reviews because the services have already been provided. As a general matter, for requests for prior or concurrent authorizations, a member or provider can appeal any decision (whether M/S or MH/SUD) regardless of whether the member accepts and receives a lower level of care.

Approvals of Lower Levels of Care

Discussions of lower levels of care are not applicable during pre-claim retrospective reviews since the service has been provided or during post-claim retrospective reviews because the claim has already been submitted. This applies to both M/S and MH/SUD services.

Initiation of Clinical Review

Pre-Claim Retrospective Review: The provider must initiate a request for pre-claim retrospective review. Sentara will not initiate any request for retrospective review. A pre-claim request for retrospective review will be conducted, upon request of the provider, for any requested service which a prior authorization was required but not obtained. This is true for M/S and MH/SUD services. A provider is made aware of this process through the Provider Manual which is available to both in-network and out-of-network providers. If an authorization was required and not obtained, the provider is required to hold the member harmless. Extensions for additional time and requested documents are consistent with M/S and MH/SUD services. The data establishes the operation of pre-claim retrospective review as being inherently consistent, in that no denials for MH/SUD outpatient services occurred in 2023 or 2024 on pre-claim retrospective review. As for inpatient MH/SUD services, denials on pre-claim retrospective review totaled 16.67% in 2023 (compared to 19.37% for M/S services) and 4.17% in 2024 (compared to 22% for M/S).

Post-Claim Retrospective Review: The provider must initiate a request for reconsideration for post-claim retrospective review. Sentara will not initiate any request for retrospective review. A post-service retrospective review will be conducted, upon request of the provider, for any requested service which a prior authorization was required but not obtained. This is true for M/S and MH/SUD services. A provider is made aware of this process through the Provider Manual which is available to both in-network and out-of-network providers. If an authorization was required and not obtained, the provider is required to hold the member harmless. Extensions for additional time and requested documents are consistent with M/S and MH/SUD services. The data establishes the operation of post-claim retrospective review as being inherently consistent, in that no denials for MH/SUD services occurred upon post-claim retrospective review in 2023 and 2024.

Initial Authorization

The type of initial authorization does not have any impact on retrospective review. In the event of an inpatient admission, once notification or a request for authorization occurs, a medical necessity review is conducted.

Step 5: Demonstration of comparability and stringency in operation.

See 45 CFR 146.137(c)(5). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD

and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.

- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

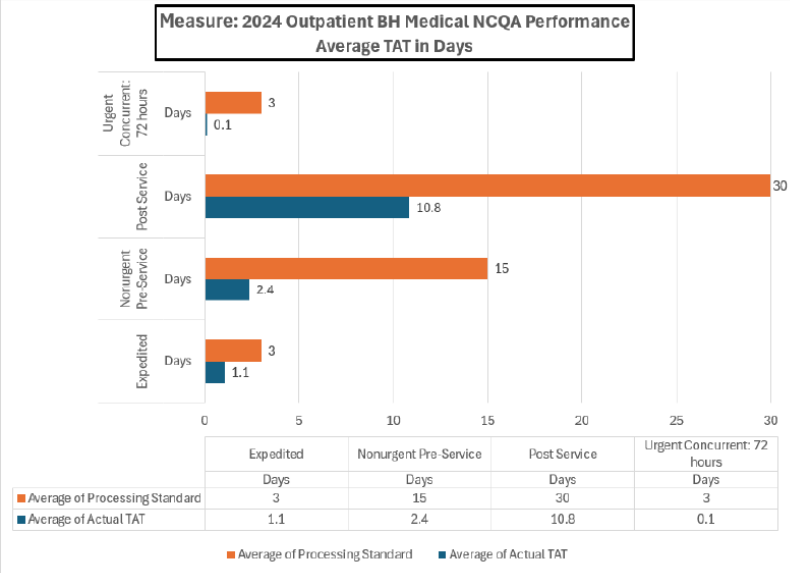
- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

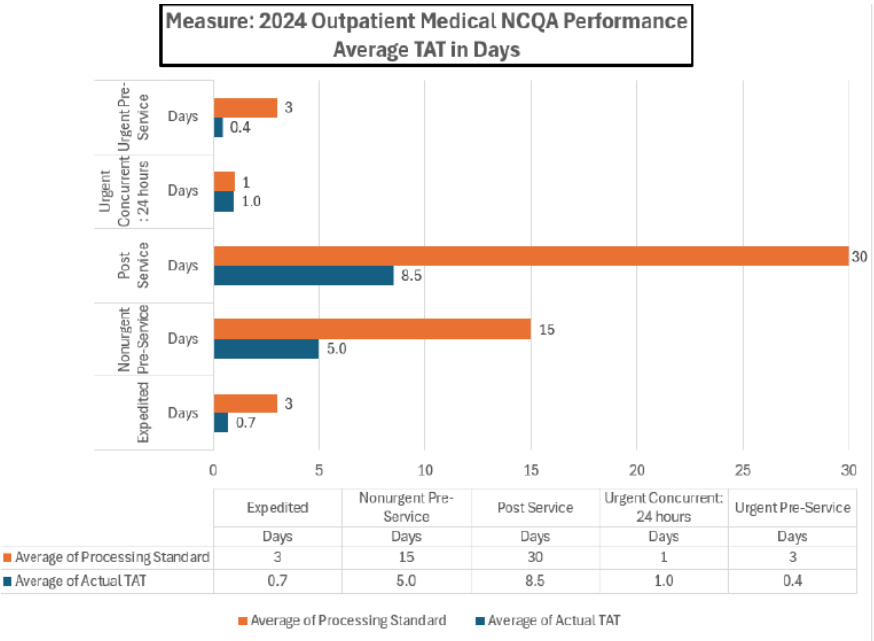
Data provided herein is for 2024 Virginia fully-insured plans. This analysis will be supplemented with 2025 data when it becomes available. See denial rates and peer-to-peer reviews for pre-claim retrospective reviews above. See denial rates for post-claim retrospective reviews above.

Pre-Claim Retrospective Review— Turnaround Times: The charts below specify pre-claim, post-service data.

2024 Outpatient MH/SUD NCQA Performance:



2024 Outpatient M/S NCQA Performance:



IRR Testing:

Sentara performs IRR testing as described below:

- Required score to pass: 80%

o How participants are evaluated: Test is developed by Sentara's utilization management leadership and educators. It consists of a variety of scenarios (inpatient, outpatient, behavioral health and medical). The same test is administered to all clinical staff who review requests for authorization determination.

o Results: 100% MH/SUD pass rate for 2022 and 2023 and M/S 97.9% for 2022 and 96% for 2023

o Separate testing occurs for MH/SUD reviewers and M/S reviewers: There are separate scenarios/questions addressing M/S or MH/SUD. The utilization team is separated by M/S and MH/SUD. If the clinical staff is on the MH/SUD team, they will take the MH/SUD test and the same is accurate for M/S.

Pre- and Post-Claim Retrospective Review: Sentara has implemented a policy regarding Measuring Staff Consistency Including Inter-rater Reliability. Testing is scored individually. The results of each individual tested should be at least 80% accurate. A report will be given to each manager/team coordinator for staff who make UM decisions and to the Chief Medical Officer (CMO) for Medical Directors. UM Staff and Medical Directors will have ongoing education regarding the use of criteria. Training will be completed with staff and Medical Directors who do not achieve at least an 80% test score.

Sentara audits monthly its utilization management processes. Sentara audit its Monthly and Quarterly Utilization report that includes for example:

o Days/1000, Admissions/1000

o Average length of stay (ALOS)

o Observation days/1000

o Readmission rate for both medical and behavioral health services

o Outpatient surgeries/1000

o Outpatient visits/1000

o Milliman Benchmarking

o High-Dollar claims

o Complex medical conditions

o Authorizations provided to non-participating providers

Sentara conducts an annual evaluation of its utilization management program, which includes an evaluation of vendors performing utilization management services for Sentara.

In Operation Data

Post-Service, Pre-Claim Retrospective Review

Sentara collected post-service, pre-claim retrospective requests for authorization data as requested for 2023 and 2024 to determine if denials were disproportionate for MH/SUD outpatient services as compared to M/S outpatient services.

In 2023, for outpatient services, there were a total of 4088 post-service, pre-claim requests for authorizations. Of these post-service, pre-claim requests for authorization, 4083 were for outpatient M/S services and 5 were for outpatient MH/SUD services. As for outpatient M/S services, the denial rate was 7.89% for outpatient M/S services. Of the 7.89% of denials, 5.57% denied for medical necessity. As it relates to MH/SUD requests for outpatient services, of the 5 requests, all 5 were approved. The denial rate was 0%. With this data, Sentara does not see disparity in the application of its utilization management program, for post-service, pre-claim retrospective review for outpatient claims.

The same trend occurred in 2024. For outpatient services, there were a total of 3032 post-service, pre-claim requests for authorization. Of these post-service, pre-claim requests for authorizations, 3025 were for outpatient M/S services and 7 were for outpatient MH/SUD services. As for inpatient M/S services, the denial rate was 5.65% for M/S services. Of the 5.65% of denials, 2.67% denied for medical necessity. As it relates to MH/SUD outpatient services, of the 7 requests, all 7 were approved. The denial rate was 0%. With this data, Sentara does not see disparity in the application of its utilization management program, for post-service, pre-claim retrospective review.

Physician review – In analyzing physician review, Sentara's main objective was to determine if the MH/SUD physician reviewers were applying discretion in a way that was more stringent or arbitrary than how M/S physicians applied discretion and to determine if they were adhering to criteria in a fashion that was no more stringent than M/S physicians' adherence to criteria. Sentara further studied MD (Medical Director) referral rates. In 2023, Sentara discovered that percentages of requests for authorizations referred for Medical Director review was higher in M/S than MH/SUD inpatient services. In 2023, 8.3% of M/S outpatient requests for authorization were referred to MD review, as compared to 0% of MH/SUD outpatient requests for authorization. This trend reversed in 2024, 4.9% of M/S outpatient requests for authorizations were referred to MD Review as compared to 28.6% for MH/SUD outpatient services. Given that 0 denials occurred for medical necessity for MH/SUD services in 2023 and 2024, MD referrals appear to be a positive review protocol and physician review is not causing any disparate impact.

In reviewing peer-to-peer review data, the objectives were largely the same. While significantly more M/S inpatient services are subject to peer review than MH/SUD inpatient services, the denial rates are much lower for MH/SUD inpatient services. In fact, no MH/SUD services (inpatient or outpatient) were referred to peer-to-peer in 2023 and 2024. With such few instances of peer to peer review, 10 total in 2023 and 2024 combined, it is difficult to determine any trends, however, denial rates indicate that utilization review is not being more stringently applied to MH/SUD inpatient services.

Appeal data further confirms that no disparity exists as to utilization review. In 2023, for MH/SUD services, 7 appeals occurred throughout the commercial line of business and

none of the 7 appeals were medical necessity appeals. In 2024, there were 5 appeals for MH/SUD services and only 1 appeal concerned medical necessity.

Sentara further compared turnaround time (TAT) and noticed an area of improvement. The TAT for MH/SUD outpatient services, while still better than the NCQA standard, was 10.8 days for post-service, pre-claim review, as compared to 8.5 days for M/S.

Post-claim Retrospective Review:

Sentara collected post-service, post-claim retrospective requests for authorization data for 2023 and 2024 to determine if denials on provider requests for reconsideration were disproportionate for MH/SUD outpatient services as compared to M/S outpatient services.

In 2023, for outpatient M/S services, there were a total of 482 post-service, post-claim requests for authorization. Of these 482 post-service, post-claim requests for authorization, 28 were denied for a denial rate of 5.81%. Of the 5.81% denied, 5.12% denied for medical necessity. There were no post-service, post-claim requests for MH/SUD outpatient services in 2023. With this data, Sentara does not see disparity in the application of its utilization management program, for post-service, post-claim retrospective review.

The same trend occurred in 2024. For outpatient services, there were a total of 1876 post-service, post-claim requests for authorization. Of these authorizations, the denial rate was 6.88% with a MD Referral Rate of 4.5%. As it relates to MH/SUD outpatient services, there were a total of 21 post-service, post-claim requests for authorization. Of the 21 post-service, post-claim requests for authorization, 10 were for outpatient MH/SUD services. Of these 10, all were approved and the denial rate was 0%. With this data, Sentara does not see disparity in the application of its post-service, post-claim retrospective review.

Physician review – In analyzing physician review, Sentara's main objective was to determine if the MH/SUD physician reviewers were applying discretion in a way that was more stringent or arbitrary than how M/S physicians applied discretion and to determine if they were adhering to criteria in a fashion that was no more stringent than M/S physicians' adherence to criteria. Sentara further studied MD (Medical Director) referral rates. Given that there were no denials for MH/SUD outpatient services upon post-service, post-claim retrospective review, Sentara finds no disparity.

Peer to Peer Data does not apply to post-service, post-claim retrospective review.

Appeal data further confirms that no disparity exists as to utilization review. In 2023, for MH/SUD services, 7 appeals occurred throughout the commercial line of business and none of the 7 appeals were medical necessity appeals. In 2024, there were 5 appeals for MH/SUD services and only 1 appeal concerned medical necessity.

Step 6: Findings and conclusions.

See 45 CFR 146.137(c)(6). The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the FAQ 45 guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara defined Retrospective Review NQTL as a clinical review following the provision of M/S or MH/SUD services. Sentara noted that retrospective reviews can occur either pre-claim or post-claim. Sentara identified the processes for seeking retrospective review. Retrospective clinical review is consistently applied to both M/S and MH/SUD services. Sentara identified the Medical Policy Committee as the body that determines medical policies and clinical guidelines, which apply regardless of whether the clinical review occurs pre- or post-service. Sentara explained its process for reviewing services for medical necessity post-service and the process for appeal. Sentara detailed its process for tracking retrospective reviews, which is consistently applied for both M/S and MH/SUD services.

Data collected includes:

- No denials occurred for MH or SUD services for any Plan in 2024.

- IRR testing descriptions and results, demonstrating passing scores and 100% pass rate for clinicians in MH/SUD.

Analysis establishes Sentara is compliant with MHPAEA. This analysis was completed in September 2026 by the following Sentara departments: Utilization Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

RETROSPECTIVE REVIEW: OUTPATIENT, OUT-OF-NETWORK

(NOT APPLICABLE TO EMERGENCY SERVICES

EXCEPT AS TO CODING EDITS)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See 45 CFR 146.137(c)(1). Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also FAQ 45 (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

Definitions

Pre-Payment Review: Sentara does not conduct any pre-payment review of providers. While corrective actions plans are utilized as outcomes for FWA audits and investigations, those corrective plans do not include pre-payment review.

Pre-Payment FWA: Sentara does not conduct any pre-payment FWA audits or investigations of providers. While the Provider Manual permits Sentara to conduct pre-payment FWA audits or investigations, Sentara does not currently conduct any pre-payment FWA review for M/S or MH/SUD services.

Coding Edits: Sentara does not conduct any pre-payment coding edits.

NOTE: *The remainder of this analysis will focus solely on pre-claim retrospective review and post-claim retrospective review (each defined below) because Sentara does not use pre-payment reviews, pre-payment FWA, coding edits, or any other form of retrospective review.*

Pre-Claim Retrospective Review: Pre-claim retrospective review means the review of the member's medical records and other supporting documentation by the Plan after services have been rendered to determine the Plan's liability for payment. Pre-claim retrospective review pertains to the time period post-service, but pre-claim submission. Specifically, pre-claim retrospective review only applies to services which required a prior authorization, and one was not obtained before the service was rendered. Post-service, pre-claim retrospective review does not apply if authorization was requested and denied. Pre-claim retrospective review also does not apply once a claim has been submitted. Pre-claim retrospective review applies to both M/S and MH/SUD services.

Post-Claim/Post-Denial Retrospective Review ("Post-Claim"): Post-claim retrospective review means the review of the member's medical records and other supporting documentation by the Plan after services have been rendered to determine the Plan's liability for payment. Post-claim retrospective review pertains to the time period post-service, post-claim submission. Services are eligible for post-claim retrospective review only upon request for reconsideration by a provider. Providers may request reconsideration of claims for services which require prior authorization that are submitted without an authorization having been granted by Sentara and later denied. Claims for services which require authorization will deny provider responsible if authorization is not obtained and no payment will be issued. Reconsideration focuses on the processing of the claim and does not allow for modification of the claim. It applies equally to both M/S and MH/SUD claims. For a first-level review, the reconsideration request must be received within 365 days from the date of service. If timely received, a medical necessity review is conducted. If medical necessity is met, the claim is authorized. If medical necessity is not satisfied, a subsequent review is conducted by a Medical Director and either approved or denied. A second-level reconsideration review occurs if requested within 60 days of the notification of the first-level claim reconsideration. For medical necessity denials, the second-level reconsideration review is conducted by a Medical Director not originally involved with the review.

Vendors:

Pre-Claim Retrospective Review: As set forth in its Prior Authorization and Concurrent Review Analyses, Sentara utilizes vendors for utilization review of certain M/S services. These vendors

perform utilization review for their respective services (as described below) for pre-claim retrospective review. Sentara does not utilize vendors for medical necessity reviews for MH/SUD services regardless of the timing of those reviews.

Post-Claim Retrospective Review: As it pertains to post-claim retrospective reviews, these reviews are conducted only if initiated by a provider under Sentara reconsideration processes. Once initiated, Sentara, through its Utilization Management Department, internally will review for medical necessity. With the exception of chiropractic services, Sentara does not utilize vendors for post-claim retrospective review for M/S or MH/SUD services. With the exception of chiropractic services, post-claim medical necessity reviews are performed internally by the Utilization Management Department using Sentara's definition of medical necessity.

With respect to chiropractic services, a vendor ("UM Vendor 1")conducts utilization review for "Chiropractic Services," as defined in Sentara commercial plan documents. All chiropractic services require prior authorization. The relationship between UM Vendor 1 and Sentara as it relates to chiropractic services is governed by a services agreement. As defined by UM Vendor 1, "Medically Necessary" or "Medical Necessity" shall mean health care services that a healthcare practitioner, exercising Prudent Clinical Judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an illness, injury, disease or its symptoms, and that are (a) in accordance with Generally Accepted Standards of Medical Practice; (b) clinically appropriate in terms of type, frequency, extent, site, and duration; and Considered Effective for the member's illness, injury, or disease; and (c) not primarily for the Convenience of the Patient or Healthcare Practitioner, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury, or disease. Sentara, not UM Vendor 1, is responsible for appeals for UM decisions for all services.

A separate third-party vendor ("UM Vendor 2") conducts utilization review for medical oncology and radiation oncology in accordance with a services agreement. UM Vendor 2 is URAC and NCQA accredited. Under the services agreement provides, UM Vendor 2 providers access to virtual care and support for members with cancer. Sentara, not UM Vendor 2, is responsible for appeals for UM decisions for all services.

A third vendor ("UM Vendor 3") conducts utilization review for non-emergent, advanced outpatient imaging, including CT/CTA, CCTA, MRI/MRA, PET Scan, Myocardial Perfusion Imaging, MUGA Scan, Stress Echocardiography, Echocardiography, Cardiac Implantable Devices, and Left Heart Catheterization in accordance with a services agreement.

UM Vendor 3 uses Sentara's definition of medical necessity as defined above. Sentara, not UM Vendor 3, is responsible for appeals for UM decisions for all services.

Separate Operating Departments or Divisions:

Pre-Claim Retrospective Review: There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Post-Claim Retrospective Review: There are no separate operating departments or divisions that administer MH/SUD distinct from M/S benefits.

Supporting Documentation

Sentara maintains an organizational chart of positions with the Utilization Management department. Moreover, Sentara maintains policies and procedures relating to retrospective review including a Utilization Management Program Description, an Annual Commercial and Exchange Utilization Management Evaluation, Provider Claim Reconsideration Procedure, Technology Assessment and Coverage Decision Policy, Administrative Denial Policy, and Medical Policy Committee Charter.

Traditional Retrospective Review

Sentara defines the traditional retrospective review as a medical necessity review that takes place after services have been rendered. Traditional retrospective review includes both pre-claim and post-claim retrospective review.

Pre-Claim Retrospective Review: All services which require an authorization are eligible for pre-claim retrospective review if a request for authorization is submitted post-service, but pre-claim. Services are not eligible for pre-claim retrospective review if the service does not require authorization or if authorization was already requested. Pre-claim retrospective review does not apply if a claim has been submitted for the requested service. A provider is responsible for initiating or requesting a pre-claim retrospective review. Sentara does not initiate requests for pre-claim retrospective review. The process mirrors that of prior authorization or concurrent review (with limited differences discussed in the analysis below). The pre-claim retrospective review process does not vary between M/S and MH/SUD services.

Post-Claim Retrospective Review: Services are eligible for post-claim retrospective review upon a reconsideration request by a provider under the Sentara reconsideration process. A provider is responsible for initiating or requesting a post-claim reconsideration. Sentara does not initiate post-claim retrospective reviews. At claim submission, if a service requiring prior authorization was not authorized the claim will be administratively denied provider responsible for no authorization. A provider may then initiate a request for post-claim retrospective review of medical records. That process is considered a reconsideration or member appeal of an adverse benefit determination and is described in Sentara's Post-Payment Retrospective Review Analysis. The reconsideration or member appeal process does not vary between MH/SUD and M/S benefits.

Services to Which NQTL Applies:

The M/S and MH/SUD services to which the preauthorization NQTL applies are those services to which the retrospective review (both pre-claim and post-claim) NQTL applies. For reference, those services are listed below as well as in Sentara's Prior Authorization Analysis:

Specific Medical/Surgical Benefits to Which NQTL Applies

Retrospective review applies to services defined in the commercial plan documents as other covered outpatient services, including: surgery, testing procedures, advanced imaging (MRI,

MRA, PET, CT, etc.), hospice, rehabilitative and habilitative services, other therapy services, and home health care.

Surgery: surgical services on an outpatient or office basis. Covered Services include: (i) accepted surgical and cutting procedures; (ii) procedures to correct congenital abnormalities that cause functional impairment, newborn congenital abnormalities or significant deformities caused by congenital or developmental abnormalities, disease, trauma, or previous therapeutic process in order to create a more normal appearance, other than for orthognathic surgery; (iii) invasive procedures, such as angiogram, arteriogram, amniocentesis, tap or puncture of the brain or spine; (iv) endoscopic exams, such as arthroscopy, bronchoscopy, colonoscopy, laparoscopy; (v) treatment of fractures and dislocations; (vi) pre-operative and post-operative care; (vii) hypodermic needles, syringes, surgical dressings, splints and other surgical supplies; (viii) physician, nursing, and other support services; (ix) services and anesthesia provided by an anesthesiologist when Medically Necessary and appropriate for your condition; (x) blood and blood products and administration.

Outpatient Advanced Imaging including (i) diagnostic Radiology including X-rays, mammograms, ultrasound, doppler studies, or nuclear medicine; (ii) diagnostic Lab and pathology services or tests; (iii) diagnostic Hearing and Vision tests; (iv) diagnostic Electrocardiograms (EKGs), electroencephalograms (EEGs) and Echocardiograms; (iv) Advanced Diagnostic Imaging procedures including Magnetic Resonance Imaging (MRI), Magnetic Resonance Angiography (MRA), Magnetic Resonance Spectroscopy (MRS), Positron Emission Tomography (PET Scans), Computerized Axial Tomography (CT Scans), Computerized Axial Tomography Angiogram (CTA Scans), Single Photon Emission Computed Tomography (SPECT Scans), QCT Bone Densitometry, PET/CT Fusion scans, Diagnostic CT Colonography, and nuclear cardiology; (v) professional services for test interpretation, X-ray reading, lab interpretation, and scan reading; (vi) diagnostic Sleep Testing; (vii) tests ordered before a surgery or Admission; (viii) BRCA and fetal screening; (ix) genetic testing and counseling is Covered when Medically Necessary.

Hospice means a coordinated program of home and inpatient care provided directly or under the direction of a licensed Hospice. We cover palliative and supportive physical, psychological, psychosocial and other health services to individuals with a terminal Illness, whose medical prognosis is death within six months, provided by a medically directed interdisciplinary team.

Rehabilitative and Habilitative Services: including: (i) Physical therapy (PT); (ii) occupational therapy (OT); (iii) speech therapy (ST); (iv) cardiac rehabilitation; (v) pulmonary rehabilitation; (vi) chiropractic/Osteopathic Manipulation therapy.

Other Therapy Services including: (i) Radiation Therapy is treatment of an Illness by x-ray, radium, or radioactive isotopes. Covered Services include treatment (teletherapy,

brachytherapy and intraoperative radiation, photon or high energy particle sources), materials and supplies needed, administration, treatment planning, and certain other Covered Services; (ii) Respiratory Therapy includes the use of dry or moist gases in the lungs, Non-pressurized inhalation treatment; intermittent positive pressure breathing treatment, air or oxygen, with or without nebulized medication, continuous positive pressure ventilation (CPAP); continuous negative pressure ventilation (CNP); chest percussion; therapeutic use of medical gases or drugs in the form of aerosols, and equipment such as resuscitators, oxygen tents, and incentive spirometers; bronco pulmonary drainage and breathing exercises; (iii) Chemotherapy includes treatment of an Illness by chemical or biological antineoplastic agents. The criteria for establishing cost sharing applicable to orally administered cancer chemotherapy drugs and cancer chemotherapy drugs that are administered intravenously or by injection will be consistently applied within the same plan; (iv) IV Infusion Therapy includes nursing, durable medical equipment and drug services that are delivered and administered to you through an IV. Also includes Total Parenteral Nutrition (TPN), enteral nutrition therapy, antibiotic therapy, pain care and chemotherapy. May include injections (intra-muscular, subcutaneous, continuous subcutaneous). See also INFUSION SERVICES; (v) Vascular rehabilitation; (vi)Vestibular rehabilitation.

Home Health Care Skilled Services: services provided by an organization licensed by the State and operating within the scope of its license when such services provide for the care and treatment of a homebound Member in his or her home under a treatment plan established and approved in writing by his/her ordering Physician, as required for the proper treatment of the Injury or Illness, in place of inpatient treatment in a Hospital or Skilled Nursing Facility.

Home Private Duty Nurse Services: services of a licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) in the home when the RN or LPN is not a relative or family member.

Specific MH/SUD Benefits to Which Prior Authorization Applies

Retrospective review applies to services defined in the plan documents as covered outpatient services including: partial hospitalization, intensive outpatient therapy, electro-convulsive therapy, Applied Behavior Analysis, Transcranial Magnetic Stimulation. Partial/intensive outpatient services, partial hospitalization, and Diagnostic and Laboratory Services and Testing are specified in the EOC.

Applied Behavior Analysis: design, implementation, and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

Partial Day/Intensive Outpatient Services: Services include an approved outpatient treatment

program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive, and multi-disciplinary treatment. Programs will provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. This also includes intensive outpatient programs for the treatment of mental health & substance use disorders which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

Partial Hospitalization: licensed or approved outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for patients with mental, emotional, or nervous disorders, and alcohol or other drug dependence who require coordinated, intensive, comprehensive and multi-disciplinary treatment. Such a program shall provide treatment over a period of six or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients. Such term shall also include intensive outpatient programs for the treatment of mental health disorders or alcohol or other drug dependence which provide treatment over a period of three or more continuous hours per day to individuals or groups of individuals who are not admitted as inpatients.

There are a number of ways Sentara identifies which services are subject to prior authorization for clinical review (and thus may be subject to retrospective review). Specifically:

Plan Documents:

The HMO and PPO plan documents state the following:
"Some Covered Services under this Plan require Pre-Authorization to be Covered. Please read the entire section on Pre-Authorization in the EOC."

Defines Pre-Authorization as "an evaluation process which assesses the medical necessity of proposed treatment and checks to see that the treatment is being provided at the appropriate level of care."

Describes preauthorization and states: "On Your Schedule of Benefits, We tell You what services require pre-authorization before You receive them. You can also look in the What is Covered Section of this document or call Member Services to find out about Pre-Authorization."

Describes generally the types of services which require preauthorization, including: Inpatient hospitalization services; Partial hospitalization services; Residential treatment services; Non-emergency ambulance transport; Inpatient and outpatient surgery; Surgery in a physician's office; Single items of durable medical equipment and orthopedic and prosthetic appliances over [$750]; Rental of durable medical equipment and orthopedic and prosthetic appliances; Repair and replacement items of durable medical equipment and orthopedic and prosthetic appliances; Artificial prosthetic limbs; Prenatal maternity services (excluding recommended preventive care services, screenings, and one breast pump per pregnancy); Home health care; Skilled Nursing Facility care; Physical, occupational, and speech therapy; Cardiac, pulmonary, and vascular rehabilitation; IV

therapy with medications; Inhalation therapy; Early intervention services; Clinical trials for treatment studies on cancer; Hospice services; Oral surgery; TMJ services; Tubal ligation; Hospitalization and anesthesia for dental procedures; Treatment of lymphedema; Magnetic Resonance Imaging (MRI); Magnetic Resonance Angiography (MRA); Positron Emission Tomography (PET) scans; Computerized Axial Tomography (CT) scans; Computerized Axial Tomography Angiogram (CTA) scans; Sleep studies; transplant services; Injectable and infused medications, biologics, and IV therapy medications defined by Our Pharmacy Committee; Intensive outpatient programs (IOP); Medical, psychological and neuro psychological diagnostic procedures and testing; Electro-convulsive therapy (ECT); Telemedicine service; Transcranial Magnetic Stimulation (TMS); Insulin pumps and insulin pump infusion sets and supplies; Chemotherapy and Chemotherapy Drugs; Radiation Therapy; Dialysis Services; Genetic Testing and Counseling. If Your plan includes any riders generally those services will require Pre-Authorization listed in the rider.

Define Covered Services and designate those which require prior authorization. These Services and others are then further defined.

Schedule of Benefits

States "Some benefits require Pre-Authorization before You receive them. These services ae marked with an * in this document."

The Schedules of Benefits designate the following service types as requiring preauthorization: outpatient therapies and services; outpatient dialysis; outpatient surgery; outpatient lab, diagnostic, imaging, and testing; outpatient advanced imaging, testing and scans; injectable and infused medications; maternity care; inpatient M/S services including inpatient hospital services, transplants, skilled nursing facility services; non-emergency transport; inpatient MH/SUD services including hospital services, residential treatment services, partial hospitalization, intensive outpatient program services, transcranial magnetic stimulation, electro-convulsive therapy, autism spectrum disorder, other outpatient services; diabetes treatment including insulin pumps, pump infusion sets and supplies, talking blood glucose meters, insulin, and needles and syringes for injection; prosthetic devices and components, repair, fitting, replacement and adjustment; durable medical equipment for items over $750, repair, replacement, and rental items; wigs following cancer treatment; early invention services including speech and language therapy, occupational therapy, physical therapy, assistance technology services and devices; home health care; private duty nursing; hospice care; reconstructive breast surgery for members who have had a mastectomy; infertility services including endometrial biopsies, semen analysis, hysterosalpingography, Sims-Huhner test, diagnostic laparoscopy; clinical trial services; allergy testing and serum; telemedicine services; chiropractic services; hearing aids and related services for children 18 and younger

Provider Manual

The Provider Manual states:

"Except in the case of emergency treatment, prior authorization will be required for: all inpatient hospitalizations, all partial hospitalizations (mental health or substance abuse), all outpatient

surgeries/short stays/observations and IV therapy and drug infusions, all skilled nursing facility admissions, all acute rehabilitation, all intensive outpatient programs, all out-of-area services or referrals to nonparticipating providers (prior to scheduling) for members that do not have out-of-network benefits included in their plan. All the following services require prior authorization regardless of the place of service: Commercial plan DME single purchased items greater than $750 and all rentals, orthotics/prosthetics, single purchased items greater than $750 and all rentals, repair, replacement, and duplicates, home health, hospice, IV infusions, plastic surgery, all rehabilitation programs (cardiac, vascular, vestibular, pulmonary, etc.), therapies (PT, OT, ST), applied behavioral analysis, early intervention services (part H certificate required), OB global notification, transplant services, human and synthetic tissue, oral surgery and related services, advanced imaging studies (PET, CT, CTA, MRI, MRA, MR-CT), sleep studies, hyperbaric therapy, electronic bone stimulator, any surgical or diagnostic procedure for which anesthesiology or conscious sedation is billed, injectable drugs indicated on the online prior-authorization forms, genetic testing (if covered by group/plan), bone densitometry if less than 24 months since last study."

Prior Authorization List: (accessible at http://pal.sentarahealthplans.com/)

Tool allows anyone to access and search for procedure code or description to determination whether prior authorization is required.

Procedure and Revenue Codes:

As previously stated, all inpatient services require prior authorization.

Certain services such as PT, OT, and ST, can be used for both MH/SUD and M/S conditions. Specific to these therapies, Sentara ensures MHPAEA compliance through benefit structure. Currently, no numerical visit limitations are placed on PT, OT, and ST for MH/SUD, unlike the annual visit limits for M/S. For other services such as non-emergency transport, Sentara does not preauthorize services strictly by diagnosis. If a medical necessity review is required for the service, it will include all pertinent clinical information required to make a determination based on the appropriate necessity criteria used whether that be internal medical policies or MCG (which incorporate ASAM). For example, Sentara tracks transportation authorizations but does not track whether authorization for non-emergency transportation was reviewed for an underlying M/S or MH/SUD condition.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See 45 CFR 146.137(c)(2). Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources

from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:

(A) A detailed description of the factor;

(B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and

(C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Sentara incorporates by reference its Analyses for Prior Authorization and Concurrent Authorization. The only factor and standard that differs between Prior Authorization and Retrospective Review is that Retrospective Review applies when prior or concurrent authorization was required but not obtained.

Step 3: Description of how factors are used in the design and application of the NQTL.

See 45 CFR 146.137(c)(3). Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s)

[Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].

- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Sentara incorporates by reference its Analyses for Prior Authorization and Concurrent Authorization.

Step 4: Demonstration of comparability and stringency as written.

See 45 CFR 146.137(c)(4). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Documentation of Each Factor Identified as Defined in Step Two:

The following factors are implicated in determining whether Prior Authorization applies to certain services:

Service	Factors
All outpatient, M/S services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, M/S services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – MCG if available; Sentara Medical Policy Committee if no applicable MCG criteria
All outpatient, MH/SUD services (in-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria
All outpatient, MH/SUD services (out-of-network) (see services described in Step 1 above)	Industry standards and clinical guidelines – ASAM if available; Sentara Medical Policy Committee if no applicable ASAM criteria

As explained above, the only factor that determines whether retrospective review (pre-claim or post-claim) applies is whether the claim is for a service requiring prior authorization or concurrent authorization when the provider failed to obtain one.

How Factors are Comparably Applied:

Sentara applies applicable industry standards (MCG for M/S and ASAM for MH/SUD) equally to all services in the respective classifications. Industry standards are applied without discretion, regardless of whether the particular service is M/S or MH/SUD. For services (either M/S or MH/SUD) for which there is no applicable industry standard, the Sentara MPC evaluates and reviews the requested service.

Reasons for Any Deviations or Variations:

There are no variations or deviations in the design or application of prior authorization between M/S and MH/SUD benefits.

Comparison of Existing Written Documents:

The policies and procedures identified and defined in the preauthorization NQTL apply to the retrospective review NQTL. There are no separate operating departments or divisions that perform utilization review for MH/SUD as separate from M/S benefits.

Prior Authorization, Concurrent Review, and Retrospective Review

Pre-Claim Retrospective Review: Policies and procedures for pre-claim retrospective review are identical to those for preauthorization and concurrent review except for two aspects. First, the timing of the review is different. For pre-claim retrospective review, the timing consists of post-service, pre-claim services. Second, and relatedly, discussions of lower levels of care are not applicable since the service has been provided. Reviewing Medical Directors do use the same peer-to-peer process when reviewing medical necessity pre-claim, post-service as they do when reviewing medical necessity pre-claim, pre-service. This process applies to both M/S and MH/SUD services.

Post-Claim Retrospective Review: Sentara's policies and procedures for retrospective review are identical" to those for preauthorization and concurrent review except for a few key differences described herein. The first difference is the timing of the review. For post-claim retrospective review, a reconsideration request occurs from the provider post-claim and after the claim has denied. There are differences in the process for clinical review when conducted post-claim at the request for reconsideration by the provider. One difference is that UM Vendor 1 is the only vendor used to conduct medical necessity reviews in the reconsideration process. While vendors never conduct utilization review for MH/SUD services, as described in Sentara's Medical Necessity Analysis, vendors are used for certain M/S services. With the exception of UM Vendor 1, these vendors are not used when the clinical review is conducted retrospectively through the post-service reconsideration process. Also, Sentara does not conduct peer-to-peer reviews and does not negotiate lower levels of care because the service has been rendered the claim submitted. This process applies to both M/S and MH/SUD services.

Traditional Retrospective Review:

Clinical Review Processes

Pre-Claim Retrospective Review: All clinical review requests are assessed based on approved clinical criteria and guidelines (as explained in Sentara's Medical Necessity Analysis for commercial lines of business, when no internal medical policies exist for any MH/SUD or M/S service, MCG is utilized without incorporation or supplementation of any internal guidelines or policies.). For pre-claim retrospective review, reviews and decisions will be completed within 30 days of received the request. If an authorization request results in an adverse determination, providers and members are notified of post-service decisions via adverse benefit determinations which contain appeal instructions. Providers or members have 180 days from notice of an adverse benefit determination to ask for an appeal. When Sentara reviews an appeal, Sentara looks at all comments, documents, records, and other information submitted to Sentara. Appeals involving medical necessity will be reviewed by a clinical peer reviewer, with the same qualification as described in Sentara's Prior Authorization Analysis, who did not participate in

the first coverage decision. When Sentara completes the appeal, Sentara will send written notification of the decision. If Sentara Health Plans doesn't change the initial decision the notice will include:

1. The specific reason for the decision;

2. The specific plan provisions Sentara Health Plans based the decision on; and

3. Information on any independent external appeal rights. In general, the internal appeal process must be exhausted prior to filing an independent external appeal. An exception exists for the treatment of cancer.

The levels of review include a request for authorization which is handled by clinicians, including "Registered Nurses, Licensed Practical Nurses, Clinical Pharmacists, Clinical Psychologists, and Board certified Medical and Behavioral Health Physicians (Medical Directors)." The process does include access to Board Certified Physicians to serve as physician specialty advisors. At the discretion of the medical director or for appeals and grievances, cases are referred to these physicians to review for medical necessity or appropriateness. If a request for authorization results in an adverse benefit determination, providers and members have 180 days to request an appeal. Providers may also request a peer review or reconsideration, which is not considered part of the appeal. There is one level of internal appeals. Registered and practical nurses can authorize, but not deny a service. Any denials of medical necessity must be conducted by a Medical or Behavioral Health Physician (Medical Director) depending on the service type. Post-claim retrospective clinical review upon a request by a provider for reconsideration does not include peer-to-peer review.

Post-Claim Retrospective Review: All clinical review requests are assessed based on approved clinical criteria and guidelines (as explained in Sentara's Medical Necessity Analysis, for commercial lines of business, when no internal medical policies exist for any MH or M/S service, MCG is utilized without incorporation or supplementation of any internal guidelines or policies.). For a first-level review post-claim provider reconsideration requests, the reconsideration request must be received within 365 days from the date of service. If timely received, a review is conducted to determine medical necessity. If medical necessity is not satisfied, a subsequent review is conducted by a Medical Director and either approved or denied. A second-level reconsideration review occurs if requested within 60 days of the notification of the first-level claim reconsideration. For medical necessity denials, the second-level reconsideration review is conducted by a Medical Director not originally involved with the review. A post-service, pre-claim request for authorization is handled by clinicians, including "Registered Nurses, Licensed Practical Nurses, Clinical Pharmacists, Clinical Psychologists, and Board certified Medical and Behavioral Health Physicians (Medical Directors)." The process does include access to Board Certified Physicians to serve as physician specialty advisors. At the discretion of the medical director or for appeals and grievances, cases are referred to these physicians to review for medical necessity or appropriateness. If a request for authorization results in an adverse benefit determination, providers and members have 180 days to request an appeal. There is one level of internal appeals. Registered and practical nurses can authorize, but not deny a service. Any denials of medical necessity must be conducted by a Medical or Behavioral Health Physician (Medical Director) depending on the service type. Post-claim retrospective clinical review upon a request by a provider for reconsideration does not include peer-to-peer review.

Tracking of Denials

Sentara tracks and reports all claim denials and closed internal and external appeals and complaints. Sentara tracks administrative denials as compared to denials for medical necessity. For appeals, Sentara tracks whether the denials were upheld, partially upheld or overturned in closed internal appeals and closed external reviews.

Pre-Claim Retrospective Review:

2023: M/S IP

702 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 663 were initiated by in-network providers and 39 from out-of-network providers for a 5.56% of out-of-network providers. The denial rate of the 702 requests was 19.37%, and 20.8% of the requests were referred to MD.

2023: MH/SUD IP

24 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 20 were initiated by in-network providers and 4 from out-of-network providers for a 16.67% of out-of-network providers. Of the 24 requests, 20 were approved for a 16.67% denial rate. 16.7% of the requests were referred to MD. Only 1 of the 4 denials constituted a medical necessity denial.

2023: M/S OP

4083 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 3760 were initiated by in-network providers and 323 from out-of-network providers for a 7.91% of out-of-network providers. The denial rate of the 4083 requests was 7.89%, and 8.3% of the requests were referred to MD.

2023: MH/SUD OP

5 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 4 were initiated by in-network providers and 1 from out-of-network providers for a 20% of out-of-network providers. Of the 5 requests, 5 were approved for a 0% denial rate. 0% of the requests were referred to MD.

2024: M/S IP

450 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 433 were initiated by in-network providers and 17 from out-of-network providers for a 3.78% of out-of-network providers. Of the 450 requests, 352 were approved for a 22% denial rate. 22% of the requests were referred to MD.

2024: MH/SUD IP

24 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 20 were initiated by in-network providers and 4 from out-of-network providers for a 16.67% of out-of-network providers. Of the 24 requests, 23 were approved for a 4.17% denial rate. 8.3% of the requests were referred to MD.

2024: M/S OP

3025 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 2869 were initiated by in-network providers and 156 from out-of-network providers for a 5.16% of out-of-network providers. The denial rate of the 3025 requests was 5.65%, and 4.9% of the requests were referred to MD.

2024: MH/SUD OP

7 Total Requests for Pre-Claim, Post-Service Retrospective Review. Of these requests, 5 were initiated by in-network providers and 2 from out-of-network providers for a 28.57% of out-of-network providers. Of the 7 requests, 7 were approved for a 0% denial rate. 28.6% of the requests were referred to MD.

Post-Claim Retrospective Review: For post-service, post-claim requests for reconsideration, the authorization volume by review can be reported as follows:

2023: M/S

503 Total Requests for Post-Claim Retrospective Review. Of these requests 484 were initiated by in-network providers and 19 by out-of-network providers for a 3.78% of out-of-network providers. Of the 503 requests, 21 were for inpatient services and 482 were for outpatient services. All requests for inpatient services were approved. Of the 482 requests for outpatient services, 28 were denied for a denial rate of 5.57%. Of the 5.57%, 5.12% denied for medical necessity. The MD referral rate was 4.1%.

2023: MH/SUD

5 Total Requests for Retrospective Review (Post-Service). Of these requests, 4 were initiated by in-network providers and 1 from an out-of-network provider for a 20% of out-of-network providers. Of the 5 requests, all were for inpatient services and all were approved for a 0% denial rate. None of the 5 requests were referred to Medical Directors. There were no MH/SUD Requests for Retrospective Review for outpatient services in 2023.

2024: M/S

2056 Total Requests for Retrospective Review (Post-Service). Of these requests,1974 were initiated by in-network providers and 82 from out-of-network providers for a 3.99% of out-of-network providers. Of the 2056 total requests, 1926 were approved, 131 were denied and 1 claim was partially denied for a denial rate of 6.42%. Of the 2056 claims, 180 were for inpatient services. Of these 180 claims, the denial rate was 1.67%. The MD Referral Rate for inpatient services was 0 .6%. Of the 2056 claims, 1876 were for outpatient services. Of these 1876 claims, the denial rate was 6.88%. The MD Referral Rate for outpatient services was 4.5%. Of the total 131 denials and 1 partial denial, 110 were denied as not being medically necessary and 21 were administratively denied for non-covered service or benefit exhaustion. The Medical Director referral rate was 4.1%.

2024: MH/SUD

21 Total Requests for Retrospective Review (Post-Service). Of these requests, 19 were initiated by in-network providers and 2 from out-of-network providers for a 9.52% of out-of-network providers. Of the 21 total requests, all 21 were approved for a 0% denial rate. Of the 21

claims, 11 were for inpatient services. Of these 11 claims, the denial rate was 0%. Of the 21 claims, 10 were for outpatient services. Of these 10 claims, the denial rate was 0%.

Appeals Data:

2023: In 2023 there were 0 MH/SUD provider medical necessity appeals, compared with 19 M/S medical necessity appeals.

2024: In 2024, there was 1 MH/SUD medical necessity provider appeal, compared with 34 M/S provider medical necessity appeals.

Extent of Medical Records Required

The policies related to medical records are identified in the preauthorization NQTL. Any additional medical records establishing medical necessity are pertinent to any traditional retrospective review.

Appeal Rights

In the context of the internal appeal process, any denial or reduction of benefits and/or nonpayment based upon a determination of medical necessity is treated as an Adverse Benefit Determination and subject to the appeal process outlined in the plans. Written notice of Adverse Benefit Determinations is required except for Urgent Claims, where notification may be provided orally and then confirmed in writing up to three days after the oral notice. Written notice of an Adverse Benefit Determination includes the following:

• The specific reason or reasons for the Adverse Benefit Determination;

• Reference to the specific Plan provisions on which the determination is based;

• A description of the Plan's appeal process and applicable time limits. For Urgent Care Claims it will include a description of the expedited appeals process.

Any member is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and all other information relevant to the Claim for benefits. This includes copies of any internal rule, guideline, protocol, or other criteria relied upon in making the Adverse Benefit Determination.

For denials due to Medical Necessity, Experimental treatment, or similar exclusion or limit, members are entitled to receive, upon request and free of charge, an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Member's medical circumstances.

After notification of an Adverse Benefit Determination, a member has 180 days to request an appeal. Upon appeal, all comments, documents, records, and other information submitted is reviewed. Additional information may be provided. The clinical peer reviewer reviewing the appeal will not have participated in the original coverage decision. Should a member disagree with the Final Benefit Determination, an external appeal is available. There are no differences in the process for appeals of retrospective reviews as it relates to MH/SUD and M/S benefits.

Lower levels of care are not authorized in retrospective reviews because the services have already been provided. As a general matter, for requests for prior or concurrent authorizations, a member or provider can appeal any decision (whether M/S or MH/SUD) regardless of whether the member accepts and receives a lower level of care.

Approvals of Lower Levels of Care

Discussions of lower levels of care are not applicable during pre-claim retrospective reviews since the service has been provided or during post-claim retrospective reviews because the claim has already been submitted. This applies to both M/S and MH/SUD services.

Initiation of Clinical Review

Pre-Claim Retrospective Review: The provider must initiate a request for pre-claim retrospective review. Sentara will not initiate any request for retrospective review. A pre-claim request for retrospective review will be conducted, upon request of the provider, for any requested service which a prior authorization was required but not obtained. This is true for M/S and MH/SUD services. A provider is made aware of this process through the Provider Manual which is available to both in-network and out-of-network providers. If an authorization was required and not obtained, the provider is required to hold the member harmless. Extensions for additional time and requested documents are consistent with M/S and MH/SUD services. The data establishes the operation of pre-claim retrospective review as being inherently consistent, in that no denials for MH/SUD outpatient services occurred in 2023 or 2024 on pre-claim retrospective review. As for inpatient MH/SUD services, denials on pre-claim retrospective review totaled 16.67% in 2023 (compared to 19.37% for M/S services) and 4.17% in 2024 (compared to 22% for M/S).

Post-Claim Retrospective Review: The provider must initiate a request for reconsideration for post-claim retrospective review. Sentara will not initiate any request for retrospective review. A post-service retrospective review will be conducted, upon request of the provider, for any requested service which a prior authorization was required but not obtained. This is true for M/S and MH/SUD services. A provider is made aware of this process through the Provider Manual which is available to both in-network and out-of-network providers. If an authorization was required and not obtained, the provider is required to hold the member harmless. Extensions for additional time and requested documents are consistent with M/S and MH/SUD services. The data establishes the operation of post-claim retrospective review as being inherently consistent, in that no denials for MH/SUD services occurred upon post-claim retrospective review in 2023 and 2024.

Initial Authorization

The type of initial authorization does not have any impact on retrospective review. In the event of an inpatient admission, once notification or a request for authorization occurs, a medical necessity review is conducted.

Step 5: Demonstration of comparability and stringency in operation.

See 45 CFR 146.137(c)(5). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD

and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.

- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

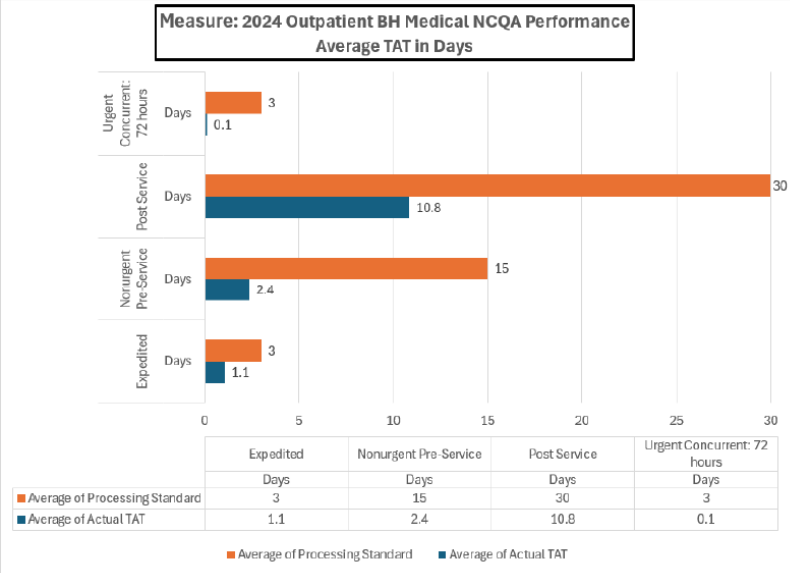
- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

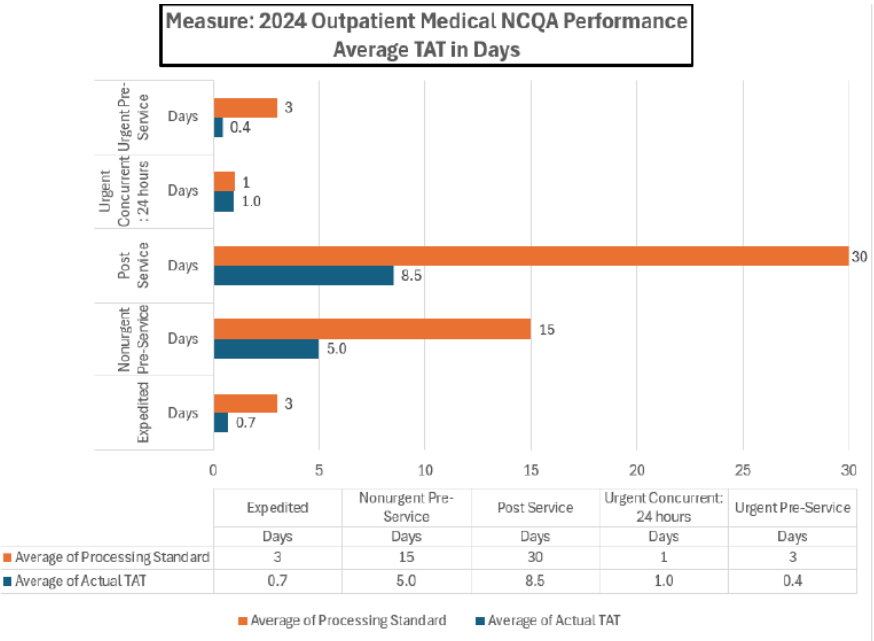
Data provided herein is for 2024 Virginia fully-insured plans. This analysis will be supplemented with 2025 data when it becomes available. See denial rates and peer-to-peer reviews for pre-claim retrospective reviews above. See denial rates for post-claim retrospective reviews above.

Pre-Claim Retrospective Review— Turnaround Times: The charts below specify pre-claim, post-service data.

2024 Outpatient MH/SUD NCQA Performance:



2024 Outpatient M/S NCQA Performance:



IRR Testing:

Sentara performs IRR testing as described below:

- Required score to pass: 80%

o How participants are evaluated: Test is developed by Sentara's utilization management leadership and educators. It consists of a variety of scenarios (inpatient, outpatient, behavioral health and medical). The same test is administered to all clinical staff who review requests for authorization determination.

o Results: 100% MH/SUD pass rate for 2022 and 2023 and M/S 97.9% for 2022 and 96% for 2023

o Separate testing occurs for MH/SUD reviewers and M/S reviewers: There are separate scenarios/questions addressing M/S or MH/SUD. The utilization team is separated by M/S and MH/SUD. If the clinical staff is on the MH/SUD team, they will take the MH/SUD test and the same is accurate for M/S.

Pre- and Post-Claim Retrospective Review: Sentara has implemented a policy regarding Measuring Staff Consistency Including Inter-rater Reliability. Testing is scored individually. The results of each individual tested should be at least 80% accurate. A report will be given to each manager/team coordinator for staff who make UM decisions and to the Chief Medical Officer (CMO) for Medical Directors. UM Staff and Medical Directors will have ongoing education regarding the use of criteria. Training will be completed with staff and Medical Directors who do not achieve at least an 80% test score.

Sentara audits monthly its utilization management processes. Sentara audit its Monthly and Quarterly Utilization report that includes for example:

o Days/1000, Admissions/1000

o Average length of stay (ALOS)

o Observation days/1000

o Readmission rate for both medical and behavioral health services

o Outpatient surgeries/1000

o Outpatient visits/1000

o Milliman Benchmarking

o High-Dollar claims

o Complex medical conditions

o Authorizations provided to non-participating providers

Sentara conducts an annual evaluation of its utilization management program, which includes an evaluation of vendors performing utilization management services for Sentara.

In Operation Data

Post-Service, Pre-Claim Retrospective Review

Sentara collected post-service, pre-claim retrospective requests for authorization data as requested for 2023 and 2024 to determine if denials were disproportionate for MH/SUD outpatient services as compared to M/S outpatient services.

In 2023, for outpatient services, there were a total of 4088 post-service, pre-claim requests for authorizations. Of these post-service, pre-claim requests for authorization, 4083 were for outpatient M/S services and 5 were for outpatient MH/SUD services. As for outpatient M/S services, the denial rate was 7.89% for outpatient M/S services. Of the 7.89% of denials, 5.57% denied for medical necessity. As it relates to MH/SUD requests for outpatient services, of the 5 requests, all 5 were approved. The denial rate was 0%. With this data, Sentara does not see disparity in the application of its utilization management program, for post-service, pre-claim retrospective review for outpatient claims.

The same trend occurred in 2024. For outpatient services, there were a total of 3032 post-service, pre-claim requests for authorization. Of these post-service, pre-claim requests for authorizations, 3025 were for outpatient M/S services and 7 were for outpatient MH/SUD services. As for inpatient M/S services, the denial rate was 5.65% for M/S services. Of the 5.65% of denials, 2.67% denied for medical necessity. As it relates to MH/SUD outpatient services, of the 7 requests, all 7 were approved. The denial rate was 0%. With this data, Sentara does not see disparity in the application of its utilization management program, for post-service, pre-claim retrospective review.

Physician review – In analyzing physician review, Sentara's main objective was to determine if the MH/SUD physician reviewers were applying discretion in a way that was more stringent or arbitrary than how M/S physicians applied discretion and to determine if they were adhering to criteria in a fashion that was no more stringent than M/S physicians' adherence to criteria. Sentara further studied MD (Medical Director) referral rates. In 2023, Sentara discovered that percentages of requests for authorizations referred for Medical Director review was higher in M/S than MH/SUD inpatient services. In 2023, 8.3% of M/S outpatient requests for authorization were referred to MD review, as compared to 0% of MH/SUD outpatient requests for authorization. This trend reversed in 2024, 4.9% of M/S outpatient requests for authorizations were referred to MD Review as compared to 28.6% for MH/SUD outpatient services. Given that 0 denials occurred for medical necessity for MH/SUD services in 2023 and 2024, MD referrals appear to be a positive review protocol and physician review is not causing any disparate impact.

In reviewing peer-to-peer review data, the objectives were largely the same. While significantly more M/S inpatient services are subject to peer review than MH/SUD inpatient services, the denial rates are much lower for MH/SUD inpatient services. In fact, no MH/SUD services (inpatient or outpatient) were referred to peer-to-peer in 2023 and 2024. With such few instances of peer to peer review, 10 total in 2023 and 2024 combined, it is difficult to determine any trends, however, denial rates indicate that utilization review is not being more stringently applied to MH/SUD inpatient services.

Appeal data further confirms that no disparity exists as to utilization review. In 2023, for MH/SUD services, 7 appeals occurred throughout the commercial line of business and

none of the 7 appeals were medical necessity appeals. In 2024, there were 5 appeals for MH/SUD services and only 1 appeal concerned medical necessity.

Sentara further compared turnaround time (TAT) and noticed an area of improvement. The TAT for MH/SUD outpatient services, while still better than the NCQA standard, was 10.8 days for post-service, pre-claim review, as compared to 8.5 days for M/S.

Post-claim Retrospective Review:

Sentara collected post-service, post-claim retrospective requests for authorization data for 2023 and 2024 to determine if denials on provider requests for reconsideration were disproportionate for MH/SUD outpatient services as compared to M/S outpatient services.

In 2023, for outpatient M/S services, there were a total of 482 post-service, post-claim requests for authorization. Of these 482 post-service, post-claim requests for authorization, 28 were denied for a denial rate of 5.81%. Of the 5.81% denied, 5.12% denied for medical necessity. There were no post-service, post-claim requests for MH/SUD outpatient services in 2023. With this data, Sentara does not see disparity in the application of its utilization management program, for post-service, post-claim retrospective review.

The same trend occurred in 2024. For outpatient services, there were a total of 1876 post-service, post-claim requests for authorization. Of these authorizations, the denial rate was 6.88% with a MD Referral Rate of 4.5%. As it relates to MH/SUD outpatient services, there were a total of 21 post-service, post-claim requests for authorization. Of the 21 post-service, post-claim requests for authorization, 10 were for outpatient MH/SUD services. Of these 10, all were approved and the denial rate was 0%. With this data, Sentara does not see disparity in the application of its post-service, post-claim retrospective review.

Physician review – In analyzing physician review, Sentara's main objective was to determine if the MH/SUD physician reviewers were applying discretion in a way that was more stringent or arbitrary than how M/S physicians applied discretion and to determine if they were adhering to criteria in a fashion that was no more stringent than M/S physicians' adherence to criteria. Sentara further studied MD (Medical Director) referral rates. Given that there were no denials for MH/SUD outpatient services upon post-service, post-claim retrospective review, Sentara finds no disparity.

Peer to Peer Data does not apply to post-service, post-claim retrospective review.

Appeal data further confirms that no disparity exists as to utilization review. In 2023, for MH/SUD services, 7 appeals occurred throughout the commercial line of business and none of the 7 appeals were medical necessity appeals. In 2024, there were 5 appeals for MH/SUD services and only 1 appeal concerned medical necessity.

Step 6: Findings and conclusions.

See 45 CFR 146.137(c)(6). The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the FAQ 45 guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara defined Retrospective Review NQTL as a clinical review following the provision of M/S or MH/SUD services. Sentara noted that retrospective reviews can occur either pre-claim or post-claim. Sentara identified the processes for seeking retrospective review. Retrospective clinical review is consistently applied to both M/S and MH/SUD services. Sentara identified the Medical Policy Committee as the body that determines medical policies and clinical guidelines, which apply regardless of whether the clinical review occurs pre- or post-service. Sentara explained its process for reviewing services for medical necessity post-service and the process for appeal. Sentara detailed its process for tracking retrospective reviews, which is consistently applied for both M/S and MH/SUD services.

Data collected includes:

- No denials occurred for MH or SUD services for any Plan in 2024.

- IRR testing descriptions and results, demonstrating passing scores and 100% pass rate for clinicians in MH/SUD.

Analysis establishes Sentara is compliant with MHPAEA. This analysis was completed in September 2026 by the following Sentara departments: Utilization Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

POST-PAYMENT RETROSPECTIVE REVIEW:

INPATIENT, IN-NETWORK

(APPLICABLE TO EMERGENCY SERVICES)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See **45 CFR 146.137(c)(1).** Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also **FAQ 45** (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

General Description of NQTL

Post-payment retrospective review means the review of the member's medical records and other supporting documentation by Sentara after services have been rendered and payment has been made to the provider to confirm Sentara's liability for payment.

Post-Payment Coding Edits

Sentara does not perform post-payment coding edits. Coding edits are utilized to ensure correct claim submission and adjudication *pre-payment*. Sentara utilizes vendors for claims review services post-payment. Sentara utilizes a vendor ("Post-Payment Vendor 1") for post-payment claims review of inpatient claims. Post-Payment Vendor 1 does not perform claim review services for inpatient MH/SUD claims. Sentara utilizes a second vendor ("Post-Payment Vendor 2") related to post-payment claims review of all claims for professional services. This claims review process is a part of the Program Integrity Unit ("PIU"), which is responsible for fraud, waste, and abuse ("FWA") investigations.

Post-Payment Clinical Review

Sentara does not perform post-payment clinical review.

The remainder of this analysis will focus on fraud, waste, and abuse investigations because that is the only form of post-payment retrospective review Sentara uses.

Fraud, Waste, and Abuse Investigations

Post-payment retrospective review is limited to the functions of the PIU, which include both audit functions and FWA investigations. Claim review through audits and/or investigations includes a review of clinical records.

Sentara has adopted the Commonwealth of Virginia's definition of fraud, waste, and abuse (FWA) as any "suspicious claims activity," which is any claim that an insurance company has reason to believe, based upon evidence, and may contain one or more material misrepresentations. Sentara, in its Provider Manual and Provider Guide to Fraud, Waste, and Abuse, further defines fraud as intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit or financial gain.

The Provider Guide to Fraud, Waste, and Abuse further provides examples of fraud including: (i) rendering and billing for non-medically necessary services; (ii) upcoding-billing higher level service than provided; (iii) misrepresentation of benefits; (iv) encounter data falsification; (v) underutilization; (vi) attestation/condition of participation. The Provider Guide to Fraud, Waste, and Abuse defines "Waste" as "the overutilization of services or other practices that result in unnecessary costs." The Provider Guide to Fraud, Waste, and Abuse defines "Abuse" as "activities that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost, reimbursement for services that are not medically necessary, or fail to meet professionally recognized standards for healthcare." The distinguishing factors between "fraud," as compared to "waste" and "abuse" are intent and knowledge. The PIU is a dedicated team that focuses on detecting, resolving, and preventing potential FWA by analyzing claims data, monitoring trends, and conducting in-depth investigations to uncover suspicious activities and

unusual patterns of potential abusive behavior. PIU conducts audits and investigations of M/S and MH/SUD services. The same definitions of "fraud, waste, and abuse" apply to both M/S and MH/SUD.

The Program Integrity Unit conducts data mining by pulling claims data and identifying outliers. The Program Integrity Unit also uses a vendor for proactive lead generation. Sentara contracts with Post-Payment Vendor 2. to provide FWA Management services including both software modules (platforms) and special investigations unit services ("SIU") for professional services only. Post-Payment Vendor 2provides audit services on outpatient, professional services auditing for correct coding, supporting documentation, and ensuring billed services were rendered.

There are not separate departments within the PIU related to M/S and MH/SUD claims. Actions by the PIU apply to both M/S and MH/SUD services. Notably, inpatient MH/SUD services are not audited internally or by outside vendors.

Inpatient Services: As it relates to FWA, a component of the PIU is contracting with vendors to provide claim review services. Sentara contracts with Post-Payment Vendor 1 to provide claim review services pursuant to a vendor services agreement. Post-Payment Vendor 1 performs claim review services for M/S inpatient claims only, specifically DRG and Level of Care post-pay audits. All audits performed by Post-Payment Vendor 1 in 2024 were desk audits. Post-Payment Vendor 1 does not perform claim review services for any MH/SUD services. Sentara also internally audits M/S inpatient claims when the payment tendered is $5K or more over billed charges. In 2024, there were no commercial claims which paid $5K or more than billed charges. Sentara does not perform internal audits for MH/SUD services.

Outpatient Services: Sentara also contracts with Post-Payment Vendor 2 to provide FWA Management services including both software modules and special investigations unit services ("SIU") for outpatient professional services only.

Oversight of Vendors

Post-Payment Vendors 1 and 2 are associated with the FWA form of the NQTL. None of these vendors are affiliated with Sentara and the agreements are negotiated as arms-length exchanges. Sentara's PIU Department monitored and assessed vendors through regularly scheduled meetings. Utilization management vendors perform no services for FWA.

As discussed in detail in Sentara's Retrospective Review Analysis, Sentara conducts two forms of Retrospective Review: (i) post-service, pre-claim retrospective review; and (ii) post-service, post-claim retrospective review. The process for retrospective clinical review is analyzed in Sentara's Retrospective Review Analysis.

List of Services Subject to FWA

FWA: All outpatient M/S and MH/SUD services are subject to Program Integrity Audit. Providers will be selected based on their utilization and billing patterns, relative to their peers. There is no limitation of codes reviewed. A 12-month look-back period applies.

Services Reviewed During Reporting Period for Commercial LOBs (2025)

Classification	Descriptions of Claims Audited
Inpatient, In-Network (M/S)	The following types of claims are subject to FWA: (i) M/S claims that paid at $5,000 or more than billed charges; (ii) claims identified in Post-Payment Vendor 1 audits, which pertain to inpatient M/S hospital claims only; (iii) claims or providers referred to Sentara by internal or external sources; and (iv) leads initiated by Post-Payment Vendor 2, which pertain to inpatient and outpatient professional services claims only.
Inpatient, In-Network (MH/SUD)	No claims are subject to audit.
Outpatient, In-Network (M/S)	The following types of claims are subject to FWA: (i) M/S claims that paid at $5,000 or more than billed charges; (ii) claims or providers referred to Sentara by internal or external sources; and (iii) leads initiated by Post-Payment Vendor 2, which pertain to inpatient and outpatient professional services claims only.
Outpatient, In-Network (MH/SUD)	The following types of claims are subject to FWA: (i) claims or providers referred to Sentara by internal or external sources; and (ii) leads initiated by Post-Payment Vendor 2, which pertain to inpatient and outpatient professional services claims only.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See **45 CFR 146.137(c)(2).** Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:

(A) A detailed description of the factor;

(B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and

(C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

FWA:

Sentara flags for internal review (i) M/S claims that paid at $5,000 or more than billed charges; (ii) claims identified in Post-Payment Vendor 1, which pertain to inpatient M/S hospital claims only, (iii) claims or providers referred to Sentara by internal or external sources; and (iv) leads initiated by Post-Payment Vendor 2, which pertain to inpatient and outpatient professional services claims only.

NOTE: MH/SUD inpatient claims are not subject to audit.

The factors and standards used for each of these categories of FWA are discussed below.

Sentara Internal Review of M/S Claims Paid $5K or More of Billed Charges

Sentara treats all M/S claims in this classification the same.

Claims Identified by Post-Payment Vendor 1 (M/S Hospital)

For commercial lines of business, audits performed by Post-Payment Vendor 1 are for paid M/S inpatient hospital claims only. No discretion is exercised by Sentara, as Post-Payment Vendor 1 is provided monthly data extract of all paid claims. In other words, Sentra does not select or "carve out" data prior to transmission to Post-Payment Vendor 1.

Post-Payment Vendor 1 provides Sentara with claim review files for Sentara's review. Sentara then confirms the claim selection for review and identifies the claims to be audited by approving or denying the claims for audit. For 2024, the Director of Program Integrity cannot recall a claim file that was denied by Sentara. Post-Payment Vendor 1 performs only desk audits on M/S inpatient services.

External or Internal Referrals to Sentara PIU

Referrals derive both internally and externally from a number of sources including email, hotline or direct contact. Sentara maintains an annual report of referral type for all lines of business, including commercial. In 2024, for the commercial LOB, Sentara received 358 referrals. Of these 358 referrals, 292 were not pursued.

Referrals are also reported by the FWA hotline, email, and direct contact with Sentara employees. In the case of these referrals, the PIU will follow the process set forth in the Monitoring and Audit Plan for commercial FWA investigations. In 2024, for commercial LOB, 67 hotline calls were received, 278 emails, and 13 referrals from other sources like communications made directly to staff. 292 of these referrals were not investigated.

For FWA investigations, whether an audit is a desk or on-site audit depends on the information provided in the referral. For example, if the complained of issue is one that requires observation, an on-site audit will occur. Sentara does not track whether an audit was a desk or on-site audit by service type (M/S and MH/SUD) and does not collect data on whether on-site audits are for M/S or MH/SUD claims. In 2024, for commercial LOB, Sentara did not conduct any on-site audits.

The PIU's "investigation" of any FWA referrals or leads related to member driven FWA are referred to law enforcement (identity theft). The appeal process described above does not apply to member-driven FWA. The PIU did not investigate any member-driven FWA in 2024. As to member liability, members are not responsible for claim payments procured by FWA.

Claims Identified by Post-Payment Vendor 2 (Professional Services Claims)

Sentara contracts with Post-Payment Vendor 2 to provide FWA Management Services for professional services. Sentara sends Post-Payment Vendor 2 a monthly data file of all paid claim for professional services. Using proprietary algorithms and suite of solutions, Post-Payment Vendor 2 analyzes provider billing behavior and flags providers for further review. Sentara is able to access and modify the flags used by Post-Payment Vendor 2.

Peer to peer comparisons are conducted to identify an outlier provider. An example would be comparing all providers within a specific specialty billing for the same services. A provider would be identified as an outlier if they are more than two standard deviations above or below the trend line. Sentara also uses industry standard red flags to identify areas of concern. Such red flags are overutilization of services, billing anomalies, duplicate billing. Post-Payment Vendor 2 provided access to Sentara to review and comment on flags applied. It also provides Sentara's investigators with the ability to pull data and analyze the data themselves. Post-Payment Vendor 2's platforms perform sampling and statistical aggregates, trend analysis, and outlier analysis through an algorithm.

Post-Payment Vendor 2 also provides investigation "SIU" services. These SIU constitute investigative support including lead generation, clinical review services, investigations and

consulting services. The SIU services encompass both leads from Sentara, as described above, and leads generated by Post-Payment Vendor 2 through its FWA Management Services. For those leads investigated by Post-Payment Vendor 2, lead packages will be completed and sent to Sentara for review. Once the "Lead" is approved, Post-Payment Vendor 2 will complete a statistical sample of records to review and results and provide such information to Sentara. Post-Payment Vendor 2 investigative staff will submit the post-pay medical records to medical review staff. Post-Payment Vendor 2 will then provide a summary to Sentara. Post-Payment Vendor 2 also provides investigative support using their PIU investigators and clinical staff. All investigations go through SHP's PIU and the FWA Subcommittee as necessary. The PIU department reviews that file and determines which claims will be subject to further audit or investigation. For 2024, the Director of Program Integrity cannot recall a claim file that was denied by Sentara.

For FWA investigations, whether an audit is a desk or on-site audit depends on the information provided in the referral. For example, if the complained of issue is one that requires observation, an on-site audit will occur. Sentara does not track whether an audit was a desk or on-site audit by service type (M/S and MH/SUD) and does not collect data on whether on-site audits are for M/S or MH/SUD claims. In 2024, for commercial LOB, Sentara did not conduct any on-site audits.

Time Periods for FWA Audits

For audits and investigations conducted by the PIU, once a provider is identified, paid claims for that provider will be reviewed for the prior 9 months. The Virginia Code limits recovery to a 12-month look back period.

Step 3: Description of how factors are used in the design and application of the NQTL.

See 45 CFR 146.137(c)(3). Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

FWA:

All outpatient services are subject to audit by the Program Integrity Unit. No cost threshold applies. The Program Integrity Unit conducts data mining by pulling claims data and identifying outliers. The Program Integrity Unit also uses a vendor to conduct investigations on outpatient, professional services auditing for correct coding, supporting documentation, ensuring billed services were rendered. Sentara does not treat "fraud", "waste", and "abuse" as independent bases for audits. As such, separate factors are not used for each of the three types of behaviors.

The FWA Subcommittee is charged with (i) monitoring FWA compliance for Governmental (Medicaid, Medicare, FEHB) programs (including Part D); (ii) reviewing and making regulatory reporting decisions on providers, members, employers, or brokers suspected of fraud, waste, or abuse; (iii) oversight of new or proposed FWA programs or policies; (iv) ensuring consistency and appropriateness of investigative process and reporting; (v) ensuring Program Integrity Unit (PIU) processes balance compliance requirements with network integrity; (vi) balancing risks vs. rewards and making business decisions regarding PIU case activity; and (vii) make recommendations to Senior Leadership Team (SLT) regarding any cases that may involve litigation. This Committee is headed by the PIU and includes representatives from legal, clinical, pharmacy, compliance, government relations, claims, underwriting, and network management.

Please see the response in Step One for definitions of fraud, waste, and abuse. As explained in Step One, the definitions do not vary for M/S and MH/SUD. Please see the response in Step Two for a discussion of the FWA vendors Sentara uses, which claims are given to vendors, and what vendors are instructed to look for when reviewing claims.

Step 4: Demonstration of comparability and stringency as written.

See **45 CFR 146.137(c)(4).** The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

FWA:

Documentation of Each Factor Identified and Defined in Step Two:

All inpatient services are subject to audit by the Program Integrity Unit. No cost threshold applies. The Program Integrity Unit conducts data mining by pulling claims data and identifying outliers. The Program Integrity Unit also uses a vendor for proactive lead generation. Vendors are engaged for post-payment audits for inpatient services, reviewing for correct DRG, readmissions, length of stay, itemized bill audits, correct coding, and supporting documentation. Another vendor conducts investigations on outpatient, professional services auditing for correct coding, supporting documentation, ensuring billed services were rendered. No specific cost threshold triggers FWA except for inpatient claims that paid $5K or more than billed charges.

Data on provider services for specified time periods are compiled and compared with other providers within the same specialty/provider type and geographic peer groups. Twelve months of claims data will be pulled for commercial products. Providers will be selected based on their utilization and billing patterns, relative to their peers. Providers who are an outlier may be subject to further analysis, including desk or onsite investigations. Investigations will include a review of the provider's medical records that pertain to the billed services.

Applicable types of claims include, but are not limited to:

1. Claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment (DRG validation audits)

2. Claims being reviewed to validate items and services billed are documented in the medical record for hospital bill audits (also known as hospital charge audits)

3. Claims with unlisted or miscellaneous codes

4. Claims for services requiring clinical review

5. Claims for services found to possibly conflict with covered benefits

6. Claims for services found to possibly conflict with medical necessity

7. Claims being reviewed for potential fraud, waste and abuse or demonstrated patterns of billing/coding inconsistencies

8. Other documentation required by other entities such as the Centers for Medicare and Medicaid Services (CMS), and state or federal regulation

9. Documentation for such services as the provision of durable medical equipment, prosthetics, orthotics, and supplies, rehabilitation services, and home health care

The factors described above describe the types of claims that may be subject to FWA. However, all paid claims are subject to audit. For outpatient claims, all paid professional services claims are subject to audit by Post-Payment Vendor 2. For professional services claims reviewed by Post-Payment Vendor 2, those claims are not tracked to distinguish between M/S and MH/SUD services and the volume of claims prohibits a manual review. To

establish the process employed by Post-Payment Vendor 2, Sentara routinely evaluates and confirms that the following process is adhered to for both M/S and MH/SUD services: data files are received from Post-Payment Vendor 2 for both M/S and MH/SUD services. A lead package is then sent to Sentara PIU and the PIU approves, partially approves, or rejects the lead package based on the factors described above with no one factor being dispositive. Leads are accompanied by lead narratives for each provider and a case tracker is used to follow the status of the review. The same process is used for both M/S and MH/SUD claim review.

How Factors Are Comparably Applied:

All of Sentara's Program Integrity policies and procedures apply equally to M/S and MH/SUD services.

Reasons for Any Deviations or Variations:

There are no deviations or variations in the design or application of FWA between MH/SUD and M/S benefits.

Comparison of Existing Written Documents and Processes Therein:

SHP's Program Integrity Unit employs a policy "Program Integrity Audit, Reconsideration and Appeals." Other policies include (i) Program Integrity Plan/Compliance Plan and (ii) Detection, Prevention and Reporting. Review for policies is conducted by the Program Integrity Unit, including specific review to ensure comparable application between M/S and MH/SUD services. Further, the specific processes applied by Sentara are discussed in detail throughout this analysis and are adhered to equally for M/S and MH/SUD services.

How Processes are Comparably Applied, Reasons for Variations or Any Deviations:

There are no deviations or variations in the processes regarding FWA between MH/SUD and M/S benefits.

FWA Processes:

SHP's Program Integrity Unit employs a policy "Program Integrity Audit, Reconsideration and Appeals."

Other policies include (i) Program Integrity Plan/Compliance Plan and (ii) Detection, Prevention and Reporting.

Review for policies is conducted by the Program Integrity Unit, including specific review to ensure comparable application between M/S and MH/SUD services.

Outcomes and Actions:

Outcomes of corrective action, settlement, education, reaudit, and termination do not apply to any requested retrospective clinical review. The outcomes apply to FWA only. The description of potential outcomes is below and apply only to FWA. These outcomes are not mutually exclusive and may be used in conjunction with one another. For example, a corrective action plan may also have a restitution component.

• Reversal of claims/retraction/recoupment: utilized where a provider is overpaid in error as discovered in an audit conducted the by audit division of the PIU.

• Educational requirements/corrective action: in cases of waste and abuse, provider education may be provided to prevent further incidents and, if needed, a corrective action may be issued which will require a provider to sign and agree to corrective measures.

• Termination or recission: in cases of fraud, waste, and abuse that go uncorrected after education, Sentara reserves the right to terminate a provider. These cases are brought before the FWA Compliance Subcommittee. This Committee is headed by the PIU and includes representatives from legal, clinical, pharmacy, compliance, government relations, claims, underwriting, and network management.

A provider has 30 days to request reconsideration or appeal an audit finding. If the provider does not request a reconsideration or appeal, the findings of the audit will be implemented including off-setting future payments to the provider. Sentara notifies a provider at least 30 days in advance of any offset. Providers receive remittance advice showing offsets. Any provider or member initiated post-service retrospective review would not result in recoupment. Recoupment applies only to FWA.

Appeal Rights and Member Liability:

Upon completion of an audit, SHP's Program Integrity Department or its designee will provide a findings letter to the provider or facility. The findings letter will be provided when the audit is completed in its entirety.

The findings letter will list items such as charges unsupported by adequate documentation, under-billed items, late billed items, and charges requiring additional supporting documentation. If the provider or facility agrees with the audit findings, the provider or facility has thirty (30) business days to reimburse SHP the amount indicated in the findings letter. Should the provider or facility disagree with the findings, the provider or facility may request a reconsideration of the findings in writing within thirty (30) business days of the date of receipt of the audit findings.

If the provider or facility does not request a reconsideration of the findings within the thirty (30) business day timeframe, the initial determination will stand, and Sentara will offset and recover the overpayment against future payments.

A reconsideration of the audit findings must be in writing and received by Sentara's Program Integrity Department or its designee within thirty (30) business days of the date of receipt of the audit findings unless State Statute expressly indicates otherwise. The request for reconsideration must specifically detail the findings from the audit findings that the provider or facility disputes, as well as the basis for the provider's or facility's reconsideration. All findings disputed by the provider or facility in the reconsideration must be accompanied by relevant supporting documentation.

Upon receipt of a timely reconsideration along with complete supporting documentation as required under this policy, Sentara's Program Integrity Department or its designee shall issue a reconsideration response to the provider or facility. Sentara's Program Integrity Department or its designee's response will address each disputed finding contained in the provider's or facility's reconsideration. Sentara's Program Integrity Department or its designee's reconsideration response will indicate what adjustments, if any, will be made to the overpayment amounts outlined in the findings letter. The reconsideration response will be sent via certified mail to the provider or facility within sixty (60) business days of the date Sentara's Program Integrity Department or its designee received the provider's or facility's reconsideration request. Revisions to the audit findings will be included in the mailing.

If the provider or facility agrees with the reconsideration findings, the provider or facility has thirty (30) business days to reimburse Sentara the amount indicated in the findings letter. Should the provider or facility disagree with the findings, then the provider or facility may request an appeal of the reconsideration findings in writing within thirty (30) business days of the date of receipt of the reconsideration findings.

If the provider or facility does not request a final appeal of the reconsideration within the thirty (30) business day timeframe, the reconsideration determination will stand, and Sentara will offset and recover the overpayment against future payments.

A final appeal of the reconsideration findings must be in writing and received by Sentara's Program Integrity Department or its designee within thirty (30) business days of the date of the audit findings unless State Statute expressly indicates otherwise. The request for a final appeal must specifically detail the findings from the audit findings that the provider or facility disputes, as well as the basis for the provider's or facility's final appeal. All findings disputed by the provider or facility in the final appeal must be accompanied by relevant supporting documentation.

Upon receipt of a timely final appeal along with complete supporting documentation as required under this policy, Sentara's Program Integrity Department or its designee shall issue a final appeal response to the provider or facility. Sentara's Program Integrity Department or its designee's response will address each disputed finding contained in the provider's or facility's final appeal. Sentara's Program Integrity Department or its designee's final appeal response will indicate what adjustments, if any, will be made to the overpayment amounts outlined in the findings letter. The final appeal response will be sent via certified mail to the provider or facility within sixty (60) business days of the date Sentara's Program Integrity Department or its designee received the provider's or facility's final appeal request. Revisions to the final audit findings will be included in the mailing.

The provider or facility will have thirty (30) business days from the date of the final appeal response to send a check to Sentara. If a check is not received within the thirty (30) business day timeframe, Sentara will recoup the overpayment indicated in the final appeal response by offsetting from future remits. If the provider or facility still disagrees with Sentara's Program

Integrity Department or its designee's final appeal audit findings, the provider or facility may then appeal to the appropriate governmental agency if applicable. The provider's or facilities written request for an extension to submit an appeal or payment will be reviewed by Sentara's Program Integrity Department on a case-by-case basis. If the provider or facility chooses to request an appeal extension, the request should be submitted in writing no later than fifteen (15) business days from receipt of the audit findings letter. One appeal extension may be granted during the appeal process at Sentara's Program Integrity Department discretion, for up to fifteen (15) business days from the date the appeal would otherwise have been due. Any extension of the appeal timeframes contained in this policy will be expressly conditioned upon the provider's or facility's agreement to waive the requirements of any applicable state prompt pay statute and/or provision in a contract which limits the timeframe by which a recoupment must be completed.

Appeal rights apply to both in-network and out-of-network providers. Members are not financially responsible for payment procured by provider FWA. This is true for both M/S and MH/SUD services.

Explanations of benefits or other correspondence will not be issued to the member when recoupment occurs due to paid claims having findings of FWA during post-payment retrospective review, but a member will be notified that a provider has been terminated from the network. Members are never held liable for findings of FWA by a provider.

Step 5: Demonstration of comparability and stringency in operation.

See **45 CFR 146.137(c)(5).** The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences

are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

FWA: See enclosed data pulls, which show the frequency and outcomes of post-payment retrospective reviews for 2024 Virginia fully-insured plans. Sentara will supplement this analysis with 2025 data when it becomes available.

In-Operation Metrics and Audit Results Documentation:

Outcomes Data for 2024 Virginia fully-insured plans (will supplement with 2025 data when available):

- No outpatient claims were flagged for FWA post-payment retrospective reviews.

- No emergency claims were flagged for FWA post-payment retrospective reviews.

- No out of network claims were flagged for FWA post-payment retrospective reviews.

- No MH claims were flagged for FWA post-payment retrospective reviews.

- No SUD claims were flagged for FWA post-payment retrospective reviews.

Inpatient: In 2024, there were no commercial claims paying $5K or more over billed charges audited by Sentara. Sentara does not audit inpatient MH/SUD services internally or through vendors. To the extent a referral is reported related to a MH/SUD claim, the process for investigation of those referrals applies equally to M/S and MH/SUD claims.

Outpatient: All paid professional services claims are subject to audit by Post-Payment Vendor 2.

Step 6: Findings and conclusions.

See 45 CFR 146.137(c)(6). The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section

146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the **FAQ 45** guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara defined Post-Payment Retrospective Review NQTL as (i) a clinical review following the provision of M/S or MH/SUD services and payments of claims (see Retrospective Review analysis); (ii) Fraud, Waste, and Abuse ("FWA") investigations; and (iii) coding edits, although coding edits are employed post-service and pre-payment. Sentara identified the Program Integrity Unit as having oversight over FWA. Sentara noted that all forms of post-payment retrospective review apply to both M/S and MH/SUD claims. Sentara identified the processes for seeking clinical post-payment retrospective review as consistent with preauthorization and concurrent review NQTLs, except that the clinical review occurs post-payment. Sentara identified how FWA investigations are initiated and included links to the policies utilized. Sentara explains that it utilizes vendors for FWA and coding edits. Sentara identified and provided the processes for appeal for all types of post-payment retrospective review. Sentara

detailed its process for tracking post-payment retrospective reviews, which is consistently applied for both M/S and MH/SUD services.

Data collected includes:

- No MH or SUD disorders claims were flagged for post-payment retrospective review in the reporting period.

Analysis establishes Sentara is compliant with MHPAEA. This analysis was completed in September 2026 by the following Sentara departments: Program Integrity, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

POST-PAYMENT RETROSPECTIVE REVIEW:

OUTPATIENT, IN-NETWORK

(APPLICABLE TO EMERGENCY SERVICES)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See **45 CFR 146.137(c)(1).** Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also **FAQ 45** (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

General Description of NQTL

Post-payment retrospective review means the review of the member's medical records and other supporting documentation by Sentara after services have been rendered and payment has been made to the provider to confirm Sentara's liability for payment.

Post-Payment Coding Edits

Sentara does not perform post-payment coding edits. Coding edits are utilized to ensure correct claim submission and adjudication *pre-payment*. Sentara utilizes vendors for claims review services post-payment. Sentara utilizes a vendor ("Post-Payment Vendor 1") for post-payment claims review of inpatient claims. Post-Payment Vendor 1 does not perform claim review services for inpatient MH/SUD claims. Sentara utilizes a second vendor ("Post-Payment Vendor 2") related to post-payment claims review of all claims for professional services. This claims review process is a part of the Program Integrity Unit ("PIU"), which is responsible for fraud, waste, and abuse ("FWA") investigations.

Post-Payment Clinical Review

Sentara does not perform post-payment clinical review.

The remainder of this analysis will focus on fraud, waste, and abuse investigations because that is the only form of post-payment retrospective review Sentara uses.

Fraud, Waste, and Abuse Investigations

Post-payment retrospective review is limited to the functions of the PIU, which include both audit functions and FWA investigations. Claim review through audits and/or investigations includes a review of clinical records.

Sentara has adopted the Commonwealth of Virginia's definition of fraud, waste, and abuse (FWA) as any "suspicious claims activity," which is any claim that an insurance company has reason to believe, based upon evidence, and may contain one or more material misrepresentations. Sentara, in its Provider Manual and Provider Guide to Fraud, Waste, and Abuse, further defines fraud as intentional deception or misrepresentation made by a person or entity with the knowledge that the deception could result in payment of an unauthorized benefit or financial gain.

The Provider Guide to Fraud, Waste, and Abuse further provides examples of fraud including: (i) rendering and billing for non-medically necessary services; (ii) upcoding-billing higher level service than provided; (iii) misrepresentation of benefits; (iv) encounter data falsification; (v) underutilization; (vi) attestation/condition of participation. The Provider Guide to Fraud, Waste, and Abuse defines "Waste" as "the overutilization of services or other practices that result in unnecessary costs." The Provider Guide to Fraud, Waste, and Abuse defines "Abuse" as "activities that are inconsistent with sound fiscal, business, or medical practices that result in an unnecessary cost, reimbursement for services that are not medically necessary, or fail to meet professionally recognized standards for healthcare." The distinguishing factors between "fraud," as compared to "waste" and "abuse" are intent and knowledge. The PIU is a dedicated team that focuses on detecting, resolving, and preventing potential FWA by analyzing claims data, monitoring trends, and conducting in-depth investigations to uncover suspicious activities and

unusual patterns of potential abusive behavior. PIU conducts audits and investigations of M/S and MH/SUD services. The same definitions of "fraud, waste, and abuse" apply to both M/S and MH/SUD.

The Program Integrity Unit conducts data mining by pulling claims data and identifying outliers. The Program Integrity Unit also uses a vendor for proactive lead generation. Sentara contracts with Post-Payment Vendor 2. to provide FWA Management services including both software modules (platforms) and special investigations unit services ("SIU") for professional services only. Post-Payment Vendor 2provides audit services on outpatient, professional services auditing for correct coding, supporting documentation, and ensuring billed services were rendered.

There are not separate departments within the PIU related to M/S and MH/SUD claims. Actions by the PIU apply to both M/S and MH/SUD services. Notably, inpatient MH/SUD services are not audited internally or by outside vendors.

Inpatient Services: As it relates to FWA, a component of the PIU is contracting with vendors to provide claim review services. Sentara contracts with Post-Payment Vendor 1 to provide claim review services pursuant to a vendor services agreement. Post-Payment Vendor 1 performs claim review services for M/S inpatient claims only, specifically DRG and Level of Care post-pay audits. All audits performed by Post-Payment Vendor 1 in 2024 were desk audits. Post-Payment Vendor 1 does not perform claim review services for any MH/SUD services. Sentara also internally audits M/S inpatient claims when the payment tendered is $5K or more over billed charges. In 2024, there were no commercial claims which paid $5K or more than billed charges. Sentara does not perform internal audits for MH/SUD services.

Outpatient Services: Sentara also contracts with Post-Payment Vendor 2 to provide FWA Management services including both software modules and special investigations unit services ("SIU") for outpatient professional services only.

Oversight of Vendors

Post-Payment Vendors 1 and 2 are associated with the FWA form of the NQTL. None of these vendors are affiliated with Sentara and the agreements are negotiated as arms-length exchanges. Sentara's PIU Department monitored and assessed vendors through regularly scheduled meetings. Utilization management vendors perform no services for FWA.

As discussed in detail in Sentara's Retrospective Review Analysis, Sentara conducts two forms of Retrospective Review: (i) post-service, pre-claim retrospective review; and (ii) post-service, post-claim retrospective review. The process for retrospective clinical review is analyzed in Sentara's Retrospective Review Analysis.

List of Services Subject to FWA

FWA: All outpatient M/S and MH/SUD services are subject to Program Integrity Audit. Providers will be selected based on their utilization and billing patterns, relative to their peers. There is no limitation of codes reviewed. A 12-month look-back period applies.

Services Reviewed During Reporting Period for Commercial LOBs (2025)

Classification	Descriptions of Claims Audited
Inpatient, In-Network (M/S)	The following types of claims are subject to FWA: (i) M/S claims that paid at $5,000 or more than billed charges; (ii) claims identified in Post-Payment Vendor 1 audits, which pertain to inpatient M/S hospital claims only; (iii) claims or providers referred to Sentara by internal or external sources; and (iv) leads initiated by Post-Payment Vendor 2, which pertain to inpatient and outpatient professional services claims only.
Inpatient, In-Network (MH/SUD)	No claims are subject to audit.
Outpatient, In-Network (M/S)	The following types of claims are subject to FWA: (i) M/S claims that paid at $5,000 or more than billed charges; (ii) claims or providers referred to Sentara by internal or external sources; and (iii) leads initiated by Post-Payment Vendor 2, which pertain to inpatient and outpatient professional services claims only.
Outpatient, In-Network (MH/SUD)	The following types of claims are subject to FWA: (i) claims or providers referred to Sentara by internal or external sources; and (ii) leads initiated by Post-Payment Vendor 2, which pertain to inpatient and outpatient professional services claims only.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See **45 CFR 146.137(c)(2).** Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:

(A) A detailed description of the factor;

(B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and

(C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.
- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

FWA:

Sentara flags for internal review (i) M/S claims that paid at $5,000 or more than billed charges; (ii) claims identified in Post-Payment Vendor 1, which pertain to inpatient M/S hospital claims only, (iii) claims or providers referred to Sentara by internal or external sources; and (iv) leads initiated by Post-Payment Vendor 2, which pertain to inpatient and outpatient professional services claims only.

NOTE: MH/SUD inpatient claims are not subject to audit.

The factors and standards used for each of these categories of FWA are discussed below.

Sentara Internal Review of M/S Claims Paid $5K or More of Billed Charges

Sentara treats all M/S claims in this classification the same.

Claims Identified by Post-Payment Vendor 1 (M/S Hospital)

For commercial lines of business, audits performed by Post-Payment Vendor 1 are for paid M/S inpatient hospital claims only. No discretion is exercised by Sentara, as Post-Payment Vendor 1 is provided monthly data extract of all paid claims. In other words, Sentra does not select or "carve out" data prior to transmission to Post-Payment Vendor 1.

Post-Payment Vendor 1 provides Sentara with claim review files for Sentara's review. Sentara then confirms the claim selection for review and identifies the claims to be audited by approving or denying the claims for audit. For 2024, the Director of Program Integrity cannot recall a claim file that was denied by Sentara. Post-Payment Vendor 1 performs only desk audits on M/S inpatient services.

External or Internal Referrals to Sentara PIU

Referrals derive both internally and externally from a number of sources including email, hotline or direct contact. Sentara maintains an annual report of referral type for all lines of business, including commercial. In 2024, for the commercial LOB, Sentara received 358 referrals. Of these 358 referrals, 292 were not pursued.

Referrals are also reported by the FWA hotline, email, and direct contact with Sentara employees. In the case of these referrals, the PIU will follow the process set forth in the Monitoring and Audit Plan for commercial FWA investigations. In 2024, for commercial LOB, 67 hotline calls were received, 278 emails, and 13 referrals from other sources like communications made directly to staff. 292 of these referrals were not investigated.

For FWA investigations, whether an audit is a desk or on-site audit depends on the information provided in the referral. For example, if the complained of issue is one that requires observation, an on-site audit will occur. Sentara does not track whether an audit was a desk or on-site audit by service type (M/S and MH/SUD) and does not collect data on whether on-site audits are for M/S or MH/SUD claims. In 2024, for commercial LOB, Sentara did not conduct any on-site audits.

The PIU's "investigation" of any FWA referrals or leads related to member driven FWA are referred to law enforcement (identity theft). The appeal process described above does not apply to member-driven FWA. The PIU did not investigate any member-driven FWA in 2024. As to member liability, members are not responsible for claim payments procured by FWA.

Claims Identified by Post-Payment Vendor 2 (Professional Services Claims)

Sentara contracts with Post-Payment Vendor 2 to provide FWA Management Services for professional services. Sentara sends Post-Payment Vendor 2 a monthly data file of all paid claim for professional services. Using proprietary algorithms and suite of solutions, Post-Payment Vendor 2 analyzes provider billing behavior and flags providers for further review. Sentara is able to access and modify the flags used by Post-Payment Vendor 2.

Peer to peer comparisons are conducted to identify an outlier provider. An example would be comparing all providers within a specific specialty billing for the same services. A provider would be identified as an outlier if they are more than two standard deviations above or below the trend line. Sentara also uses industry standard red flags to identify areas of concern. Such red flags are overutilization of services, billing anomalies, duplicate billing. Post-Payment Vendor 2 provided access to Sentara to review and comment on flags applied. It also provides Sentara's investigators with the ability to pull data and analyze the data themselves. Post-Payment Vendor 2's platforms perform sampling and statistical aggregates, trend analysis, and outlier analysis through an algorithm.

Post-Payment Vendor 2 also provides investigation "SIU" services. These SIU constitute investigative support including lead generation, clinical review services, investigations and

consulting services. The SIU services encompass both leads from Sentara, as described above, and leads generated by Post-Payment Vendor 2 through its FWA Management Services. For those leads investigated by Post-Payment Vendor 2, lead packages will be completed and sent to Sentara for review. Once the "Lead" is approved, Post-Payment Vendor 2 will complete a statistical sample of records to review and results and provide such information to Sentara. Post-Payment Vendor 2 investigative staff will submit the post-pay medical records to medical review staff. Post-Payment Vendor 2 will then provide a summary to Sentara. Post-Payment Vendor 2 also provides investigative support using their PIU investigators and clinical staff. All investigations go through SHP's PIU and the FWA Subcommittee as necessary. The PIU department reviews that file and determines which claims will be subject to further audit or investigation. For 2024, the Director of Program Integrity cannot recall a claim file that was denied by Sentara.

For FWA investigations, whether an audit is a desk or on-site audit depends on the information provided in the referral. For example, if the complained of issue is one that requires observation, an on-site audit will occur. Sentara does not track whether an audit was a desk or on-site audit by service type (M/S and MH/SUD) and does not collect data on whether on-site audits are for M/S or MH/SUD claims. In 2024, for commercial LOB, Sentara did not conduct any on-site audits.

Time Periods for FWA Audits

For audits and investigations conducted by the PIU, once a provider is identified, paid claims for that provider will be reviewed for the prior 9 months. The Virginia Code limits recovery to a 12-month look back period.

Step 3: Description of how factors are used in the design and application of the NQTL.

See 45 CFR 146.137(c)(3). Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

FWA:

All outpatient services are subject to audit by the Program Integrity Unit. No cost threshold applies. The Program Integrity Unit conducts data mining by pulling claims data and identifying outliers. The Program Integrity Unit also uses a vendor to conduct investigations on outpatient, professional services auditing for correct coding, supporting documentation, ensuring billed services were rendered. Sentara does not treat "fraud", "waste", and "abuse" as independent bases for audits. As such, separate factors are not used for each of the three types of behaviors.

The FWA Subcommittee is charged with (i) monitoring FWA compliance for Governmental (Medicaid, Medicare, FEHB) programs (including Part D); (ii) reviewing and making regulatory reporting decisions on providers, members, employers, or brokers suspected of fraud, waste, or abuse; (iii) oversight of new or proposed FWA programs or policies; (iv) ensuring consistency and appropriateness of investigative process and reporting; (v) ensuring Program Integrity Unit (PIU) processes balance compliance requirements with network integrity; (vi) balancing risks vs. rewards and making business decisions regarding PIU case activity; and (vii) make recommendations to Senior Leadership Team (SLT) regarding any cases that may involve litigation. This Committee is headed by the PIU and includes representatives from legal, clinical, pharmacy, compliance, government relations, claims, underwriting, and network management.

Please see the response in Step One for definitions of fraud, waste, and abuse. As explained in Step One, the definitions do not vary for M/S and MH/SUD. Please see the response in Step Two for a discussion of the FWA vendors Sentara uses, which claims are given to vendors, and what vendors are instructed to look for when reviewing claims.

Step 4: Demonstration of comparability and stringency as written.

See **45 CFR 146.137(c)(4).** The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

FWA:

Documentation of Each Factor Identified and Defined in Step Two:

All inpatient services are subject to audit by the Program Integrity Unit. No cost threshold applies. The Program Integrity Unit conducts data mining by pulling claims data and identifying outliers. The Program Integrity Unit also uses a vendor for proactive lead generation. Vendors are engaged for post-payment audits for inpatient services, reviewing for correct DRG, readmissions, length of stay, itemized bill audits, correct coding, and supporting documentation. Another vendor conducts investigations on outpatient, professional services auditing for correct coding, supporting documentation, ensuring billed services were rendered. No specific cost threshold triggers FWA except for inpatient claims that paid $5K or more than billed charges.

Data on provider services for specified time periods are compiled and compared with other providers within the same specialty/provider type and geographic peer groups. Twelve months of claims data will be pulled for commercial products. Providers will be selected based on their utilization and billing patterns, relative to their peers. Providers who are an outlier may be subject to further analysis, including desk or onsite investigations. Investigations will include a review of the provider's medical records that pertain to the billed services.

Applicable types of claims include, but are not limited to:

1. Claims being reviewed to validate the correct diagnosis related group (DRG) assignment/payment (DRG validation audits)

2. Claims being reviewed to validate items and services billed are documented in the medical record for hospital bill audits (also known as hospital charge audits)

3. Claims with unlisted or miscellaneous codes

4. Claims for services requiring clinical review

5. Claims for services found to possibly conflict with covered benefits

6. Claims for services found to possibly conflict with medical necessity

7. Claims being reviewed for potential fraud, waste and abuse or demonstrated patterns of billing/coding inconsistencies

8. Other documentation required by other entities such as the Centers for Medicare and Medicaid Services (CMS), and state or federal regulation

9. Documentation for such services as the provision of durable medical equipment, prosthetics, orthotics, and supplies, rehabilitation services, and home health care

The factors described above describe the types of claims that may be subject to FWA. However, all paid claims are subject to audit. For outpatient claims, all paid professional services claims are subject to audit by Post-Payment Vendor 2. For professional services claims reviewed by Post-Payment Vendor 2, those claims are not tracked to distinguish between M/S and MH/SUD services and the volume of claims prohibits a manual review. To

establish the process employed by Post-Payment Vendor 2, Sentara routinely evaluates and confirms that the following process is adhered to for both M/S and MH/SUD services: data files are received from Post-Payment Vendor 2 for both M/S and MH/SUD services. A lead package is then sent to Sentara PIU and the PIU approves, partially approves, or rejects the lead package based on the factors described above with no one factor being dispositive. Leads are accompanied by lead narratives for each provider and a case tracker is used to follow the status of the review. The same process is used for both M/S and MH/SUD claim review.

How Factors Are Comparably Applied:

All of Sentara's Program Integrity policies and procedures apply equally to M/S and MH/SUD services.

Reasons for Any Deviations or Variations:

There are no deviations or variations in the design or application of FWA between MH/SUD and M/S benefits.

Comparison of Existing Written Documents and Processes Therein:

SHP's Program Integrity Unit employs a policy "Program Integrity Audit, Reconsideration and Appeals." Other policies include (i) Program Integrity Plan/Compliance Plan and (ii) Detection, Prevention and Reporting. Review for policies is conducted by the Program Integrity Unit, including specific review to ensure comparable application between M/S and MH/SUD services. Further, the specific processes applied by Sentara are discussed in detail throughout this analysis and are adhered to equally for M/S and MH/SUD services.

How Processes are Comparably Applied, Reasons for Variations or Any Deviations:

There are no deviations or variations in the processes regarding FWA between MH/SUD and M/S benefits.

FWA Processes:

SHP's Program Integrity Unit employs a policy "Program Integrity Audit, Reconsideration and Appeals."

Other policies include (i) Program Integrity Plan/Compliance Plan and (ii) Detection, Prevention and Reporting.

Review for policies is conducted by the Program Integrity Unit, including specific review to ensure comparable application between M/S and MH/SUD services.

Outcomes and Actions:

Outcomes of corrective action, settlement, education, reaudit, and termination do not apply to any requested retrospective clinical review. The outcomes apply to FWA only. The description of potential outcomes is below and apply only to FWA. These outcomes are not mutually exclusive and may be used in conjunction with one another. For example, a corrective action plan may also have a restitution component.

• Reversal of claims/retraction/recoupment: utilized where a provider is overpaid in error as discovered in an audit conducted the by audit division of the PIU.

• Educational requirements/corrective action: in cases of waste and abuse, provider education may be provided to prevent further incidents and, if needed, a corrective action may be issued which will require a provider to sign and agree to corrective measures.

• Termination or recission: in cases of fraud, waste, and abuse that go uncorrected after education, Sentara reserves the right to terminate a provider. These cases are brought before the FWA Compliance Subcommittee. This Committee is headed by the PIU and includes representatives from legal, clinical, pharmacy, compliance, government relations, claims, underwriting, and network management.

A provider has 30 days to request reconsideration or appeal an audit finding. If the provider does not request a reconsideration or appeal, the findings of the audit will be implemented including off-setting future payments to the provider. Sentara notifies a provider at least 30 days in advance of any offset. Providers receive remittance advice showing offsets. Any provider or member initiated post-service retrospective review would not result in recoupment. Recoupment applies only to FWA.

Appeal Rights and Member Liability:

Upon completion of an audit, SHP's Program Integrity Department or its designee will provide a findings letter to the provider or facility. The findings letter will be provided when the audit is completed in its entirety.

The findings letter will list items such as charges unsupported by adequate documentation, under-billed items, late billed items, and charges requiring additional supporting documentation.

If the provider or facility agrees with the audit findings, the provider or facility has thirty (30) business days to reimburse SHP the amount indicated in the findings letter. Should the provider or facility disagree with the findings, the provider or facility may request a reconsideration of the findings in writing within thirty (30) business days of the date of receipt of the audit findings.

If the provider or facility does not request a reconsideration of the findings within the thirty (30) business day timeframe, the initial determination will stand, and Sentara will offset and recover the overpayment against future payments.

A reconsideration of the audit findings must be in writing and received by Sentara's Program Integrity Department or its designee within thirty (30) business days of the date of receipt of the audit findings unless State Statute expressly indicates otherwise. The request for reconsideration must specifically detail the findings from the audit findings that the provider or facility disputes, as well as the basis for the provider's or facility's reconsideration. All findings disputed by the provider or facility in the reconsideration must be accompanied by relevant supporting documentation.

Upon receipt of a timely reconsideration along with complete supporting documentation as required under this policy, Sentara's Program Integrity Department or its designee shall issue a reconsideration response to the provider or facility. Sentara's Program Integrity Department or its designee's response will address each disputed finding contained in the provider's or facility's reconsideration. Sentara's Program Integrity Department or its designee's reconsideration response will indicate what adjustments, if any, will be made to the overpayment amounts outlined in the findings letter. The reconsideration response will be sent via certified mail to the provider or facility within sixty (60) business days of the date Sentara's Program Integrity Department or its designee received the provider's or facility's reconsideration request. Revisions to the audit findings will be included in the mailing.

If the provider or facility agrees with the reconsideration findings, the provider or facility has thirty (30) business days to reimburse Sentara the amount indicated in the findings letter. Should the provider or facility disagree with the findings, then the provider or facility may request an appeal of the reconsideration findings in writing within thirty (30) business days of the date of receipt of the reconsideration findings.

If the provider or facility does not request a final appeal of the reconsideration within the thirty (30) business day timeframe, the reconsideration determination will stand, and Sentara will offset and recover the overpayment against future payments.

A final appeal of the reconsideration findings must be in writing and received by Sentara's Program Integrity Department or its designee within thirty (30) business days of the date of the audit findings unless State Statute expressly indicates otherwise. The request for a final appeal must specifically detail the findings from the audit findings that the provider or facility disputes, as well as the basis for the provider's or facility's final appeal. All findings disputed by the provider or facility in the final appeal must be accompanied by relevant supporting documentation.

Upon receipt of a timely final appeal along with complete supporting documentation as required under this policy, Sentara's Program Integrity Department or its designee shall issue a final appeal response to the provider or facility. Sentara's Program Integrity Department or its designee's response will address each disputed finding contained in the provider's or facility's final appeal. Sentara's Program Integrity Department or its designee's final appeal response will indicate what adjustments, if any, will be made to the overpayment amounts outlined in the

findings letter. The final appeal response will be sent via certified mail to the provider or facility within sixty (60) business days of the date Sentara's Program Integrity Department or its designee received the provider's or facility's final appeal request. Revisions to the final audit findings will be included in the mailing.

The provider or facility will have thirty (30) business days from the date of the final appeal response to send a check to Sentara. If a check is not received within the thirty (30) business day timeframe, Sentara will recoup the overpayment indicated in the final appeal response by offsetting from future remits. If the provider or facility still disagrees with Sentara's Program Integrity Department or its designee's final appeal audit findings, the provider or facility may then appeal to the appropriate governmental agency if applicable. The provider's or facilities written request for an extension to submit an appeal or payment will be reviewed by Sentara's Program Integrity Department on a case-by-case basis. If the provider or facility chooses to request an appeal extension, the request should be submitted in writing no later than fifteen (15) business days from receipt of the audit findings letter. One appeal extension may be granted during the appeal process at Sentara's Program Integrity Department discretion, for up to fifteen (15) business days from the date the appeal would otherwise have been due. Any extension of the appeal timeframes contained in this policy will be expressly conditioned upon the provider's or facility's agreement to waive the requirements of any applicable state prompt pay statute and/or provision in a contract which limits the timeframe by which a recoupment must be completed.

Appeal rights apply to both in-network and out-of-network providers. Members are not financially responsible for payment procured by provider FWA. This is true for both M/S and MH/SUD services.

Explanations of benefits or other correspondence will not be issued to the member when recoupment occurs due to paid claims having findings of FWA during post-payment retrospective review, but a member will be notified that a provider has been terminated from the network. Members are never held liable for findings of FWA by a provider.

Step 5: Demonstration of comparability and stringency in operation.

See **45 CFR 146.137(c)(5).** The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies,

evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

FWA: See enclosed data pulls, which show the frequency and outcomes of post-payment retrospective reviews for 2024 Virginia fully-insured plans. Sentara will supplement this analysis with 2025 data when it becomes available.

In-Operation Metrics and Audit Results Documentation:

Outcomes Data for 2024 Virginia fully-insured plans (will supplement with 2025 data when available):

- No outpatient claims were flagged for FWA post-payment retrospective reviews.

- No emergency claims were flagged for FWA post-payment retrospective reviews.

- No out of network claims were flagged for FWA post-payment retrospective reviews.

- No MH claims were flagged for FWA post-payment retrospective reviews.

- No SUD claims were flagged for FWA post-payment retrospective reviews.

Inpatient: In 2024, there were no commercial claims paying $5K or more over billed charges audited by Sentara. Sentara does not audit inpatient MH/SUD services internally or through vendors. To the extent a referral is reported related to a MH/SUD claim, the process for investigation of those referrals applies equally to M/S and MH/SUD claims.

Outpatient: All paid professional services claims are subject to audit by Post-Payment Vendor 2.

Step Six: Findings and conclusions.

See 45 CFR 146.137(c)(6). The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and

medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the **FAQ 45** guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara defined Post-Payment Retrospective Review NQTL as (i) a clinical review following the provision of M/S or MH/SUD services and payments of claims (see Retrospective Review analysis); (ii) Fraud, Waste, and Abuse ("FWA") investigations; and (iii) coding edits, although coding edits are employed post-service and pre-payment. Sentara identified the Program Integrity Unit as having oversight over FWA. Sentara noted that all forms of post-payment

retrospective review apply to both M/S and MH/SUD claims. Sentara identified the processes for seeking clinical post-payment retrospective review as consistent with preauthorization and concurrent review NQTLs, except that the clinical review occurs post-payment. Sentara identified how FWA investigations are initiated and included links to the policies utilized. Sentara explains that it utilizes vendors for FWA and coding edits. Sentara identified and provided the processes for appeal for all types of post-payment retrospective review. Sentara detailed its process for tracking post-payment retrospective reviews, which is consistently applied for both M/S and MH/SUD services.

Data collected includes:

- No MH or SUD disorders claims were flagged for post-payment retrospective review in the reporting period.

Analysis establishes Sentara is compliant with MHPAEA. This analysis was completed in September 2026 by the following Sentara departments: Program Integrity, Compliance, and Legal.

2023 APPEALS

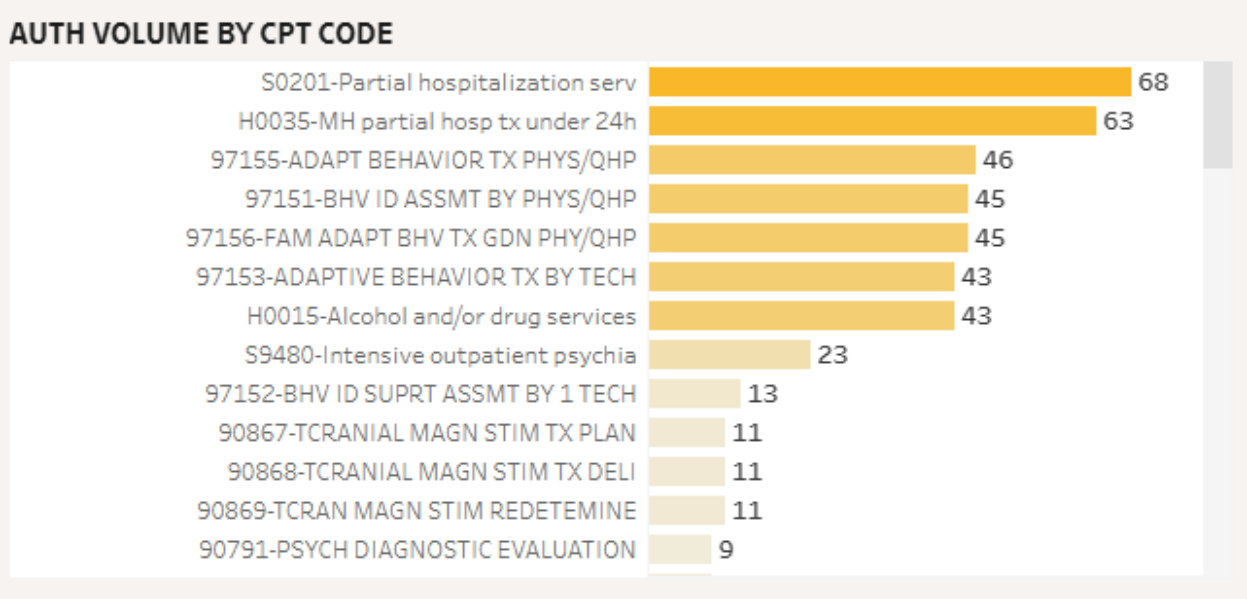
Received Appeals	LOB	Member Received	Closed	Provider Received	Closed
Optima Health Plan	1	138	138	88	86
Optima Individual	1X	130	130	60	59
Optima Managed Care	17A	21	21	12	12
OHIC	5	30	28	5	5
COVA	1V	16	16	6	6
OHIC OOA indemnity	4A	2	2	0	0
OHP Mandated	1H	0	0	0	0
Grand Total		337	335	171	168
Member Appeals Decisions	**Total**	**Overturned**	**Upheld**	**Voided**	**Invalid**
Optima Health Plan	138	40	92	0	0
Optima Individual	130	52	76	1	0
Optima Managed Care	21	4	16	0	0
OHIC	30	8	20	1	1
COVA	16	3	13	0	0
OHIC OOA indemnity	2	1	1	0	0
OHP Mandated	0	0	0	0	0
Provider Appeals Decisions	**Total**	**Overturned**	**Upheld**	**Voided**	**Invalid**
Optima Health Plan	88	23	54	3	1
Optima Individual	60	15	34	1	1
Optima Managed Care	12	5	7	0	0
OHIC	5	3	1	0	0
COVA	6	3	3	0	0
OHIC OOA indemnity	0	0	0	0	0
OHP Mandated	0	0	0	0	0
Member Appeal Reasons	**Total**	**Billing/Financial**	**DME**	**OP Procedure**	**Other**
Optima Health Plan	138	48	5	2	4
Optima Individual	130	49	0	1	2
Optima Managed Care	21	18	0	1	1
OHIC	30	9	3	0	1
COVA	16	0	0	0	0
OHIC OOA indemnity	2	0	0	0	0
OHP Mandated	0	0	0	0	0
Provider Appeal Reasons	**Total**	**MS Medical Necessity**	**BH Medical Necessity**	**Other**	
Optima Health Plan	88	9	0	79	

Optima Individual	60	6	0	54	
Optima Managed Care	12	3	0	9	
OHIC	5	0	0	5	
COVA	6	1	0	5	
OHIC OOA indemnity	0	0	0	0	
OHP Mandated	0	0	0	0	

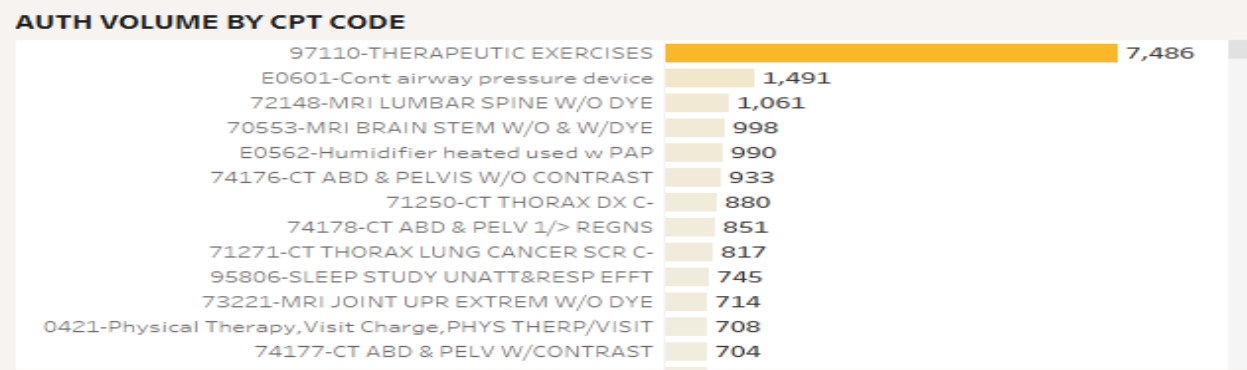
Withdrawn		
6		
1		
1		
0		
0		
0		
0		
Withdrawn		
7		
9		
0		
1		
0		
0		
0		
Pharmacy	**Radiology**	**BH/SU**
74	0	5
78	0	0
1	0	0
15	0	2
16	0	0
2	0	0
0	0	0

2023: Authorization Volume by CPT Code

MH/SUD Outpatient

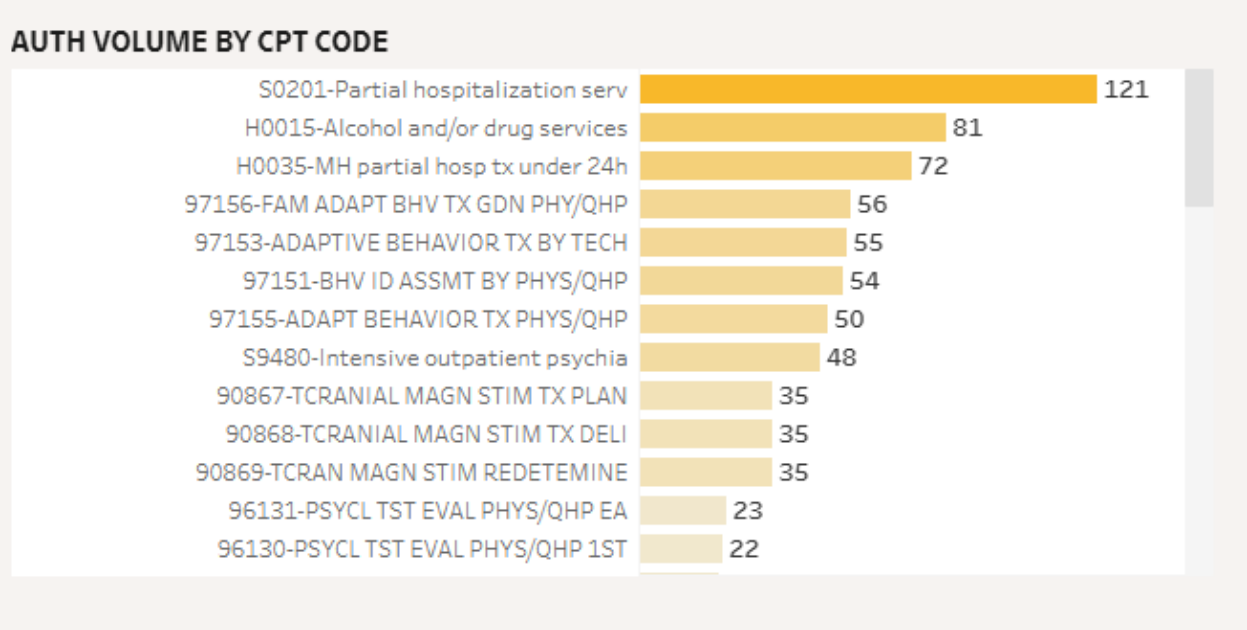


M/S Outpatient

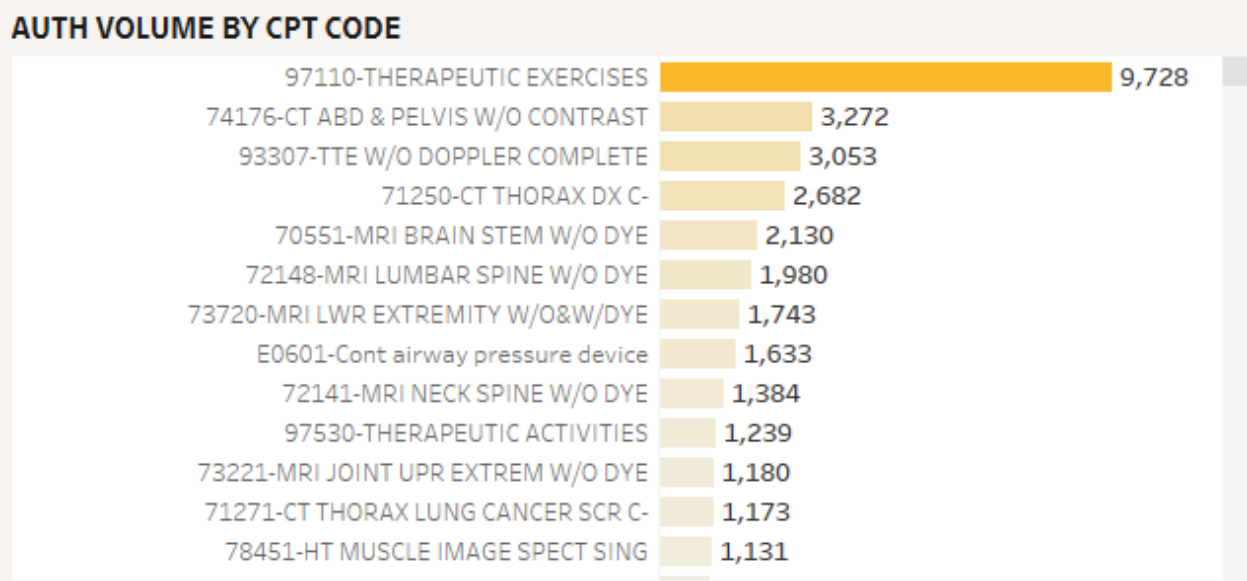


2024 Out of Network

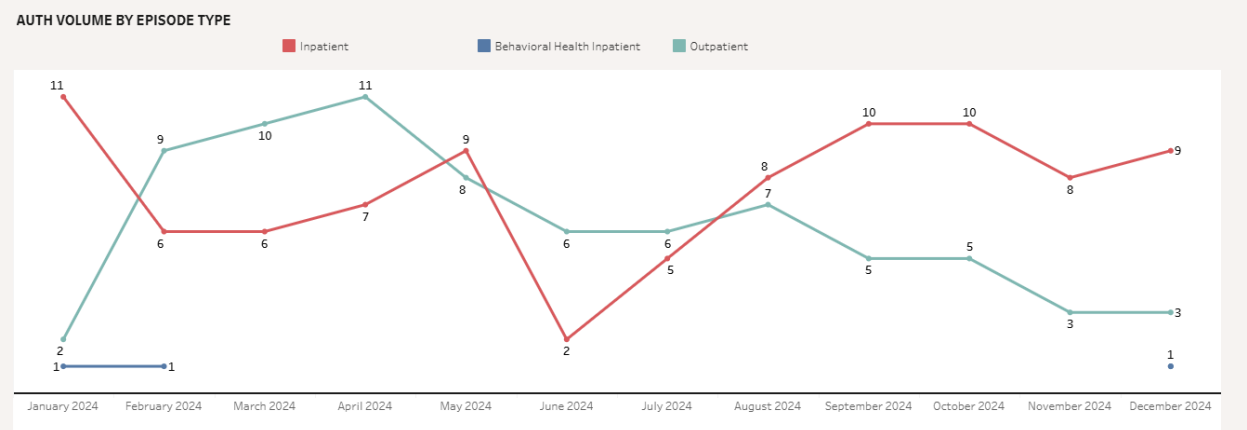
MH/SUD Outpatient



M/S Outpatient

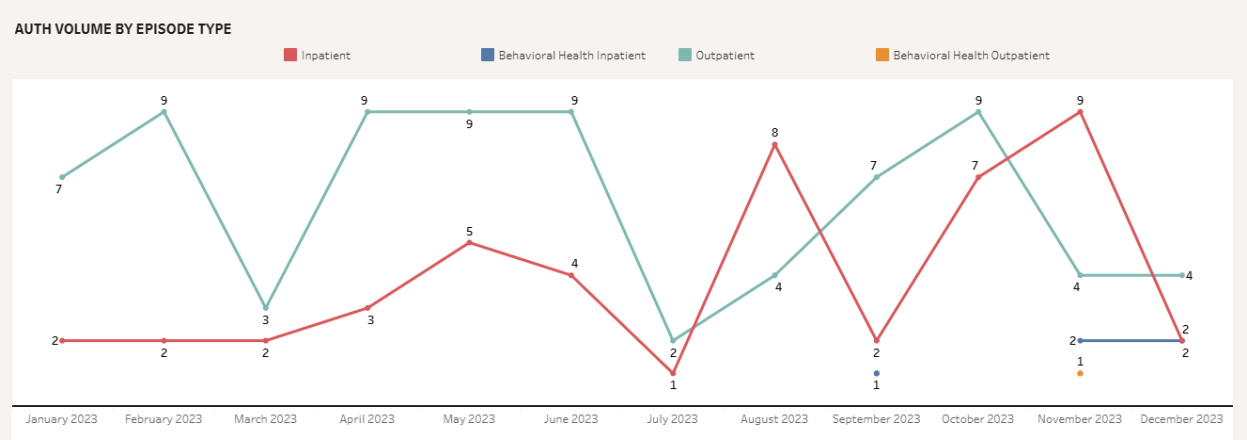


2024 Peer to Peer



	Grand Total	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024
Grand Total	160	14	16	16	18	17	8	11	15	15	15	11	13
Inpatient	85	11	6	6	7	9	2	5	8	10	10	8	9
Behavioral Health Inpatient	2	1	1										1
Outpatient	73	2	9	10	11	8	6	6	7	5	5	3	3

2023 Peer to Peer



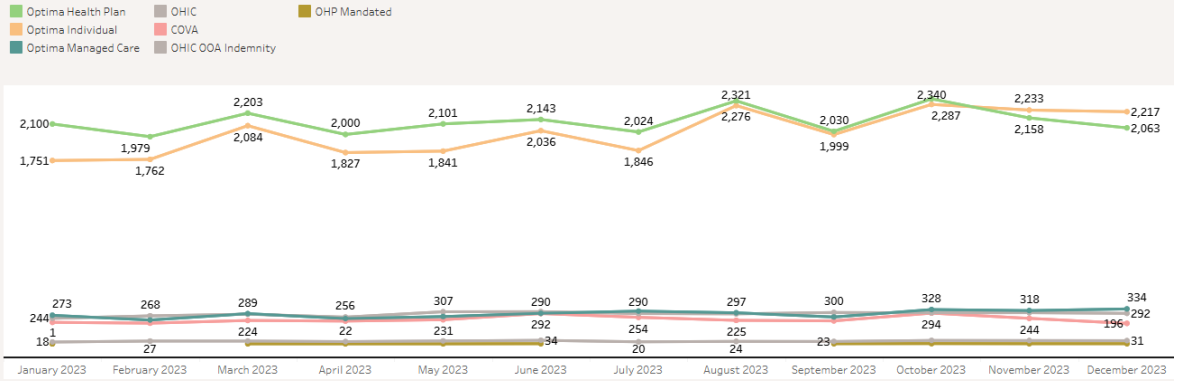
	Grand Total	January 2023	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..
Grand Total	126	9	11	5	12	14	13	3	12	10	16	16	8
Inpatient	46	2	2	2	3	5	4	1	8	2	7	9	2
Behavioral Health Inpatient	3									1		2	2
Outpatient	76	7	9	3	9	9	9	2	4	7	9	4	4
Behavioral Health Outpatient	1											1	

UM data and analysis (1/1/23-12/31/23)

Authorization Summary

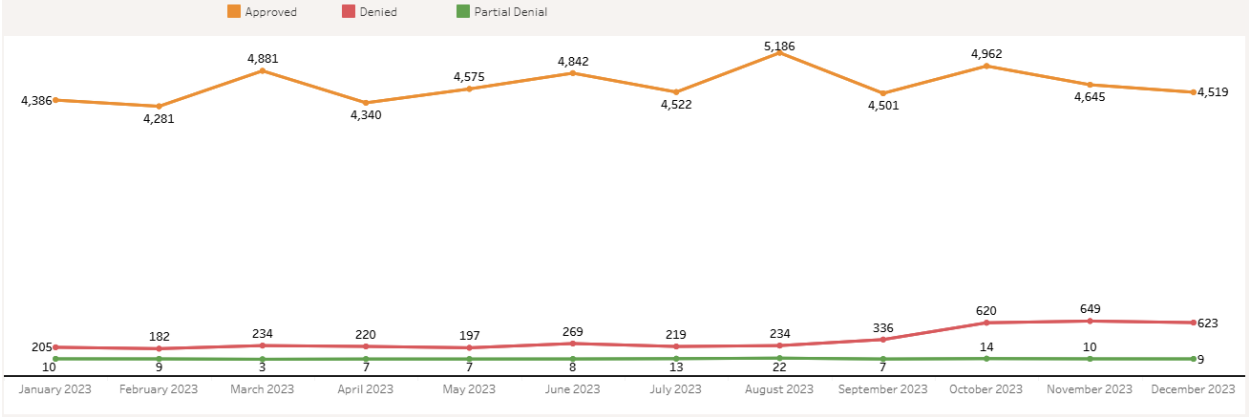
Distinct Count of Auths in Filtered Data	Total OON Auths	Total In Network Auths	% OON
58,786	2,594	56,192	4.41%

AUTH VOLUME BY LOB



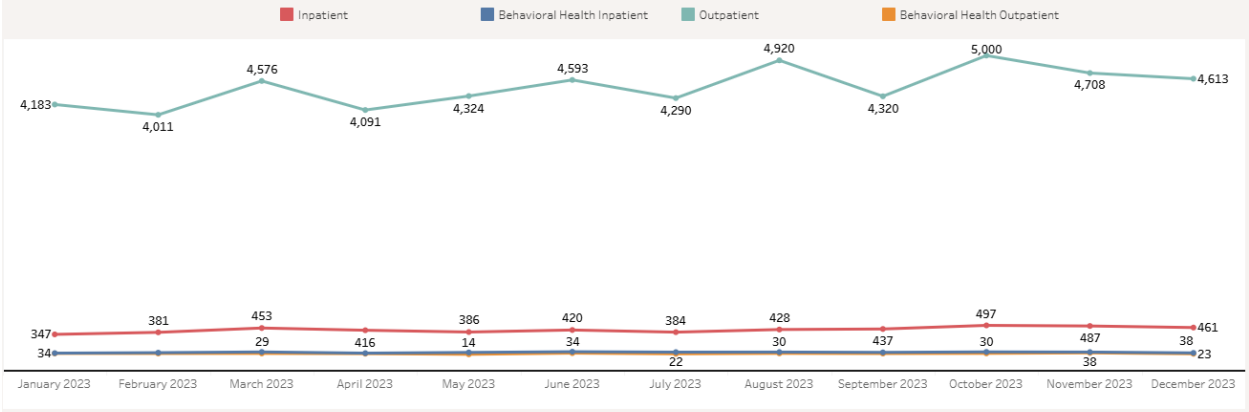
	Grand Total	January 2023	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..
Grand Total	58,786	4,593	4,462	5,112	4,566	4,770	5,105	4,747	5,430	4,831	5,582	5,285	5,135
Optima Health Plan	25,125	2,100	1,979	2,203	2,000	2,101	2,143	2,024	2,321	2,030	2,340	2,158	2,063
Optima Individual	23,823	1,751	1,762	2,084	1,827	1,841	2,036	1,846	2,276	1,999	2,287	2,233	2,217
Optima Managed Care	3,377	273	228	289	242	261	292	313	297	257	328	318	334
OHIC	3,365	244	268	284	256	307	308	290	287	300	297	298	292

AUTH VOLUME BY DECISION



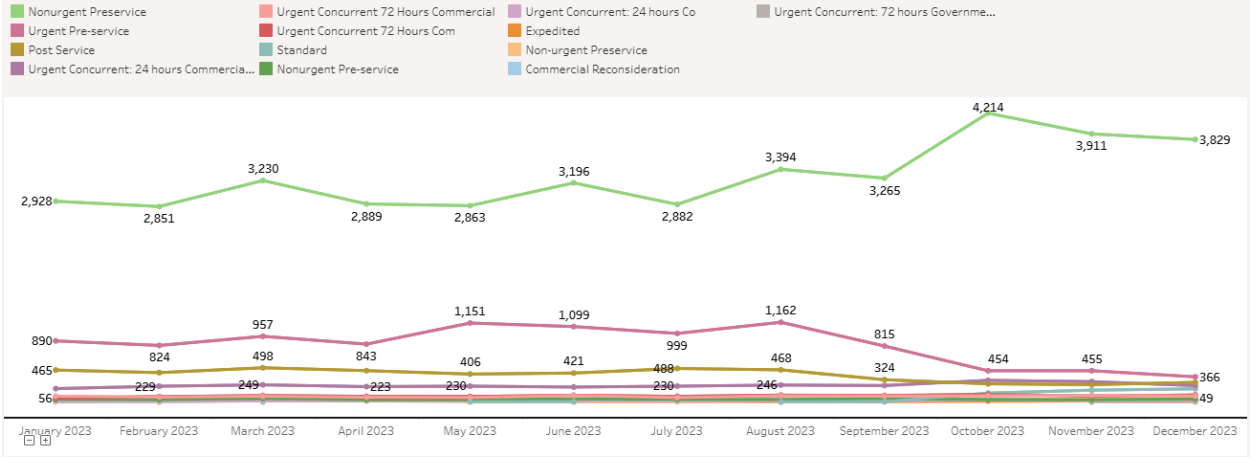
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Grand Total	58,786	4,593	4,462	5,112	4,566	4,770	5,105	4,747	5,430	4,831	5,582	5,285	5,135
Approved	54,841	4,386	4,281	4,881	4,340	4,575	4,842	4,522	5,186	4,501	4,962	4,645	4,519
Denied	3,970	205	182	234	220	197	269	219	234	336	620	649	623
Partial Denial	119	10	9	3	7	7	8	13	22	7	14	10	9

AUTH VOLUME BY EPISODE TYPE



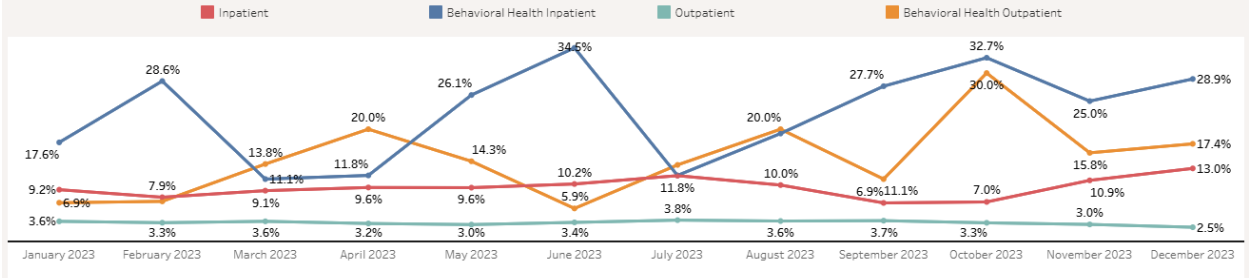
	Grand Total	January 2023	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..
Grand Total	58,786	4,593	4,462	5,112	4,566	4,770	5,105	4,747	5,430	4,831	5,582	5,285	5,135
Inpatient	4,753	347	381	453	416	386	420	384	428	437	497	487	461
Behavioral Health Inpatient	508	34	42	54	34	46	58	51	52	47	55	52	38
Outpatient	53,197	4,183	4,011	4,576	4,091	4,324	4,593	4,290	4,920	4,320	5,000	4,708	4,613
Behavioral Health Outpatient	328	29	28	29	25	14	34	22	30	27	30	38	23

AUTH VOLUME BY PRIORITY



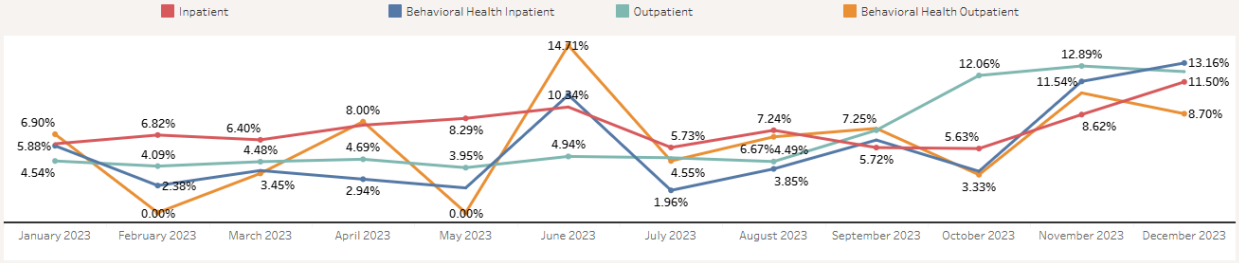
	Grand To..	January 2023	February 20..	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September ..	October 20..	November 2..	December 2..
Grand Total	58,786	4,593	4,462	5,112	4,566	4,770	5,105	4,747	5,430	4,831	5,582	5,285	5,135
Nonurgent Preservice	39,339	2,928	2,851	3,230	2,889	2,863	3,196	2,882	3,394	3,265	4,214	3,911	3,829
Urgent Pre-service	10,010	890	824	957	843	1,151	1,099	999	1,162	815	454	455	366
Post Service	4,701	465	427	498	456	406	421	488	468	324	264	252	285
Urgent Concurrent: 24 hours Commercial UM	2,906	194	229	249	223	230	217	230	246	239	315	296	238

MD REFERRAL RATE BY EPISODE TYPE



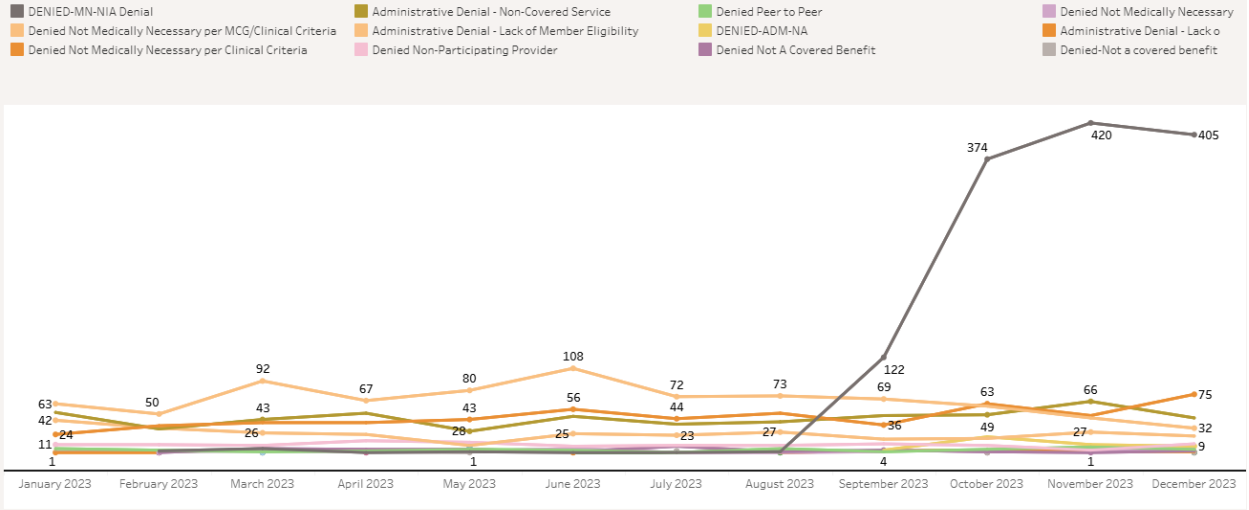
	Grand Total	January 2023	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023
Grand Total	4.2%	4.1%	4.0%	4.2%	3.9%	3.8%	4.3%	4.6%	4.4%	4.3%	4.1%	4.1%	3.7%
Inpatient	10.2%	9.2%	7.9%	9.1%	9.6%	9.6%	10.2%	11.7%	10.0%	6.9%	7.0%	10.9%	13.0%
Behavioral Health Inpatient	25.4%	17.6%	28.6%	11.1%	11.8%	26.1%	34.5%	11.8%	19.2%	27.7%	32.7%	25.0%	28.9%
Outpatient	3.4%	3.6%	3.3%	3.6%	3.2%	3.0%	3.4%	3.8%	3.6%	3.7%	3.3%	3.0%	2.5%
Behavioral Health Outpatient	14.6%	6.9%	7.1%	13.8%	20.0%	14.3%	5.9%	13.6%	20.0%	11.1%	30.0%	15.8%	17.4%

DENIAL RATE BY EPISODE TYPE



	Grand Total	January 2023	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023
Grand Total	6.95%	4.68%	4.28%	4.64%	4.97%	4.28%	5.43%	4.87%	4.71%	7.10%	11.36%	12.47%	12.31%
Inpatient	7.99%	6.05%	6.82%	6.40%	7.69%	8.29%	9.29%	5.73%	7.24%	5.72%	5.63%	8.62%	11.50%
Behavioral Health Inpatient	6.30%	5.88%	2.38%	3.70%	2.94%	2.17%	10.34%	1.96%	3.85%	6.38%	3.64%	11.54%	13.16%
Outpatient	6.87%	4.54%	4.09%	4.48%	4.69%	3.95%	4.94%	4.83%	4.49%	7.25%	12.06%	12.89%	12.40%
Behavioral Health Outpatient	6.71%	6.90%	0.00%	3.45%	8.00%	0.00%	14.71%	4.55%	6.67%	7.41%	3.33%	10.53%	8.70%

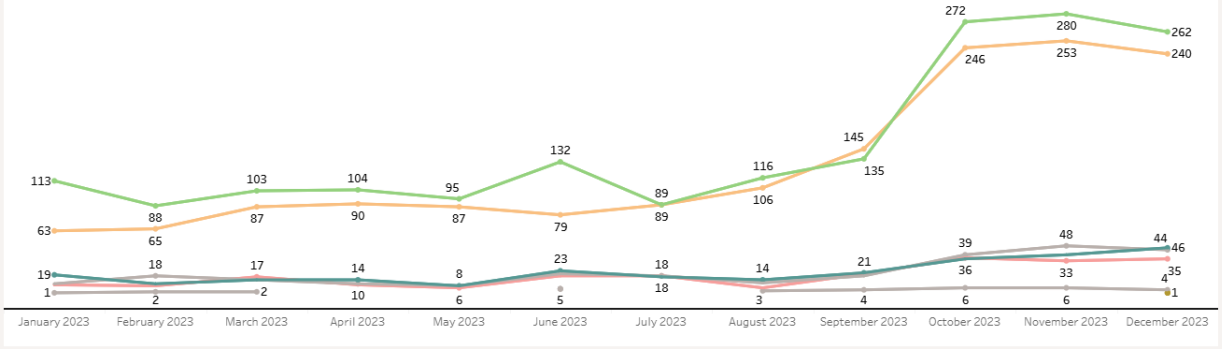
DENIAL VOLUME BY DENIAL REASON



	Grand Total	January 20..	February 2..	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September ..	October 20..	November ..	December ..
Grand Total	3,842	201	173	229	208	197	260	202	213	320	607	635	616
Administrative Denial - Lack o	16	1	1				1		1	3	4	3	2
Administrative Denial - Lack of Member Eligibility	295	42	32	26	24	10	25	23	27	18	19	27	22
Administrative Denial - Mandated paperwork not pr..	1								1				
Administrative Denial - Non-Covered Service	533	52	31	43	51	28	47	37	40	48	49	66	45
Administrative Denial- Benefit Exhausted	8					8							
Denied Member Coverage	2		1		1								
Denied Non-Participating Provider	129	11	11	10	16	14	9	10	10	12	10	4	12

DENIAL VOLUME BY LOB

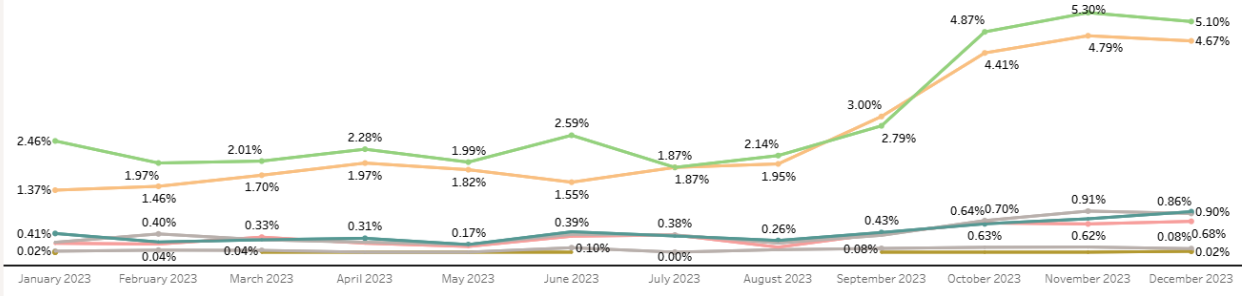
Optima Health Plan
Optima Individual
Optima Managed Care
OHIC
COVA
OHIC OOA Indemnity
OHP Mandated



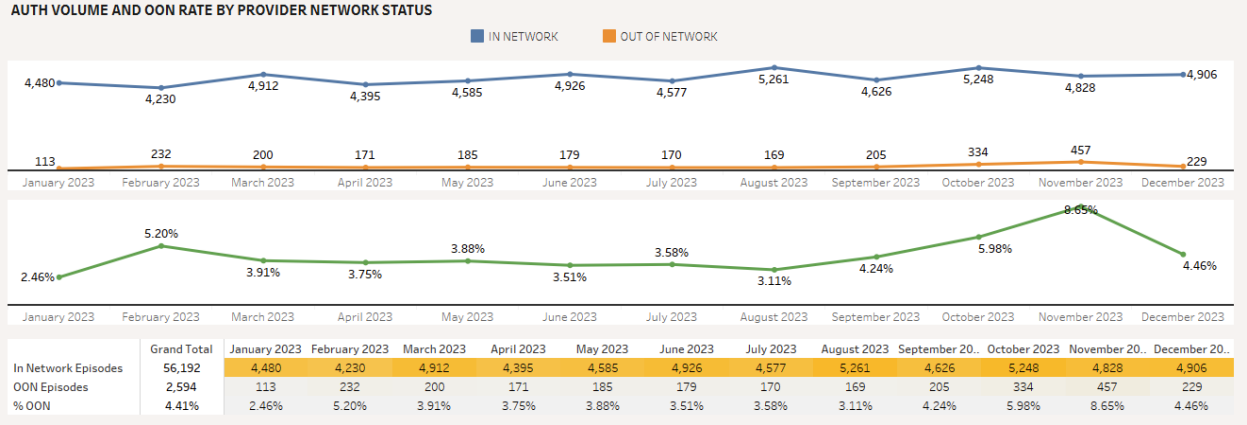
	Grand Total	January 2023	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September 20..	October 2023	November 20..	December 20..
Grand Total	4,088	215	191	237	227	204	277	231	256	343	634	659	632
Optima Health Plan	1,780	113	88	103	104	95	132	89	116	135	272	280	262
Optima Individual	1,546	63	65	87	90	87	79	89	106	145	246	253	240
Optima Managed Care	260	19	10	14	14	8	23	17	14	21	35	39	46
OHIC	255	10	18	14	10	8	20	18	11	18	39	48	44
COVA	213	9	8	17	9	6	18	18	6	20	36	33	35
OHIC OOA Indemnity	33	1	2	2			5		3	4	6	6	4
OHP Mandated	1												1

DENIAL RATE BY LOB

Optima Health Plan
Optima Individual
Optima Managed Care
OHIC
COVA
OHIC OOA Indemnity
OHP Mandated



	Grand Total	January 2023	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September 20..	October 2023	November 2023	December 2023
Grand Total	6.95%	4.68%	4.28%	4.64%	4.97%	4.28%	5.43%	4.87%	4.71%	7.10%	11.36%	12.47%	12.31%
Optima Indi..	2.63%	1.37%	1.46%	1.70%	1.97%	1.82%	1.55%	1.87%	1.95%	3.00%	4.41%	4.79%	4.67%
Optima Hea..	3.03%	2.46%	1.97%	2.01%	2.28%	1.99%	2.59%	1.87%	2.14%	2.79%	4.87%	5.30%	5.10%
Optima Ma..	0.44%	0.41%	0.22%	0.27%	0.31%	0.17%	0.45%	0.36%	0.26%	0.43%	0.63%	0.74%	0.90%
COVA	0.36%	0.20%	0.18%	0.33%	0.20%	0.13%	0.35%	0.38%	0.11%	0.41%	0.64%	0.62%	0.68%
OHIC	0.43%	0.22%	0.40%	0.27%	0.22%	0.17%	0.39%	0.38%	0.20%	0.37%	0.70%	0.91%	0.86%



	Grand Total	January 2023	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September 20..	October 2023	November 20..	December 20..
In Network Episodes	56,192	4,480	4,230	4,912	4,395	4,585	4,926	4,577	5,261	4,626	5,248	4,828	4,906
OON Episodes	2,594	113	232	200	171	185	179	170	169	205	334	457	229
% OON	4.41%	2.46%	5.20%	3.91%	3.75%	3.88%	3.51%	3.58%	3.11%	4.24%	5.98%	8.65%	4.46%

2023 Analysis

Total Auths: 58,786

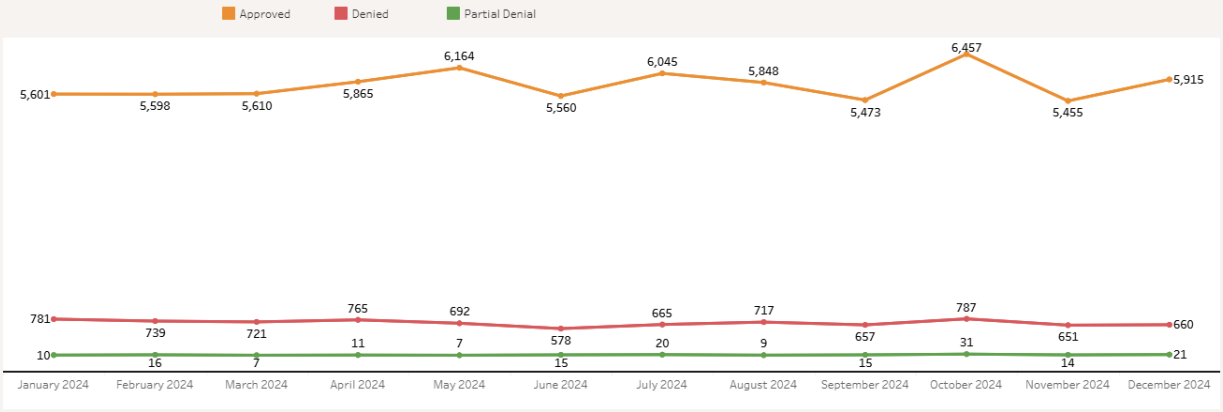
- M/S IP: 4,753
  - Approved: 4,423
  - Denied: 380
    - Administrative denial, lack of member eligibility: 42
    - Administrative denial, non-covered service: 16
    - Denied, non-participating provider: 4
    - Denied, not medically necessary: 292
    - Denied, peer to peer: 25
    - Denied, not a covered benefit: 2
  - MD referral rate: 10.2%
  - Denial rate: 7.99%
- M/S OP: 53,197
  - Approved: 49,626
  - Denied: 3,537
    - Administrative denial, lack of member eligibility: 302
    - Administrative denial, mandated paperwork not provided: 1
    - Administrative denial, non-covered service: 495
    - Administrative denial, benefit exhausted: 9
    - Denied, member coverage: 2
    - Denied, non-participating provider: 116
    - Denied, not a covered benefit: 51
    - Denied, not medically necessary: 2412
    - Denied on appeal: 3
    - Denied peer to peer: 25
  - Partial denial: 118
  - MD referral rate: 3.4%
  - Denial rate: 6.87%

- MH/SUD IP: 508
    - Approved:486
    - Denied: 32
        - Administrative Denial, Non-covered Service: 11
        - Approved Reconsideration: 1
        - Denied, Non-Participating Provider: 3
        - Denied, Not Medically Necessary: 8
        - Denied, Peer to Peer: 1
        - Denied, not a covered benefit: 1
    - MD referral rate: 25.4%
    - Denial rate: 6.3%
- MH/SUD OP: 328
    - Approved: 306
    - Denied: 21
        - Administrative denial, non-covered service: 11
        - Administrative denial, lack of member eligibility: 4
        - Denied, non-participating provider: 6
    - Partial denial: 1
    - MD referral rate: 14.6%
    - Denial rate: 6.71%

Despite higher MD referral rate for MH/SUD IP and OP services, the denial rate is consistent across all service types. Most common denial reasons across all services include lack of member eligibility, non-covered service, and not medically necessary.

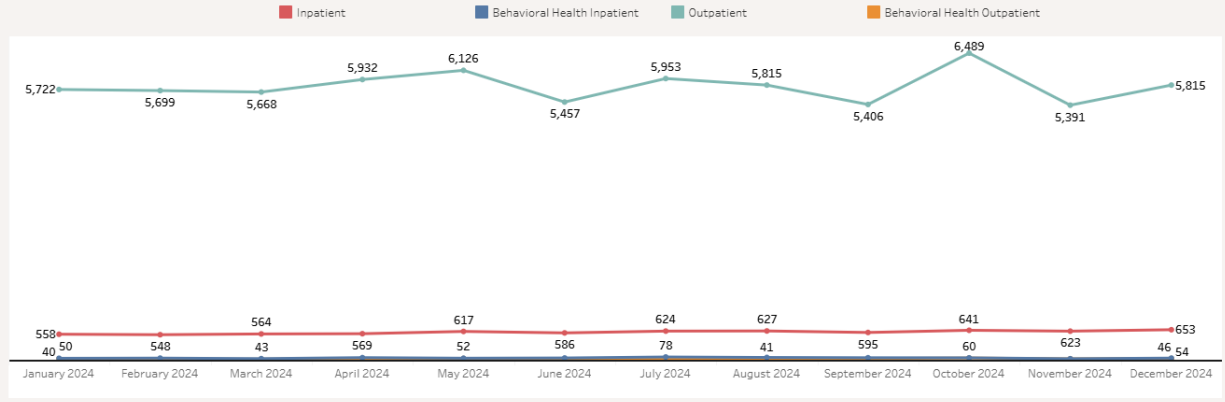
UM data and analysis (1/1/24-12/31/24)

AUTH VOLUME BY DECISION



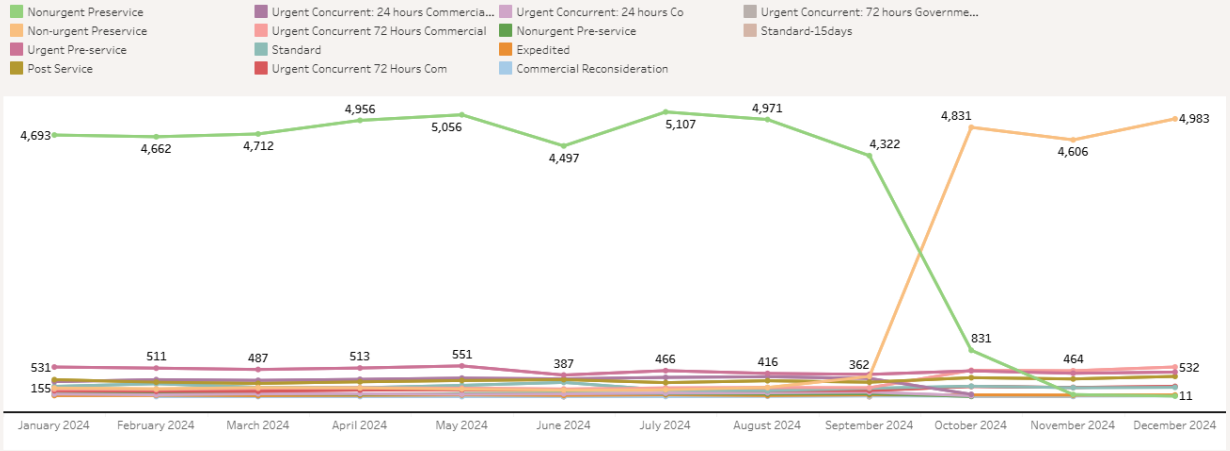
	Grand Total	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 20..	October 2024	November 2024	December 2024
Grand Total	76,871	6,370	6,331	6,307	6,611	6,840	6,134	6,698	6,551	6,109	7,246	6,094	6,568
Approved	68,618	5,601	5,598	5,610	5,865	6,164	5,560	6,045	5,848	5,473	6,457	5,455	5,915
Denied	8,409	781	739	721	765	692	578	665	717	657	787	651	660
Partial Denial	176	10	16	7	11	7	15	20	9	15	31	14	21

AUTH VOLUME BY EPISODE TYPE



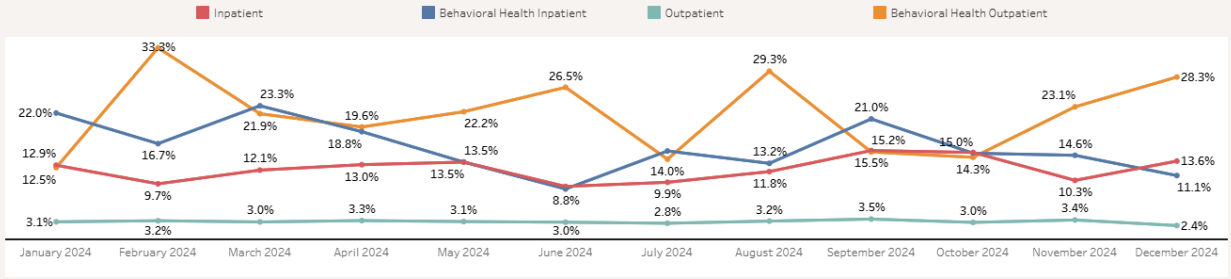
	Grand Total	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2..	October 2024	November 20..	December 20..
Grand Total	76,871	6,370	6,331	6,307	6,611	6,840	6,134	6,698	6,551	6,109	7,246	6,094	6,568
Inpatient	6,691	558	548	564	569	617	586	624	627	595	641	623	653
Behavioral Health Inpatient	605	50	54	43	64	52	57	78	68	62	60	41	54
Outpatient	69,079	5,722	5,699	5,668	5,932	6,126	5,457	5,953	5,815	5,406	6,489	5,391	5,815
Behavioral Health Outpatient	496	40	30	32	46	45	34	43	41	46	56	39	46

AUTH VOLUME BY PRIORITY



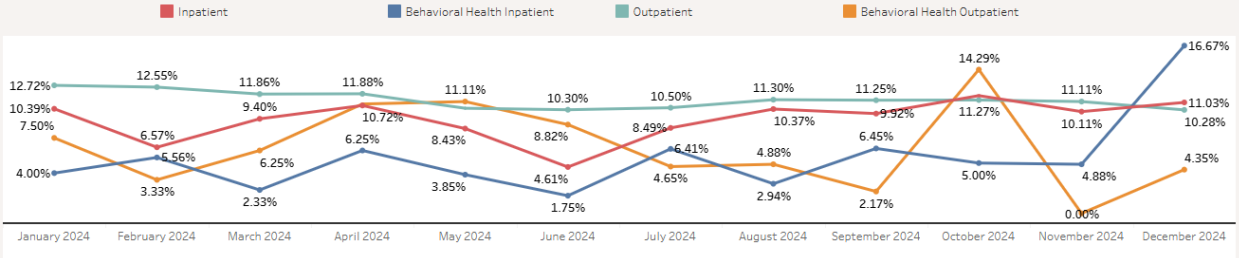
	Grand To..	January 2024	February 20..	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September ..	October 20..	November 2..	December 2..
Grand Total	76,871	6,370	6,331	6,307	6,611	6,840	6,134	6,698	6,551	6,109	7,246	6,094	6,568
Nonurgent Preservice	43,761	4,693	4,662	4,712	4,956	5,056	4,497	5,107	4,971	4,322	831	37	11
Non-urgent Preservice	15,921	155	139	163	156	134	115	123	163	362	4,831	4,606	4,983
Urgent Pre-service	5,576	531	511	487	513	551	387	466	416	399	462	419	440
Post Service	3,454	304	259	237	266	289	306	251	285	259	340	317	363

MD REFERRAL RATE BY EPISODE TYPE



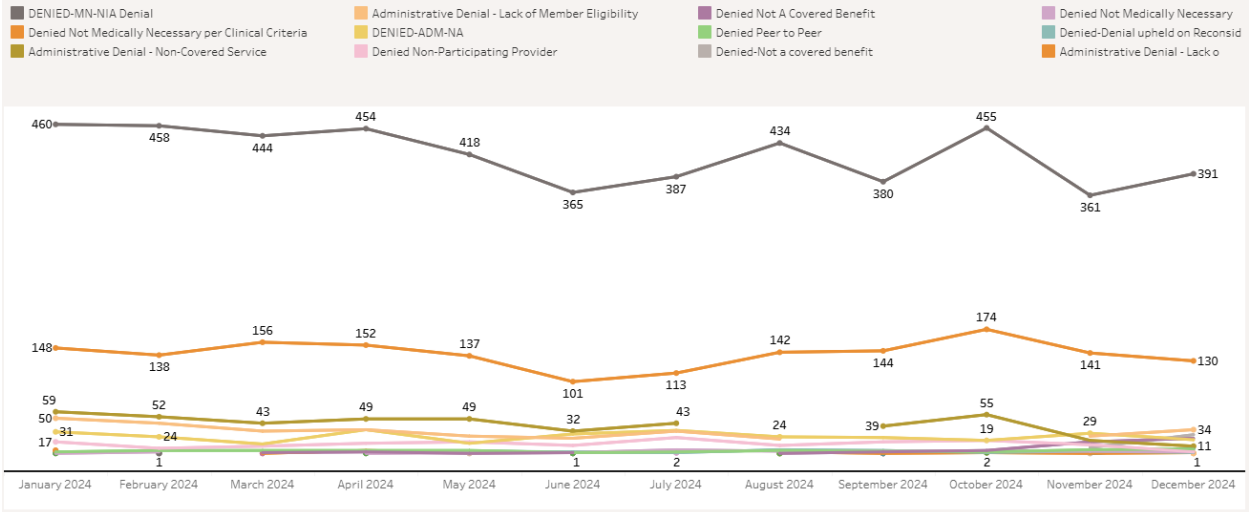
	Grand Total	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024
Grand Total	4.2%	4.1%	4.1%	4.1%	4.4%	4.2%	3.8%	3.7%	4.3%	5.0%	4.2%	4.3%	3.8%
Inpatient	13.1%	12.9%	9.7%	12.1%	13.0%	13.5%	9.2%	9.9%	11.8%	15.5%	15.1%	10.3%	13.6%
Behavioral Health Inpatient	16.9%	22.0%	16.7%	23.3%	18.8%	13.5%	8.8%	15.4%	13.2%	21.0%	15.0%	14.6%	11.1%
Outpatient	3.1%	3.1%	3.2%	3.0%	3.3%	3.1%	3.0%	2.8%	3.2%	3.5%	3.0%	3.4%	2.4%
Behavioral Health Outpatient	21.2%	12.5%	33.3%	21.9%	19.6%	22.2%	26.5%	14.0%	29.3%	15.2%	14.3%	23.1%	28.3%

DENIAL RATE BY EPISODE TYPE



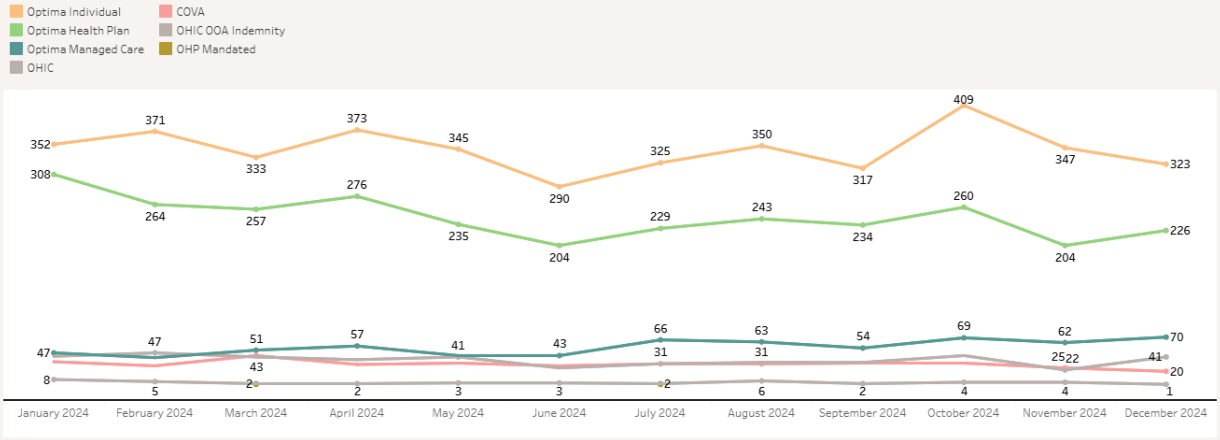
	Grand Total	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024
Grand Total	11.16%	12.42%	11.93%	11.54%	11.72%	10.22%	9.67%	10.23%	11.08%	11.00%	11.28%	10.90%	10.37%
Inpatient	10.06%	10.39%	6.57%	9.40%	10.72%	8.43%	4.61%	8.49%	10.37%	9.92%	11.70%	10.11%	11.03%
Behavioral Health Inpatient	6.28%	4.00%	5.56%	2.33%	6.25%	3.85%	1.75%	6.41%	2.94%	6.45%	5.00%	4.88%	16.67%
Outpatient	11.34%	12.72%	12.55%	11.86%	11.88%	10.45%	10.30%	10.50%	11.30%	11.25%	11.27%	11.11%	10.28%
Behavioral Health Outpatient	6.85%	7.50%	3.33%	6.25%	10.87%	11.11%	8.82%	4.65%	4.88%	2.17%	14.29%	0.00%	4.35%

DENIAL VOLUME BY DENIAL REASON

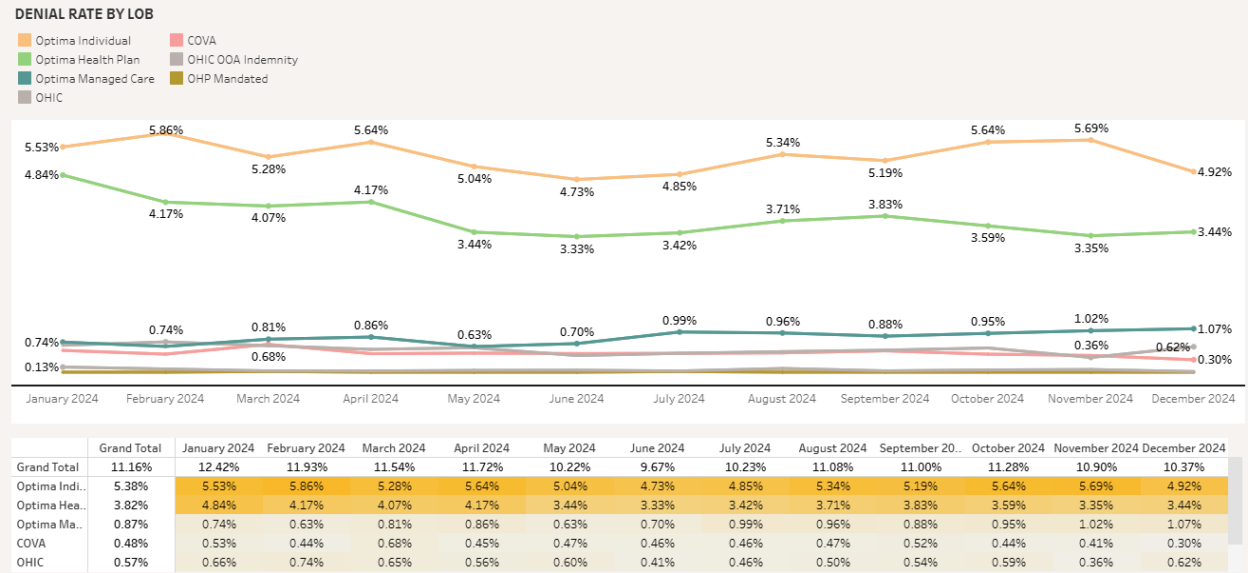


	Grand Total	January 20..	February 2..	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September ..	October 20..	November ..	December ..
Grand Total	8,161	775	732	709	752	676	570	644	655	621	740	631	659
Administrative Denial - Lack o	22	5		1	5	2			3	1	2	1	2
Administrative Denial - Lack of Member Eligibility	318	50	43	32	34	25	22	32	21			25	34
Administrative Denial - Mandated paperwork not pr..	3	1					1		1				
Administrative Denial - Non-Covered Service	451	59	52	43	49	49	32	43		39	55	19	11
Denied Behavioral Health Benefit	1		1										
Denied Member Coverage	2			1						1			
Denied Non-Participating Provider	166	17	8	11	15	17	12	23	12	17	19	13	3

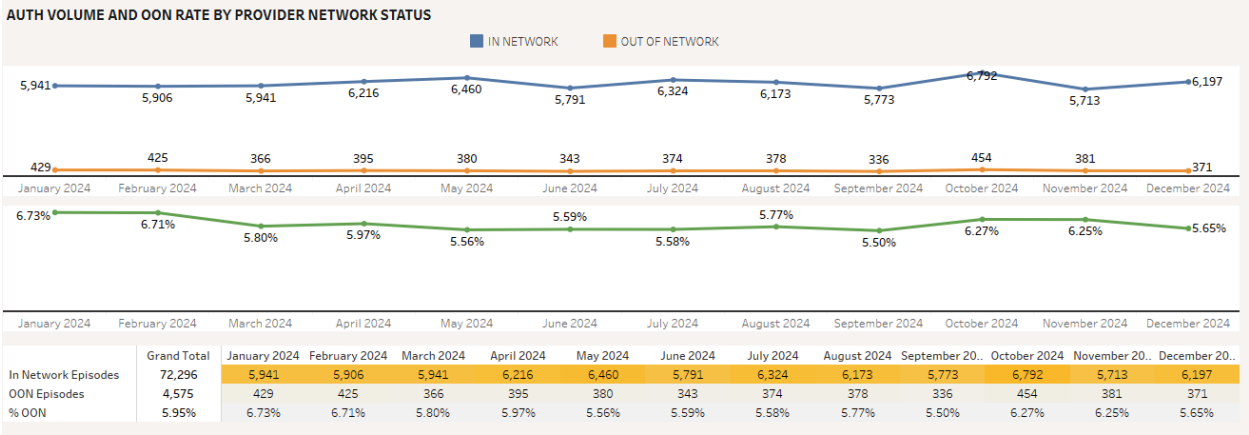
DENIAL VOLUME BY LOB



	Grand Total	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 20..	October 2024	November 20..	December 20..
Grand Total	8,582	791	755	728	775	699	593	685	726	672	817	664	681
Optima Individual	4,132	352	371	333	373	345	290	325	350	317	409	347	323
Optima Health Plan	2,939	308	264	257	276	235	204	229	243	234	260	204	226
Optima Managed Care	665	47	40	51	57	43	43	66	63	54	69	62	70
OHIC	436	42	47	41	37	41	25	31	33	33	43	22	41
COVA	366	34	28	43	30	32	28	31	31	32	32	25	20
OHIC OOA Indemnity	42	8	5	2	2	3	3	2	6	2	4	4	1
OHP Mandated	2			1				1					



	Grand Total	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 20..	October 2024	November 2024	December 2024
Grand Total	11.16%	12.42%	11.93%	11.54%	11.72%	10.22%	9.67%	10.23%	11.08%	11.00%	11.28%	10.90%	10.37%
Optima Indi..	5.38%	5.53%	5.86%	5.28%	5.64%	5.04%	4.73%	4.85%	5.34%	5.19%	5.64%	5.69%	4.92%
Optima Hea..	3.82%	4.84%	4.17%	4.07%	4.17%	3.44%	3.33%	3.42%	3.71%	3.83%	3.59%	3.35%	3.44%
Optima Ma..	0.87%	0.74%	0.63%	0.81%	0.86%	0.63%	0.70%	0.99%	0.96%	0.88%	0.95%	1.02%	1.07%
COVA	0.48%	0.53%	0.44%	0.68%	0.45%	0.47%	0.46%	0.46%	0.47%	0.52%	0.44%	0.41%	0.30%
OHIC	0.57%	0.66%	0.74%	0.65%	0.56%	0.60%	0.41%	0.46%	0.50%	0.54%	0.59%	0.36%	0.62%



	Grand Total	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 20..	October 2024	November 20..	December 20..
In Network Episodes	72,296	5,941	5,906	5,941	6,216	6,460	5,791	6,324	6,173	5,773	6,792	5,713	6,197
OON Episodes	4,575	429	425	366	395	380	343	374	378	336	454	381	371
% OON	5.95%	6.73%	6.71%	5.80%	5.97%	5.56%	5.59%	5.58%	5.77%	5.50%	6.27%	6.25%	5.65%

2024 Analysis

Total Auths: 76,871

- M/S IP:
  - Approved: 6,691
  - Denied: 673
    - Administrative denial, lack of member eligibility: 66
    - Administrative denial, non-covered service: 28
    - Denied, non-participating provider: 2
    - Denied, not medically necessary: 519
    - Denied, peer to peer: 31
    - Denied, not a covered benefit: 5
    - Denial upheld on reconsideration: 18
  - MD referral rate: 13.1%
  - Denial rate: 10.06%

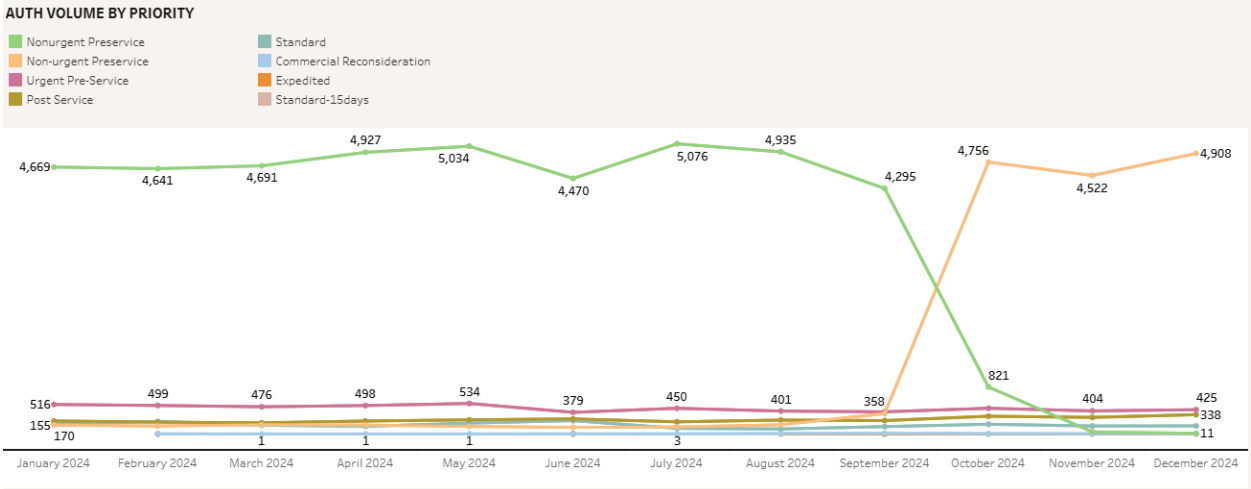
- M/S OP: 69,079
    - Approved: 61,484
    - Denied: 7,666
        - Administrative denial, lack of member eligibility: 304
        - Administrative denial, mandated paperwork not provided: 3
        - Administrative denial, non-covered service: 390
        - Administrative denial, benefit exhausted:
        - Denied, member coverage: 2
        - Denied, non-participating provider: 160
        - Denied, not a covered benefit: 58
        - Denied, not medically necessary: 1187
        - Denied, on appeal: 2
        - Denied, peer to peer: 22
    - Partial denial: 174
    - MD referral rate: 3.1%
    - Denial rate: 11.34%
- MH/SUD IP: 605
    - Approved: 575
    - Denied: 38
        - Administrative Denial, Non-covered Service: 19
        - Administrative denial, lack of member eligibility: 11
        - Denied, Non-Participating Provider: 2
        - Denied, Not Medically Necessary: 5
        - Denial upheld on reconsideration: 1
    - MD referral rate: 16.9%
    - Denial rate: 6.28%
- MH/SUD OP: 496
    - Approved: 462
    - Denied: 32
        - Administrative denial, non-covered service: 19
        - Administrative denial, lack of member eligibility: 8
        - Denied, non-participating provider: 2
        - Denied, not medically necessary: 3
    - Partial denial: 2
    - MD referral rate: 21.2%
    - Denial rate: 6.85%

Despite higher MD referral rate for MH/SUD IP and OP services, the denial rate for M/S is higher than MH/SUD services. Most common denial reasons across all services include lack of member eligibility and non-covered services.

OUTPATIENT AUTH BY PRIORITY

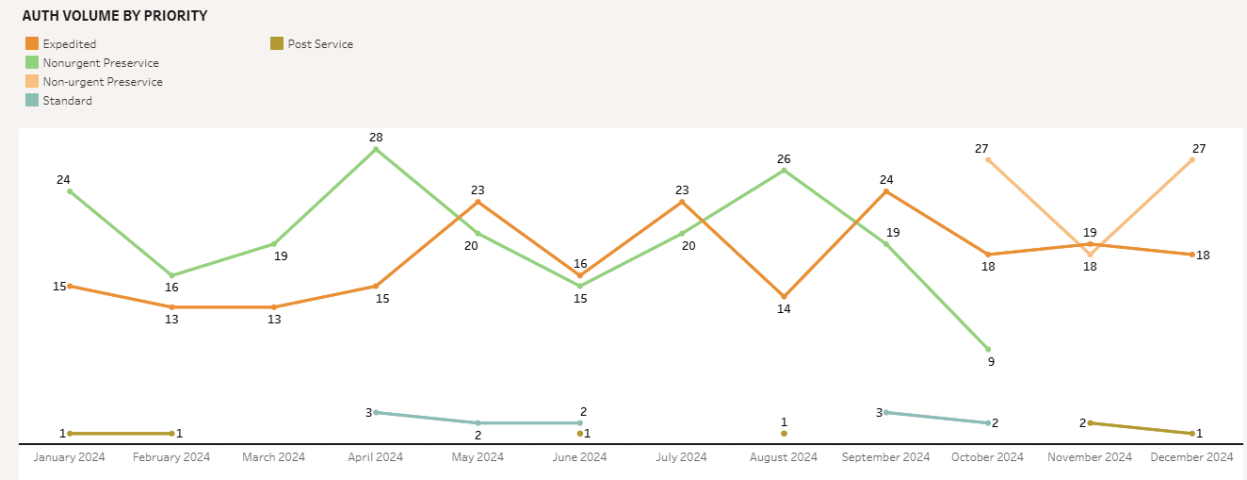
2024:

M/S



	Grand To..	January 2024	February 20..	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September ..	October 20..	November 2..	December 2..
Grand Total	69,072	5,722	5,699	5,667	5,932	6,126	5,455	5,950	5,812	5,406	6,494	5,388	5,815
Nonurgent Preservice	43,513	4,669	4,641	4,691	4,927	5,034	4,470	5,076	4,935	4,295	821	37	11
Non-urgent Preservice	15,682	155	139	163	156	132	116	123	162	358	4,756	4,522	4,908
Urgent Pre-Service	5,414	516	499	476	498	534	379	450	401	388	450	404	425
Post Service	2,982	228	208	196	227	248	264	213	244	235	311	291	338

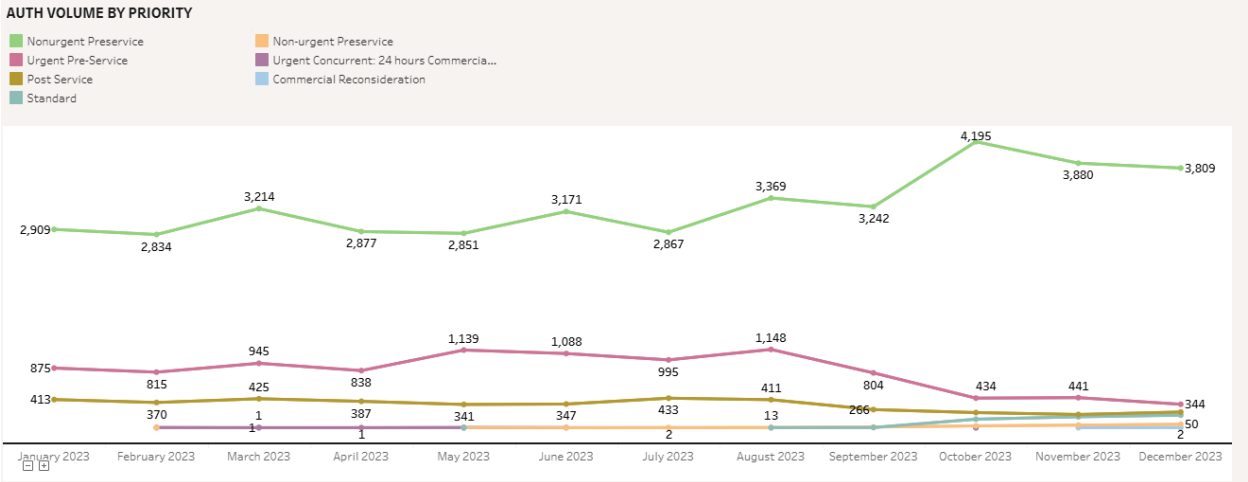
MH/SUD



	Grand To..	January 2024	February 20..	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September ..	October 20..	November 2..	December 2..
Grand Total	496	40	30	32	46	45	34	43	41	46	56	39	46
Expedited	211	15	13	13	15	23	16	23	14	24	18	19	18
Nonurgent Preservice	196	24	16	19	28	20	15	20	26	19	9		
Non-urgent Preservice	72										27	18	27
Standard	12				3	2	2			3	2		

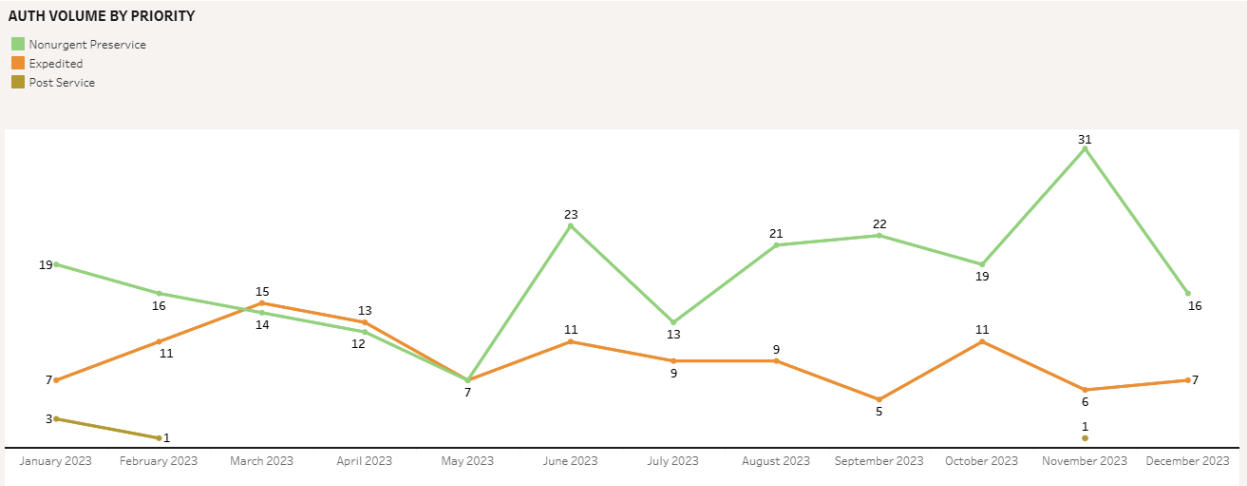
2023:

M/S



	Grand To..	January 2023	February 20..	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September ..	October 20..	November 2..	December 2..
Grand Total	53,197	4,183	4,011	4,576	4,091	4,324	4,593	4,290	4,920	4,320	5,000	4,708	4,613
Nonurgent Preservice	39,106	2,909	2,834	3,214	2,877	2,851	3,171	2,867	3,369	3,242	4,195	3,880	3,809
Urgent Pre-Service	9,861	875	815	945	838	1,139	1,088	995	1,148	804	434	441	344
Post Service	3,987	413	370	425	387	341	347	433	411	266	222	194	230
Standard	473					1			1	3	125	160	184

MH/SUD

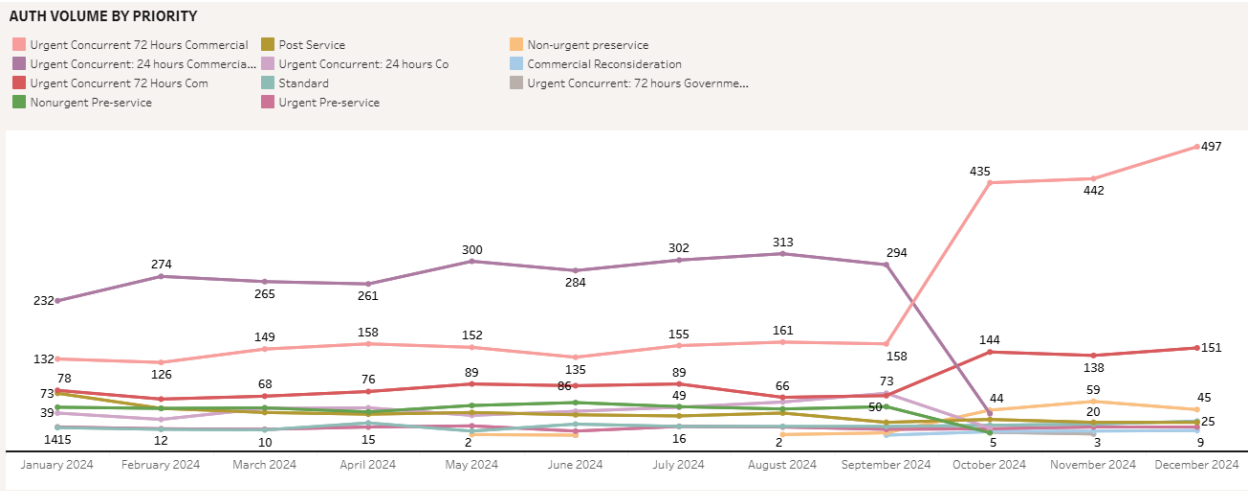


	Grand Total	January 2023	February 2023	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023
Grand Total	328	29	28	29	25	14	34	22	30	27	30	38	23
Nonurgent Preservice	212	19	16	14	12	7	23	13	21	22	19	31	16
Expedited	111	7	11	15	13	7	11	9	9	5	11	6	7
Post Service	5	3	1									1	

INPATIENT AUTH BY PRIORITY

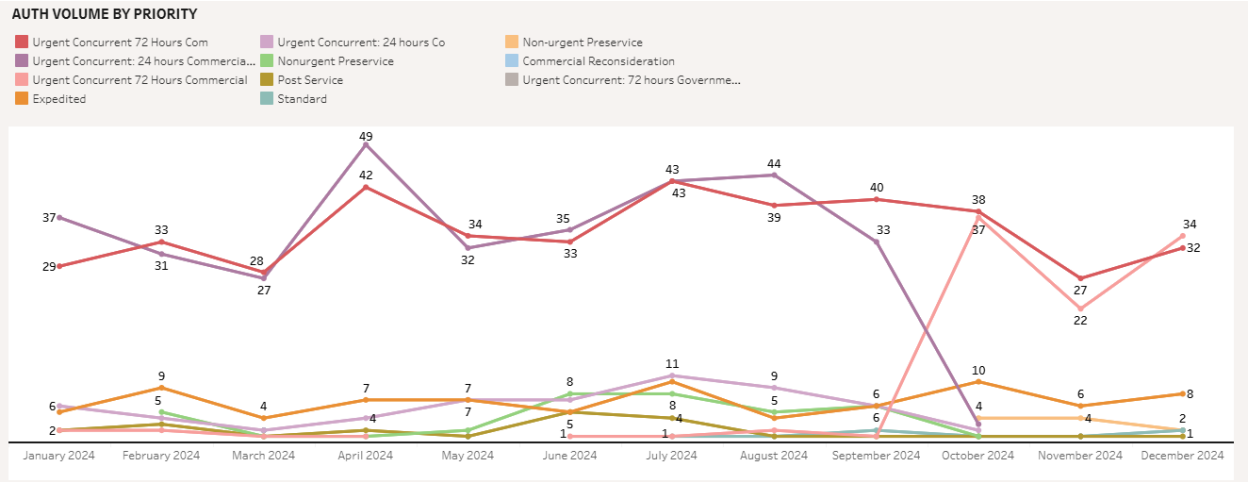
2024:

M/S



	Grand To..	January 2024	February 20..	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September ..	October 20..	November 2..	December 2..
Grand Total	6,690	558	548	564	569	617	586	624	627	595	641	623	652
Urgent Concurrent 72 Hours Commercial	2,700	132	126	149	158	152	135	155	161	158	435	442	497
Urgent Concurrent: 24 hours Commercial UM	2,563	232	274	265	261	300	284	302	313	294	38		
Urgent Concurrent 72 Hours Com	1,025	78	63	68	76	89	86	89	66	69	144	138	151
Nonurgent Pre-service	443	49	47	48	41	52	57	50	46	50	5		

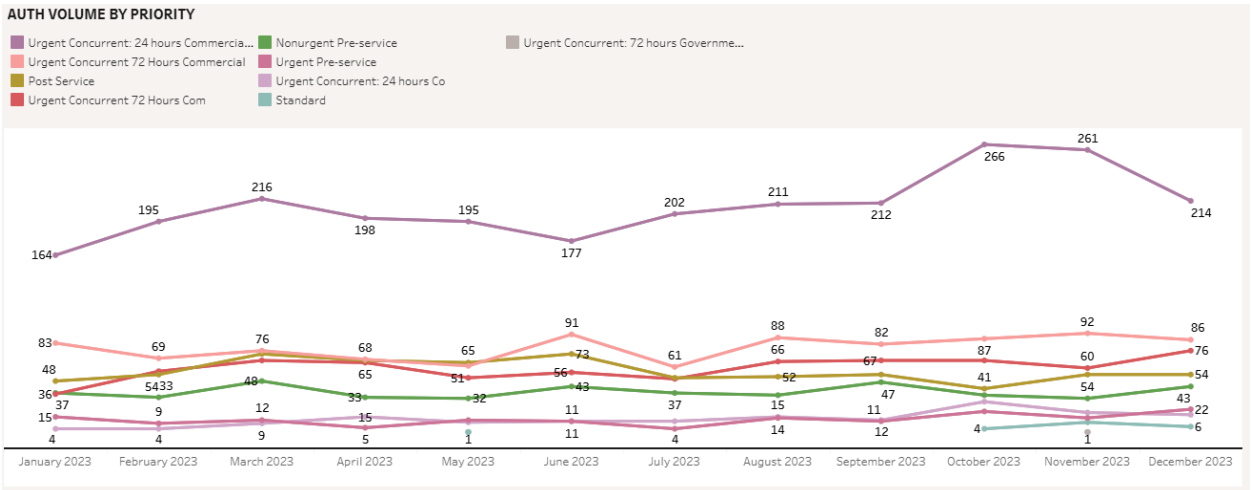
MH/SUD



	Grand To..	January 2024	February 20..	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September ..	October 20..	November 2..	December 2..
Urgent Concurrent: 24 hours Co	51	6	4	2	4	7	7	11	9	6	2		
Nonurgent Preservice	37		5	1	1	2	8	8	5	6	1		
Post Service	23	2	3	1	2	1	5	4	1	1	1	1	1
Standard	11			2		1		1	1	2	1	1	2
Non-urgent Preservice	10										4	4	2

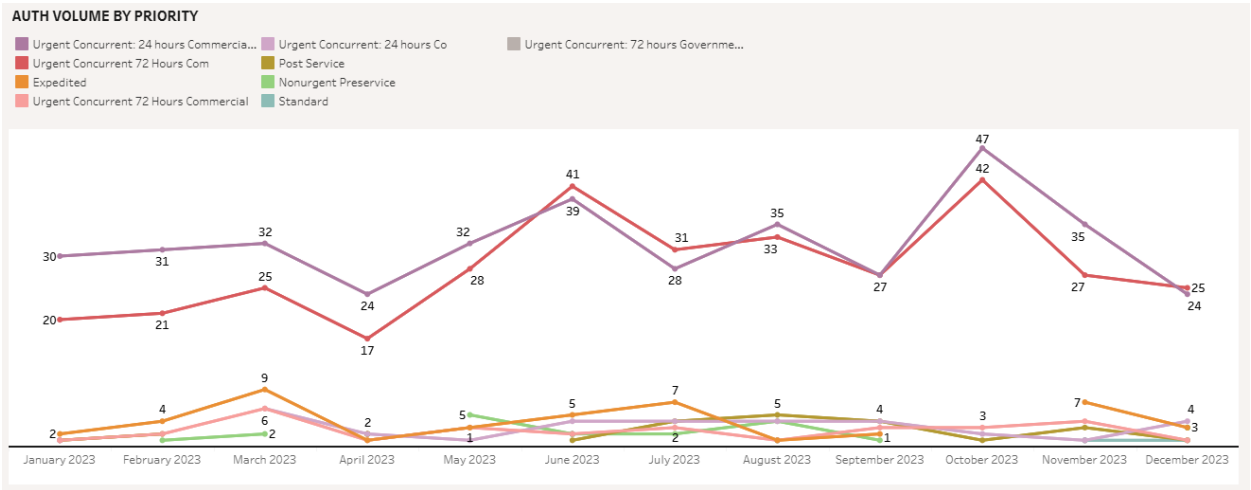
2023:

M/S



	Grand To..	January 2023	February 20..	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September ..	October 20..	November 2..	December 2..
Grand Total	4,753	347	381	453	416	386	420	384	428	437	497	487	461
Urgent Concurrent: 24 hours Commercial UM	2,511	164	195	216	198	195	177	202	211	212	266	261	214
Urgent Concurrent 72 Hours Commercial	945	83	69	76	68	62	91	61	88	82	87	92	86
Post Service	685	48	54	73	67	65	73	51	52	54	41	54	54
Urgent Concurrent 72 Hours Com	654	36	57	67	65	51	56	50	66	67	67	60	76

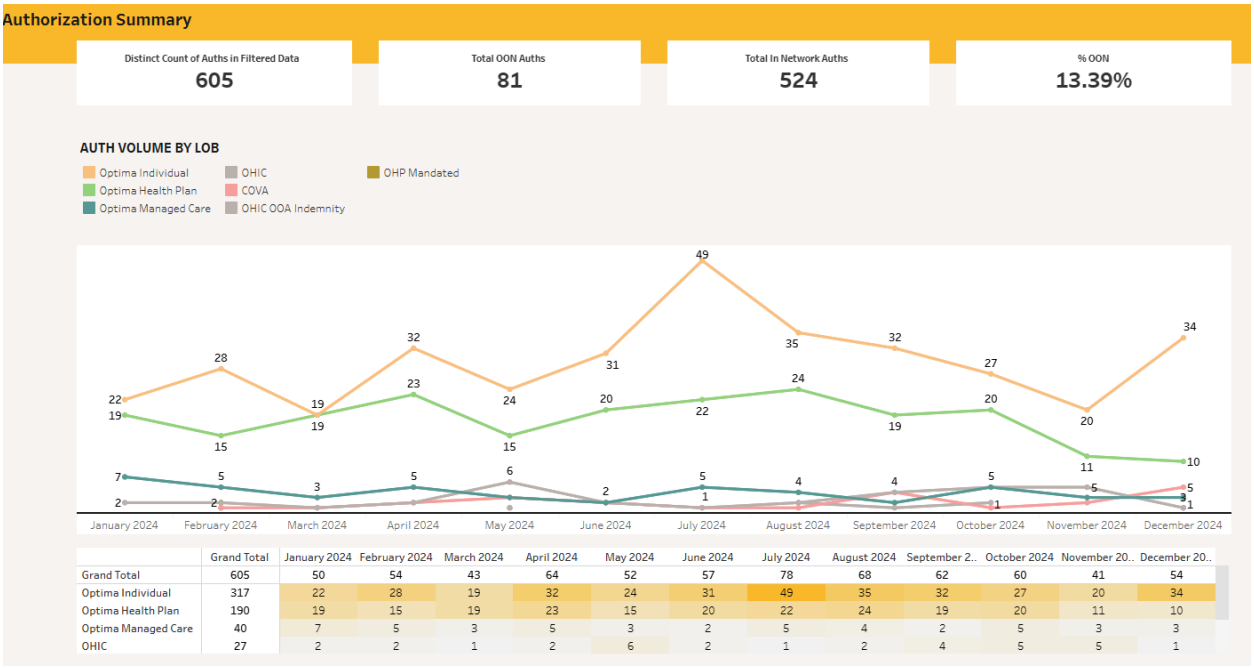
MH/SUD



	Grand To..	January 2023	February 20..	March 2023	April 2023	May 2023	June 2023	July 2023	August 2023	September ..	October 20..	November 2..	December 2..
Grand Total	508	34	42	54	34	46	58	51	52	47	55	52	38
Urgent Concurrent: 24 hours Commercial UM	384	30	31	32	24	32	39	28	35	27	47	35	24
Urgent Concurrent 72 Hours Com	312	20	21	25	17	28	41	31	33	27	42	27	25
Expedited	44	2	4	9	1	3	5	7	1	2		7	3
Urgent Concurrent 72 Hours Commercial	30	1	2	6	1	3	2	3	1	3	3	4	1

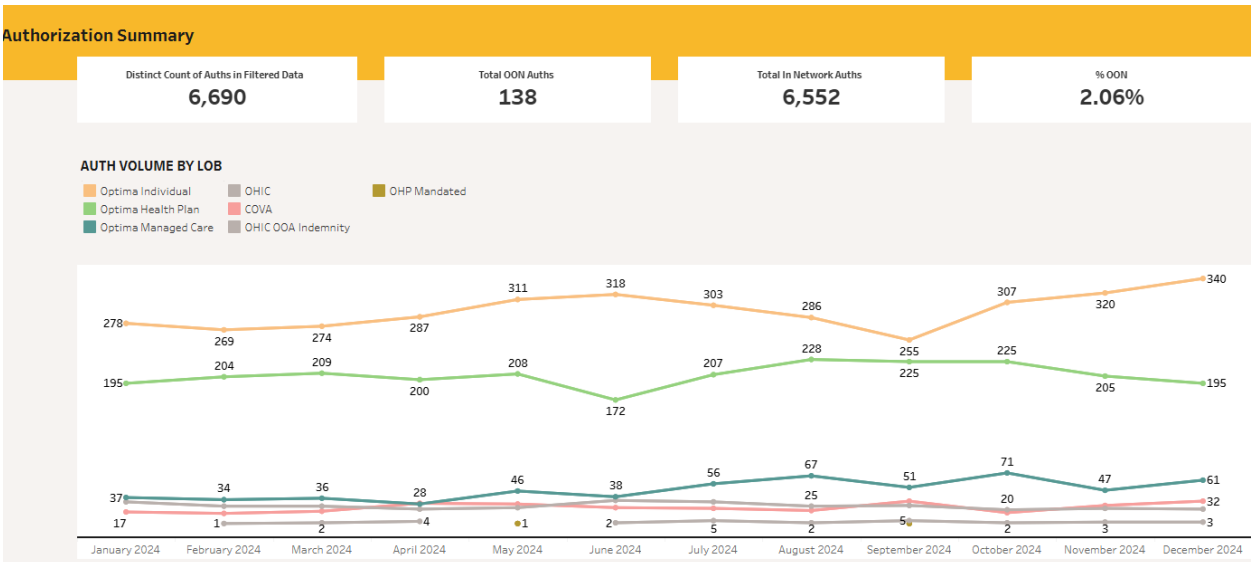
2024: Authorization by Line of Business

MH/SUD Inpatient



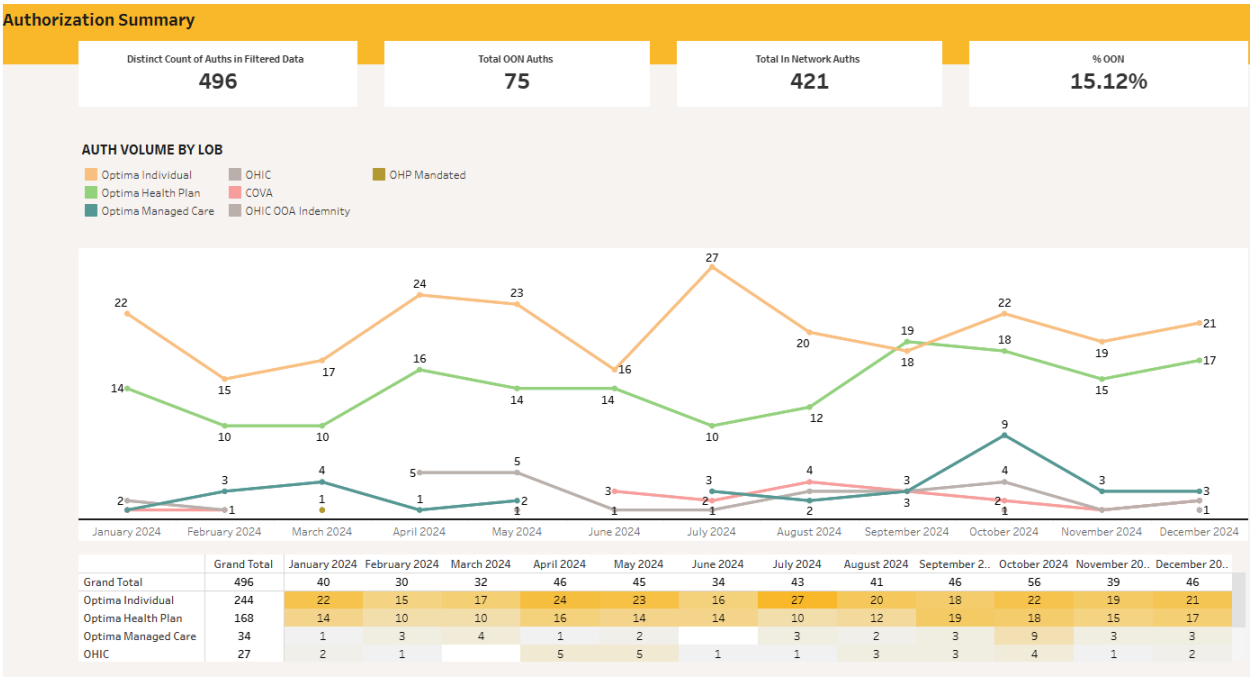
	Grand Total	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2..	October 2024	November 20..	December 20..
Grand Total	605	50	54	43	64	52	57	78	68	62	60	41	54
Optima Individual	317	22	28	19	32	24	31	49	35	32	27	20	34
Optima Health Plan	190	19	15	19	23	15	20	22	24	19	20	11	10
Optima Managed Care	40	7	5	3	5	3	2	5	4	2	5	3	3
OHIC	27	2	2	1	2	6	2	1	2	4	5	5	1

M/S Inpatient



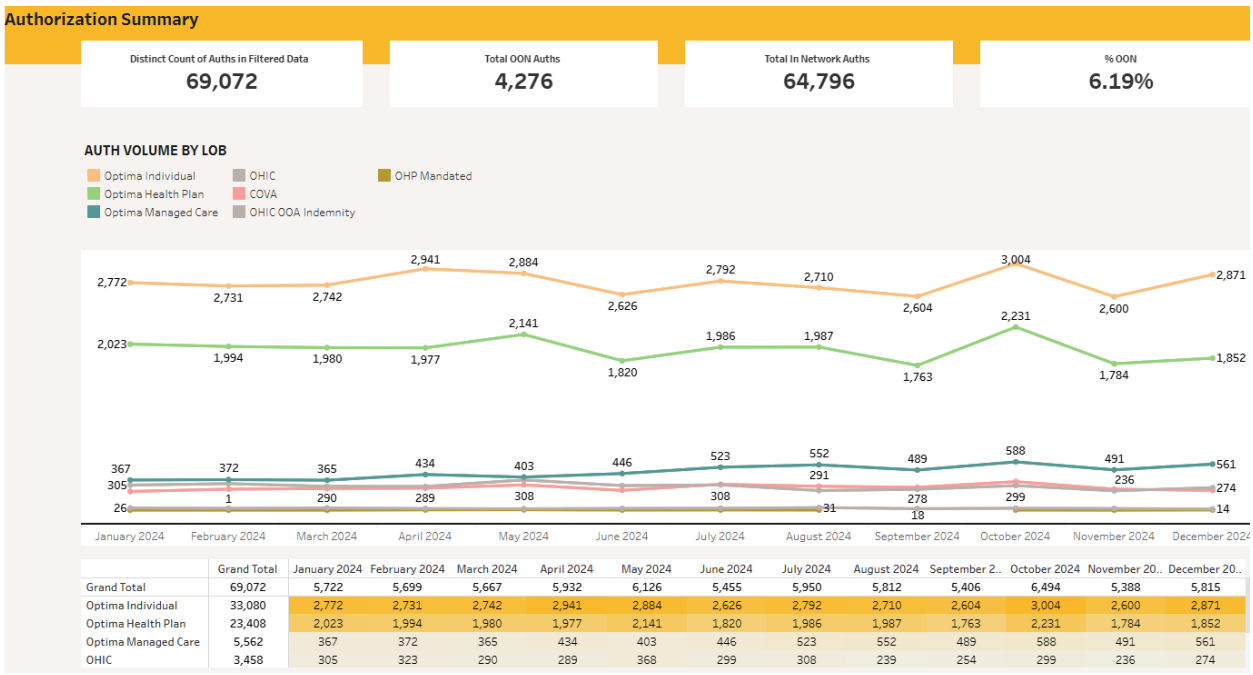
	Grand Total	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2..	October 2024	November 20..	December 20..
Grand Total	6,690	558	548	564	569	617	586	624	627	595	641	623	652
Optima Individual	3,279	278	269	274	287	311	318	303	286	255	307	320	340
Optima Health Plan	2,308	195	204	209	200	208	172	207	228	225	225	205	195
Optima Managed Care	526	37	34	36	28	46	38	56	67	51	71	47	61
OHIC	284	31	25	25	21	23	33	31	25	26	20	22	21

MH/SUD Outpatient



	Grand Total	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2..	October 2024	November 20..	December 20..
Grand Total	496	40	30	32	46	45	34	43	41	46	56	39	46
Optima Individual	244	22	15	17	24	23	16	27	20	18	22	19	21
Optima Health Plan	168	14	10	10	16	14	14	10	12	19	18	15	17
Optima Managed Care	34	1	3	4	1	2		3	2	3	9	3	3
OHIC	27	2	1		5	5	1	1	3	3	4	1	2

M/S Outpatient



	Grand Total	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2..	October 2024	November 20..	December 20..
Grand Total	69,072	5,722	5,699	5,667	5,932	6,126	5,455	5,950	5,812	5,406	6,494	5,388	5,815
Optima Individual	33,080	2,772	2,731	2,742	2,941	2,884	2,626	2,792	2,710	2,604	3,004	2,600	2,871
Optima Health Plan	23,408	2,023	1,994	1,980	1,977	2,141	1,820	1,986	1,987	1,763	2,231	1,784	1,852
Optima Managed Care	5,562	367	372	365	434	403	446	523	552	489	588	491	561
OHIC	3,458	305	323	290	289	368	299	308	239	254	299	236	274

2024 APPEALS

Received Appeals	LOB	Member received	Closed	Provider Received	Closed
Optima Health Plan	1	209	209	32	32
Optima Individual	1X	310	310	47	47
Optima Managed Care	17A	52	52	7	7
OHIC	5	38	38	12	12
COVA	1V	33	33	2	2
OHIC OOA indemnity	4A	3	3	2	2
OHP Mandated	1H	0	0	0	0
Member Appeals Decisions	**Total**	**Overturned**	**Upheld**	**Voided**	**Invalid**
Optima Health Plan	209	91	102	1	8
Optima Individual	310	156	146	6	1
Optima Managed Care	52	26	26	0	0
OHIC	38	18	19	0	0
COVA	33	9	23	1	0
OHIC OOA indemnity	3	3	0	0	0
OHP Mandated	0	0	0	0	0
Provider Appeals Decisions	**Total**	**Overturned**	**Upheld**	**Voided**	**Invalid**
Optima Health Plan	32	6	18	1	1
Optima Individual	47	20	17	3	0
Optima Managed Care	7	3	3	0	0
OHIC	12	3	5	1	0
COVA	2	1	1	0	0
OHIC OOA indemnity	2	0	1	0	0
OHP Mandated	0	0	0	0	0
Member Appeal Reasons	**Total**	**Billing/Financial**	**DME**	**OP Procedure**	**Other**
Optima Health Plan	209	10	3	21	4
Optima Individual	310	38	3	12	12
Optima Managed Care	52	2	1	3	2
OHIC	38	1	1	1	4
COVA	33	5	1	1	4
OHIC OOA indemnity	3	0	0	0	0
OHP Mandated	0	0	0	0	0
Provider Appeal Reasons	**Total**	**MS Medical Necessity**	**BH Medical Necessity**	**Other**	
Optima Health Plan	32	9	0	23	

Optima Individual	47	15	1	31	
Optima Managed Care	7	2	0	5	
OHIC	12	5	0	7	
COVA	2	0	0	2	
OHIC OOA indemnity	2	2	0	0	
OHP Mandated	0	0	0	0	

Withdrawn		
5		
1		
0		
1		
0		
0		
0		
Withdrawn		
6		
7		
1		
3		
0		
1		
0		
Pharmacy	**Radiology**	**BH/SU**
125	16	2
190	17	0
39	4	1
25	5	1
20	1	1
3	0	0
0	0	0

MONTH	LOB	HANGUPS	HOTLINE	EMAILS	OTHER SOURCE (i. e. internal emails directly to staff)	MONTHLY TOTALS	Number Not Pursued	Number In Triage/Pending Review	Number Opened as a Case/Pending Assignment
January	Medallion 4 (OFC)	0	5	9	4	**18**	12	4	2
	CCC Plus (OHCC)	0	3	6	16	**25**	11	13	1
	Medicare/DNSP	0	14	6	4	**24**	19	4	1
	Federal Employees (FEHBP)	0	0	1	0	**1**	1	0	0
	Commercial	0	8	27	5	**40**	33	6	1
	Other (provider inquiry)	0	0	0	0	**0**	0	0	0
	Insufficient Information / unable to contact source / duplicates / hangups		48	13	6	**67**	67	0	0
	Total # received	0	78	62	35	**175**	143	27	5
Feburary	Medallion 4 (OFC)	0	1	5	6	**12**	7	5	0
	CCC Plus (OHCC)	0	6	5	12	**23**	13	8	2
	Medicare/DNSP	0	12	7	3	**22**	21	1	0
	Federal Employees (FEHBP)	0	0	0	0	**0**	0	0	0
	Commercial	0	1	27	2	**30**	26	4	0
	Other (provider inquiry)	0	0	0	0	**0**	0	0	0
	Insufficient Information / unable to contact source / duplicates / hangups		47	9	10	**66**	66	0	0
	Total # received	0	67	53	33	**153**	133	18	2
March	Medallion 4 (OFC)	0	6	7	7	**20**	13	7	0
	CCC Plus (OHCC)	0	3	6	13	**22**	13	8	1
	Medicare/DNSP	0	14	8	7	**29**	22	6	1
	Federal Employees (FEHBP)	0	0	0	0	**0**	0	0	0
	Commercial	0	12	24	1	**37**	34	3	0
	Other (provider inquiry)	0	0	0	0	**0**	0	0	0
	Insufficient Information / unable to contact source / duplicates / hangups		69	21	13	**103**	103	0	0
	Total # received	0	104	66	41	**211**	185	24	2
April	Medallion 4 (OFC)	0	7	6	11	**24**	17	7	0
	CCC Plus (OHCC)	0	2	2	7	**11**	8	3	0
	Medicare/DNSP	0	12	7	9	**28**	25	0	3
	Federal Employees (FEHBP)	0	0	0	0	**0**	0	0	0
	Commercial	0	9	26	1	**36**	30	5	1

	Other (provider inquiry)	0	0	0	0	**0**	0	0	0
	Insufficient Information / unable to contact source / duplicates / hangups		55	19	15	**89**	89	0	0
	Total # received	0	85	60	43	**188**	169	15	4
May	Medallion 4 (OFC)	0	4	12	13	**29**	19	9	1
	CCC Plus (OHCC)	0	1	2	5	**8**	4	3	1
	Medicare/DNSP	0	17	6	5	**28**	22	3	3
	Federal Employees (FEHBP)	0	0	0	0	**0**	0	0	0
	Commercial	0	4	22	1	**27**	24	3	0
	Other (provider inquiry)	0	0	0	0	**0**	0	0	0
	Insufficient Information / unable to contact source / duplicates / hangups		55	8	22	**85**	85	0	0
	Total # received	0	81	50	46	**177**	154	18	5
June	Medallion 4 (OFC)	0	3	5	6	**14**	6	8	0
	CCC Plus (OHCC)	0	0	0	10	**10**	4	6	0
	Medicare/DNSP	0	15	7	1	**23**	20	2	1
	Federal Employees (FEHBP)	0	0	1	0	**1**	1	0	0
	Commercial	0	6	21	1	**28**	23	5	0
	Other (provider inquiry)	0	0	0	0	**0**	0	0	0
	Insufficient Information / unable to contact source / duplicates / hangups		48	13	14	**75**	75	0	0
	Total # received	0	72	47	32	**151**	129	21	1
July	Medallion 4 (OFC)	0	2	10	11	**23**	14	9	0
	CCC Plus (OHCC)	0	0	8	23	**31**	11	19	1
	Medicare/DNSP	0	7	7	1	**15**	14	0	1
	Federal Employees (FEHBP)	0	0	0	0	**0**	0	0	0
	Commercial	0	2	23	2	**27**	24	3	0
	Other (provider inquiry)	0	0	0	0	**0**	0	0	0
	Insufficient Information / unable to contact source / duplicates / hangups		34	14	14	**62**	62	0	0
	Total # received	0	45	62	51	**158**	125	31	2
August	Medallion 4 (OFC)	0	3	7	4	**14**	10	4	0
	CCC Plus (OHCC)	0	1	8	3	**12**	8	4	0
	Medicare/DNSP	0	13	5	4	**22**	17	1	4
	Federal Employees (FEHBP)	0	0	0	0	**0**	0	0	0
	Commercial	0	6	16	0	**22**	19	3	0

	Other (provider inquiry)	0	0	0	0	**0**	0	0	0
	Insufficient Information / unable to contact source / duplicates / hangups		51	14	16	**81**	81	0	0
	Total # received	0	74	50	27	**151**	135	12	4
September	Medallion 4 (OFC)	0	7	9	3	**19**	14	5	0
	CCC Plus (OHCC)	0	2	4	10	**16**	9	7	0
	Medicare/DNSP	0	10	4	1	**15**	10	4	1
	Federal Employees (FEHBP)	0	0	0	0	**0**	0	0	0
	Commercial	0	5	28	0	**33**	2	0	0
	Other (provider inquiry)	0	0	0	0	**0**	0	0	0
	Insufficient Information / unable to contact source / duplicates / hangups		33	10	25	**68**	68	0	0
	Total # received	0	56	55	39	**151**	0	0	0
October	Medallion 4 (OFC)	0	3	9	11	**23**	15	8	0
	CCC Plus (OHCC)	0	2	5	15	**22**	9	12	1
	Medicare/DNSP	0	12	8	2	**22**	22	0	0
	Federal Employees (FEHBP)	0	0	0	0	**0**	0	0	0
	Commercial	0	8	24	0	**32**	32	0	0
	Other (provider inquiry)	0	0	0	0	**0**	0	0	0
	Insufficient Information / unable to contact source / duplicates / hangups		25	7	23	**55**	55	0	0
	Total # received	0	50	53	51	**154**	133	20	1
November	Medallion 4 (OFC)	0	5	5	6	**16**	7	8	1
	CCC Plus (OHCC)	0	0	3	3	**6**	4	2	0
	Medicare/DNSP	0	13	7	2	**22**	18	2	2
	Federal Employees (FEHBP)	0	0	0	0	**0**	0	0	0
	Commercial	0	6	22	0	**28**	27	1	0
	Other (provider inquiry)	0	0	0	0	**0**	0	0	0
	Insufficient Information / unable to contact source / duplicates / hangups		35	15	15	**65**	65	0	0
	Total # received	0	59	52	26	**137**	121	13	3
December	Medallion 4 (OFC)	0	1	4	1	**6**	4	1	1
	CCC Plus (OHCC)	0	4	1	12	**17**	9	8	0
	Medicare/DNSP	0	9	2	2	**13**	10	1	2
	Federal Employees (FEHBP)	0	0	0	0	**0**	0	0	0
	Commercial	0	0	18	0	**18**	18	0	0
	Other (provider inquiry)	0	0	0	0	**0**	0	0	0

	Insufficient Information / unable to contact source / duplicates / hangups		37	4	13	**54**	54	0	0
	Total # received	0	51	29	28	**108**	95	10	3

MONTH	LOB	HANGUPS	HOTLINE	EMAILS	OTHER SOURCE (i. e. internal emails directly to staff)	MONTHLY TOTALS	Number Not Pursued	Number In Triage/Pending Review	Number Opened as a Case/Pending Assignment
2024 Annual Totals	Medallion 4 (OFC)	0	47	88	83	218	138	75	5
	CCC Plus (OHCC)	0	24	50	129	203	103	93	7
	Medicare/DNSP	0	148	74	41	263	220	24	19
	Federal Employees (FEHBP)	0	0	2	0	2	2	0	0
	Commercial	0	67	278	13	358	292	33	2
	Other (provider inquiry)	0	0	0	0	0	0	0	0
	Insufficient Information / unable to contact source / duplicates / hangups		537	147	186	870	870	0	0
	Total # received	0	823	639	452	1914	1625	225	33

2026 Nonquantitative Treatment Limitation (NQTL) Submission

NETWORK ADEQUACY: IN-NETWORK

(BOTH INPATIENT AND OUTPATIENT)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See **45 CFR 146.137(c)(1).** Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also **FAQ 45** (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response: *(applies to both professional and facility)*

Sentara defines the network adequacy NQTL as the policies and procedures for ensuring the network includes an adequate number of MH/SUD and M/S providers and facilities to provide covered services under the terms of the Plan.

Sentara maintains sufficient numbers and types of M/S and MH/SUD providers in its network and satisfies standards for access to these providers. Sentara measures these metrics, network composition and accessibility through regular surveys and audits. Accessibility is measured both by geographical standards and appointment times.

Plan Terms:

The Plan defines and explains Sentara's Provider Network: "Your Plan contracts with certain doctors and Hospitals to provide Your benefits. These doctors and Hospitals make up the Plan's Provider Network. We also call them Plan Providers or In-Network Providers." Insureds are provided lists of in-network providers, which are available electronically, and are directed in the Plan that they may call Member Services.

Policies and Guidelines:

Sentara maintains certain policies concerning network adequacy including Network Composition, Provider Network Adequacy, Network Performance Monitoring and Quality Improvement, Appointment Access Guidelines, Monitoring Time and Minimum Provider Adequacy, Primary Care Provider Assignment and Monitoring, Network Adequacy and Program-Specific Access Requirements, Compliance and Regulatory Oversight of Provider Network.

Monitoring Efforts and Action Plans:

Sentara measures network composition and accessibility through regular surveys and audits. Accessibility is measured both by geographical standards and appointment times. Sentara annually evaluates its network adequacy using NCQA standards. The data collected in completing reports includes member complaints and appeals for both M/S and MH/SUD, CAHPS survey for M/S, QHP surveys for M/S, ECHO Member Experience Survey for MH/SUD administered for Sentara by a third-party consultant, out-of-network utilization data. The Network Department Manager, in collaboration with other departments, performs a qualitative analysis to identify barriers, opportunities for improvement and to select appropriate interventions.

National Standards:

Sentara evaluates the availability of primary care, specialists, and prescribing and non-prescribing behavioral health care practitioners to satisfy NCQA NET 1.

Vendors Utilized for Network Adequacy:

Sentara utilizes vendors as identified below for network services:

1. Sentara utilizes a third party vendor for network services for "Chiropractic Services," as defined in Sentara commercial plan documents. This relationship is governed by a delegation agreement.

2. Sentara utilizes a third party vendor for transplant services. This relationship is governed by a master services agreement.

3. Sentara utilizes a third party vendor for "wrap-around" network services outside of Virginia and within certain service areas in Northern Virginia ("NOVA") for both M/S and MH/SUD. This relationship is governed by a customer services agreement.

4. Sentara utilizes a third party vendor for the provision of network telehealth services, both M/S and MH/SUD. This relationship is governed by a master services agreement.

Ownership of Facilities:

Sentara contracts with all facilities and providers in the same manner regardless of ownership of the provider or facility. There is no difference between "Sentara" facilities and providers and non-Sentara facilities and providers.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See **45 CFR 146.137(c)(2).** Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:
  (A) A detailed description of the factor;
  (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
  (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also **FAQ 45** guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more

weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response: *(including professional and facility)*

Sentara identifies the following factors:

Geographic Access (time and distance)

		Number of Providers/Distance in Miles		
Commercial Provider Type	**Pass %**	**Rural**	**Suburban**	**Urban**
Primary Care Provider	90%	2/30	2/8	2/8
High Volume & High Impact Specialists	90%	2/60	2/15	2/15
Behavioral Health	90%	2/60	2/15	2/15
Hospital/Ancillary	90%	1/60	1/30	1/30

		Number of Providers/Time in Minutes		
Commercial Provider Type	**Pass %**	**Rural**	**Suburban**	**Urban**
Primary Care Provider	90%	2/45	2/30	2/30
High Volume & High Impact Specialists	90%	2/75	2/30	2/30
Behavioral Health	90%	2/75	2/30	2/30

Hospital/Ancillary	90%	1/75	1/45	1/45

Availability standards (provider to member access)

Primary Care Practitioner to Member Ratios		
Practitioner Type	**Measure**	**Performance Goal**
Family and General Practitioners	To members	1:2,000
Internists	To members	1:2,000
Pediatricians	To members	1:2,000
High Volume Practitioner to Member Ratios		
OB/GYN	To members	1:2,000
Other High Volume Practitioners	To members	1:2,000
High Impact Practitioner to Member Ratios		
Oncology	To members	1:2,000
Behavioral Healthcare Practitioner to Member Ratios *(the same ratios apply to Behavioral Healthcare Practitioners Accepting New Patients)*		
Prescribers		
Psychiatry	To members	1:2,000
Psychiatric Nurse Practitioner	To members	1:2,000
Non-Prescribers		
Addiction Medicine Specialist	To members	1:2,000
Clinical Psychology	To members	1:2,000
Licensed Clinical Social Worker	To members	1:2,000
Marriage and Family Therapist	To members	1:2,000
Substance Abuse Counselors	To members	1:2,000

Access to service/waiting time standard (appointment wait times)

Service	Sentara Health Plans Commercial/Exchange Appointment Timeliness Standards
Emergency Services, including Medical and Behavioral Health Crisis Services	Emergency appointments and services, including crisis services, must be made available immediately upon the member's request.
Non-Life-Threatening Behavioral Health Emergency Services	Within 6 hours or directed to emergency care
Urgent Care Services, including Medical and Behavioral Health	Must be made within 24 hours of the member's request
Regular and Routine Services	1) Regular and routine service appointments must be made within 30 days for primary care and within 10 business days for behavioral health care. 2) Standard does not apply to appointments for routine physical examinations; for regularly scheduled visits to monitor a chronic medical condition if the schedule calls for visits less frequently; or for routine specialty services like dermatology, allergy care, etc.
Maternity Care – First Trimester Services	Within 7 calendar days of request
Maternity Care – Second Trimester Services	Within 7 calendar days of request
Maternity Care – Third Trimester Services	Within 3 business days of requests
Maternity Care – High Risk Pregnancy Services	Within 3 business days of high-risk identification, or immediately if an emergency exists

Postpartum Care Services	Within 60 days of delivery
Behavioral Health Routine Care Services (Initial and Follow-up)	Within 10 business days for initial and within 7 business day for follow-up

Step 3: Description of how factors are used in the design and application of the NQTL.

See **45 CFR 146.137(c)(3).** Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared tomedical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also **FAQ 45** guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

Sentara measures access to care as defined in the factors above in the following manners:

Member Complaints and Appeals: Sentara recognizes that access to care is a key component of quality care. To ensure all members have access to needed care, Sentara monitors and trends member complaints, grievances, and appeals. Member services tracks and monitors member inquiries and complaints regarding provider access. SHP Appeals and Grievances tracks and monitors formal grievances and appeals concerning access to care (including those escalated from Member Services).

Analysis of Availability of Practitioners: Sentara strives to provide a network of available providers that offers strong accessibility and quality of care. Network management analyzes provider ratios at least annually to determine if performance targets are met. This is analyzed in addition to geographic access reports.

Phone Survey Data for Appointment Time Audit: Sentara contracts with a consultant to conduct a phone audit of provider appointment availability for all provider types in all lines of business. Commercial results are reported in Section 5 below.

Member Satisfaction and Experience Surveys: An annual analysis of the CAHPS survey is conducted and Network Management analyzes data reflective of member issues concerning the provider network. CAHPS concerns only M/S services.

Measurement of Requests for Out of Network Services: (Sentara addresses Out of Network Services here as opposed to a separate analysis since Network Adequacy is an In-Network NQTL absent requests for out of network services). Sentara conducted a fourth quarter 2024 review of out of network authorization requests for behavioral health and non-behavioral health.

Step 4: Demonstration of comparability and stringency as written.

See 45 CFR 146.137(c)(4). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer

establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.(Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Below are the goals for each factor and metric as written:

Member Complaints and Appeals: Goals for Complaints and Appeals (both Non-Behavioral Health and Behavioral Health)

- Less than 2.0 per 1,000 members for non-behavioral grievances
- Less than 1.0 per 1,000 members for non-behavioral appeals
-

Analysis of Availability of Practitioners: Goals for availability of practitioners

- 1 provider per 2,000 members

Phone Survey of Appointment Availability: The goal for compliance for all appointment times and categories is 80%.

Member Satisfaction and Experience Surveys: CAHPS Results: Goals for CAHPS Results (for Non-Behavioral Health)

- Getting Care Quickly- 81%
- Getting Needed Care- 82.6%
- Getting Specialty Appointment- 78.9%

ECHO Member Experience Survey: Goals for ECHO Results (Behavioral Health Only)

- Meet or exceed Press Ganey BofB of 77.6%

Requests for Out of Network Services (both Non-Behavioral and Behavioral Health): Goals

- Less than 10 out of network authorization requests per 1,000 members
- Less than 10 out of network utilization per 1,000 members

Step 5: Demonstration of comparability and stringency in operation.

See 45 CFR 146.137(c)(5). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies,

evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and(B) To the extent differences in access to MH or SUD benefits are attributable to

generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.

- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Below are factors and metrics as measured in practice using predominantly 2024 data. All data is for fully insured commercial plans in Virginia. Data fields will be updated as they become available.

Member Complaints and Appeals (data comparing 2023 and 2024)

- Non-Behavioral Health Complaints Regarding Access:

  2023: 2 Complaints, .01 Complaints per 1,000 members

  2024: 5 Complaints, .02 Complaints per 1,000 member

- Non-Behavioral Health Appeals Regarding Access:

  2023: 523 Appeals, 2.19 Appeals per 1,000 members

  2024: 1,053 Appeals, 4.05 per 1,000 members, 50% appeal overturn rate

- Behavioral Health Complaints Regarding Access:

  2023: 0

  2024:0

- Behavioral Health Appeals Regarding Access:

  2023: 8 Appeals, .03 per 1,000 members

  2024: 7 Appeals, .03 per 1,000 members

The rise in non-behavioral health appeals is attributed to increased membership numbers. While non-behavioral health access appeals did not meet the established goal, they still decreased from the prior year. Sentara performed additional analysis of non-behavioral health access-related appeals. Medical access appeals are aggregated by appeal sub-categories including but not limited to Pharmacy, DME, Outpatient Procedure, Benefits Denial or Limitation, or Out of Network. There were zero out of network appeals for the reporting period for non-behavioral health suggesting that there is an adequate network of providers to service the member population. All established goals were met with respect to Commercial/ Exchange behavioral health grievances and appeals. There were no Out of Network appeals for the reporting period suggesting that there is an adequate network of providers to service the member population.

Analysis of Availability of Practitioners:

Primary Care					
Specialty	**Unique Providers**	**Members**	**Providers per 2,000 Members**	**Provider to Member Ratio**	**Performance Goal**
Family Medicine	3039	298300	20.38	1:99	1:2,000
Internal Medicine	2482	298300	16.64	1:121	1:2,000
Pediatrics	1835	53129	69.08	1:29	1:2,000

SHP satisfies the goal of 1 provider per 2,000 members for Commercial primary care. For Commercial family medicine, SHP has 1 provider per 99 members, internal medicine has 1 provider per 121 members, and pediatrics has 1 provider per 29 members. As of December 2024, 90.66% of Commercial primary care providers statewide (including pediatrics) have open panels and are accepting new members. Less than 7% of Commercial primary care providers have closed panels to SHP members. December 2024 data demonstrates that SHP has met the established goal of at least 85% of Commercial primary care providers accepting new members. Statewide, 99.2% of Commercial members have access to primary care within the established distance standards of 2 providers within 8 miles (urban and suburban) and 2 providers within 30 miles (rural). The lowest area of member access is for pediatrics in Roanoke/Alleghany (95.23%); however, this still exceeds the 90% goal for member access. SHP met the established goal for Commercial member access.

High Volume Specialists					
Specialty	**Unique Providers**	**Members**	**Providers per 2,000 Members**	**Provider to Member Ratio**	**Performance Goal**
Cardiology	1081	245171	8.82	1:277	1:2,000
Cardiology- Ped	1244	53129	46.83	1:43	1:2,000
Orthopaedic	820	245171	6.69	1:299	1:2,000
Orthopaedic- Ped	839	53129	31.58	1:64	1:2,000
OB/GYN	1562	298300	10.47	1:191	1:2,000

For Commercial, SHP satisfies the goal of having at least 1 provider for every 2,000 members for high-volume specialists. The practitioner type with the highest ratio is orthopedics with a 1 to 299 provider to member ratio. The practitioner type with the lowest ratio is cardiology-pediatric with a 1 provider to 43 members ratio. For Commercial high-volume specialists, all regions had a 100% pass rate for member access except for Roanoke/Alleghany who had a 99.95% pass rate for OB/GYN, Tidewater with a 99.15% pass rate for Orthopaedics, and Roanoke/Alleghany with a 99.93% and Tidewater 99.89% pass rate for cardiology.

Specialty	Unique Providers	Members	Provider to Member Ratio	Performance Goal
Psychiatrist	880	29800	1:277	1:2,000
Clinical Psychologists	748	298300	1:399	1:1,500[1]
Psychiatric Clinical Nurses	575	298300	1:519	1:1,500

For Commercial, SHP satisfies the provider to members ratios for all specialties. Psychiatry has the smallest member ratio with 1 provider to every 339 members while Psychiatric Clinical Nurse Specialists has the largest member ratio with 1 provider to every 519 members.

Specialty	Unique Providers	Members	Provider to Member Ratio	Performance Goal
Addiction Medicine Specialist	75	29800	1:3978	1:1,500
Clinical Social Worker	2946	298300	1:102	1:1,500
Substance Abuse Counselors	8	298300	1:37,288	1:1,500
Marriage and Family Therapy	162	298300	1:1,842	1:1,500

For Commercial, SHP satisfies provider to member ratios for Clinical Social Workers. Clinical Social Workers have a member ratio of 1 provider to every 102 members. SHP does not satisfy provider to member ratios for Addiction Medicine Specialists, Substance Abuse Counselors and Marriage & Family Therapy. Substance Abuse Counselors had the highest provider to member

[1] The 2024 behavioral health ratio was 1:1,500. This currently has been updated to 1:2,000 consistent with M/S and MH/SUD.

ratio with 1 provider to every 37,288 members and Marriage & Family Therapy had the lowest provider to member ratio with 1 provider to every 1,842 providers. For Commercial high-volume behavioral health psychiatry, SHP satisfies the goal of having a pass rate of 90% for member access for all regions. All regions had a 100% pass rate for member access. For Commercial high-volume behavioral health psychology, SHP satisfies the goal of having a pass rate of 90% for member access for all regions. All regions had a 100% pass rate for member access except for Roanoke/Alleghany who had a 99.88% pass rate for member access. For Commercial high-volume behavioral health PHMNP, SHP satisfies the goal of having a pass rate of 90% for member access for all regions. All regions had a 100% pass rate for member access.

SHP is continually evaluating the network. Network Management meets on a regular basis to monitor network deficiencies and review internal reporting, and Network Management conducts outreach and recruitment to reduce provider gaps. Network Management works to secure telehealth agreements with providers and extend single case agreements for those network shortages that currently exist. The other provider type examined, clinical social worker, meets the established ratio, so no planned interventions are required.

Appointment Time Phone Survey:

Primary Care

Appointment Type	Goal	Compliance Rate	Goal Met?
Regular and Routine Care	80%	85.3%	Y
Urgent Care	80%	76.9%	N
After-Hours Availability	95%	100%	Y

Behavioral Health Care- Prescriber

Appointment Type	Goal	Compliance Rate	Goal Met?
Non-Life Threatening Emergency	80%	59.3%	N
Urgent Care	80%	75.6%	N
Initial Visit	80%	71.8%	N
Follow Up Routine Care	80%	86.2%	Y

Behavioral Health Care- Non- Prescriber

Appointment Type	Goal	Compliance Rate	Goal Met?
Non-Life Threatening Emergency	80%	60.1%	N
Urgent Care	80%	73.9%	N
Initial Visit	80%	79.8%	N
Follow Up Routine Care	80%	81.5%	Y

Sentara met its goal of 80% compliance with established standards for Sentara providers participating in Sentara's Commercial/ Exchange lines of business for regular and routine care appointments (85.3%) and after-hours availability (100%). Sentara did not meet its 80% compliance goal for urgent care appointments for this group of providers (76.9%). Sentara only met its goal of 80% compliance with established standards for Sentara providers participating in Sentara's Commercial/ Exchange lines of business for follow up routine care appointments for behavioral health prescribers (86.2%) and non-prescribers (81.5%). Sentara did not meet its 80% compliance goal for non-life-threatening emergencies (59.3%, 60.1%), urgent care appointments (75.6%, 73.9%), or initial visits for routine care (71.8%, 79.8%) for either Commercial/ Exchange behavioral health prescribers or non-prescribers, respectively.

To address the decline in behavioral health provider compliance for initial and routine appointments, Network Management will increase education on appointment standards and scheduling best practices such as scheduling routine appointments well in advance, e.g., 12 months. Additionally, high volume and high impact specialists will be encouraged to use best practices for scheduling to increase availability of routine care appointments. SHP will continue to recruit available providers of all types in an effort to increase network size and improve availability of providers. SHP increased the provider network by 29% from August 2023 to August 2024, which included 11,000 physicians. The contracting team will continue to recruit additional specialist providers to expand the SHP network and increase appointment availability.

Member Satisfaction and Experience Surveys (data comparing 2023 and 2024):

M/S ONLY (CAHPS)

CAHPS Composite	2023	2024	Benchmark	Goal Met	Performance Changes 2023 to 2024
Getting Care Quickly	76.9	85.7	81.0	Yes	Increased by 8.8 percentage points and met goal
Getting Needed Care	79.9	81.2	82.6	No	Increased by 1.3 percentage points

					but did not meet goal
Getting Specialist Appointment		75.6	78.9	No	Further analysis following "Getting Needed Care Metric"

In further analysis of "Getting Needed Care," it was determined that obtaining a specialist appointment also fell below goal. Corrective actions include recruitment of specialties and subspeciality providers, provider education related to appointment guidelines and telehealth practices.

BEHAVIORAL HEALTH ONLY (ECHO)

The ECHO survey results indicate that 77.8% of SHP respondents indicated they always or usually get an appointment as soon as desired. This is above the Press Ganey Book of Business score of 77.6%, which meets established goal. Further broken down for Commercial members, 84% reported that they receive a behavioral health care appointment as soon as desired. Although all goals satisfied, Sentara shared ECHO results in webinar with behavioral health care providers to discuss ways to better serve members.

Requests for Out of Network Services:

10/1/24-12/31/24 Requests and Utilization for out of network benefits per 1,000 members for Non-Behavioral Health and Behavioral Health:

	Total OON Requests	**Total OON Requests Per 1,000 Members**	**Approved OON Requests**	**Approved OON Requests Per 1,000 Members**	**Denied OON Requests**	**Denies OON Requests Per 1,000 Members**	**Goal Met <10 Per 1,000 Members**
NBH	367	1.3	314	1.08	53	.18	Y
BH	38	.13	31	.11	7	.02	Y
	Total Claims for OON Services	**Total OON Claims Per 1,000 Members**	**% of OON Claims Paid**	**Number of OON Claims Paid**	**% of OON Claims Denied**	**Number of OON Claims Denied**	**Goal Met <10 Per 1,000 Members**
NBH	221	.7	71.95%	159	28.05%	62	Y

BH	2	.01	50%	1	50%	1	Y

The low number of out-of-network requests can be attributed to the robust network of providers and the continual monitoring of network adequacy. Sentara ensures that participating providers are geographically accessible to our members. Network Adequacy (geographic distribution) reporting is completed on a bi-weekly basis and a member of the Network Management leadership team reviews the adequacy reports to ensure any deficiencies and access gaps are addressed timely. Network Management leadership also initiates provider recruitment efforts to close these identified gaps.

Step 6: Findings and conclusions.

See **45 CFR 146.137(c)(6).** The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the **FAQ 45** guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara provided a definition of the Network Adequacy NQTL. In Step 1, Sentara provided Plan terms, descriptions of all policies and guidelines concerning Network Adequacy, and identified by scope vendors utilized. In Step 2, Sentara provided the factors and standards considered when developing and maintaining Network Adequacy including geographic access, availability standards, waiting time standards. In Step 3, Sentara described how those factors are used and measured in the development of an adequate network. Specifically, Sentara described how it measures provider access through member complaints, phone survey data, satisfaction survey and requests for out of network services. In Step 4, Sentara described the policies as written and demonstrated compliance with those policies in operation in Step 5. Sentara met all established goals with the exception of provider to member ratio for specialized substance use disorder providers. For both M/S and MH/SUD services, appointment times for urgent care was below the goal set as were appointment times for initial visits for behavioral health, although provider ratios were predominantly satisfied. Sentara explained its corrective action plans in Step 5.

The analysis establishes Sentara is compliant with MHPAEA.

This analysis was completed in September 2026 by members of the following departments at Sentara: Network Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

TREATMENT PLANS: ALL CLASSIFICATIONS

Sentara does not require formal documentation of treatment plans prior to determining medical necessity or issuing prior authorization. Treatment plans are but one type of clinical documentation considered when assessing medical necessity and are not independently or separately required.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

PROVIDER DIRECTORY: IN-NETWORK

(BOTH INPATIENT AND OUTPATIENT)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See **45 CFR 146.137(c)(1).** Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also **FAQ 45** (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response: *(including professional and facility)*

Sentara defines the provider directory NQTL as a comprehensive directory of online and in print providers with accurate and sufficient information to ensure ease of access to healthcare for Sentara members.

Plan Terms:

The Plan does not reference or define the Provider Directory. The Plan defines and explains Sentara's Provider Network: "Your Plan contracts with certain doctors and Hospitals to provide Your benefits. These doctors and Hospitals make up the Plan's Provider Network. We also call them Plan Providers or In-Network Providers." Insureds are provided lists of in-network providers, which are available electronically, and are directed in the Plan that they may call Member Services.

Policies and Guidelines:

Sentara maintains a policy related to the Provider Directory. The Provider Directory is created from data derived from Sentara's data management system.

Specific Topics Regarding the Terms of Provider Directories:

Sentara maintains a single provider directory which includes both M/S and MH/SUD providers. Providers must be credentialed to be included in the Provider Directory. Providers are added or removed from the Provider Directory as appropriate within 30 days of receipt.

Physician Data as required by NCQA (as applicable): name, office address and phone number, gender, specialty, hospital affiliations, medical groups, institutional affiliations, board certification, accepting new patients, language spoken by physician and clinical staff, office locations and phone numbers, digital contact information.

Facility Data as required by NCQA: hospital name, hospital location and phone number, hospital accreditation status, hospital quality data from recognized sources, digital contact information.

Changes by Providers: Participating providers are responsible for initiating new provider information or changes to their directory data by completing the Provider Update Request Form on the Sentara Provider website.

Changes by Sentara: Provider updates related to Credentialing eligibility and/or Provider Agreement changes may be requested via internal change request process by Sentara Network Management, Credentialing, or other departments as appropriate. Upon receipt of a Provider Update Request Form (or internal change request), the Provider Data Management Team (PDM) is responsible for updating all applicable credentialing, demographic, and/or participating provider data in the provider credentialing data management system, including provider terminations. Provider updates will be completed in the provider credentialing data management system within thirty (30) calendar days of receipt. Sentara updates paper and electronic directories at least monthly. On a nightly basis, current provider data from the Sentara provider credentialing management system is sent to the Provider Directory vendor for upload and update of provider directory records. The Sentara Health Plans Quality Audit Team performs audits of Provider information from provider data source to directory to ensure updates are made correctly and timely and to ensure print directories are up-to-date and available on the Sentara website.

Vendors Utilized for Provider Directory:

Sentara utilizes vendors as identified below for Provider Directory:

1. Sentara utilizes a third party vendor to upload and update provider directory records.

2. Sentara utilizes a third party vendor to perform usability testing.

List of Services Subject to NQTL:

Providers identified in the Provider Directory are not listed separately as physician/non-physician and there is not difference between Sentara and non-Sentara providers. There are not separate Provider Directories for M/S and MH/SUD services.

Ownership of Facilities:

Sentara identifies providers in its Provider Directory in the same manner regardless of ownership of the provider group or facility. There is no difference between "Sentara" facilities and providers and non-Sentara facilities and providers.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See **45 CFR 146.137(c)(2).** Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:
- (A) A detailed description of the factor;
- (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
- (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also **FAQ 45** guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more

weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response: ***(including professional and facility)***

Sentara identifies the following factors:

Changes to Provider Directory:

Changes by Providers: Participating providers are responsible for initiating new provider information or changes to their directory data by completing the Provider Update Request Form on the Sentara Provider website.

Changes by Sentara: Provider updates related to Credentialing eligibility and/or Provider Agreement changes may be requested via internal change request process by Sentara Network Management, Credentialing, or other departments as appropriate. Upon receipt of a Provider Update Request Form (or internal change request), the Provider Data Management Team (PDM) is responsible for updating all applicable credentialing, demographic, and/or participating provider data in the provider credentialing data management system, including provider terminations. Provider updates will be completed in the provider credentialing data management system within thirty (30) calendar days of receipt. Sentara updates paper and electronic directories at least monthly. On a nightly basis, current provider data from the Sentara provider credentialing management system is sent to the Provider Directory vendor for upload and update of provider directory records. The Sentara Health Plans Quality Audit Team performs audits of Provider information from provider data source to directory to ensure updates are made correctly and timely and to ensure print directories are up-to-date and available on the Sentara website.

These factors are applied identically for M/S and MH/SUD providers as well as professional and facility providers.

PDM Quality Audit: 95% confidence level and 5% margin of error

Usability Requirements: audited at least every 3 years

Step 3: Description of how factors are used in the design and application of the NQTL.

See 45 CFR 146.137(c)(3). Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to

medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response: ***(including professional and facility)***

Changes to Provider Directory:

The use of factors identified in Step 2; namely, changes requested by the provider and changes requested by Sentara departments are self-defining in design.

Changes as requested by providers are derived from the Provider Update Request Form which is found on the Sentara provider website. Both M/S and MH/SUD providers utilize this Form for requested changes.

Changes as requested by Sentara departments such as Network Management or Credentialing are facilitated through an internal change request.

For both provider initiated and internal change requests, the Provider Data Management Team is responsible for updating the information in the provider credentialing management system, including provider terminations. This is accomplished within 30 days for all requests. This timeline applies to changes for both M/S and MH/SUD providers.

On a nightly basis, current provider data from the provider credentialing management system is uploaded and updated in the provider directory records.

PDM Quality Audit: 95% confidence level and 5% margin of error

Usability Requirements: Understandability and usefulness and to members and prospective members

Step 4: Demonstration of comparability and stringency as written.

See 45 CFR 146.137(c)(4). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response: *(including professional and facility)*

Information Included in Provider Directory and Changes:

The factors and evidentiary standard are applied to both M/S and MH/SUD providers with deviation. A single policy regarding Provider Directory exists for all providers. All physicians regardless of whether M/S or MH/SUD must include name, office address and phone number, gender, specialty, hospital affiliations, medical groups, institutional affiliations, board certification, accepting new patients, language spoken by physician and clinical staff, office locations and phone numbers, digital contact information. All facilities, whether M/S or MH/SUD, must include name, location and phone number, hospital accreditation status, hospital quality data from recognized sources, digital contact information. Any changes are incorporated 30 days within receipt of information and nightly downloads occur with changes to credentialing data.

PDM Quality Audit: Sentara conducts an audit through random sampling extracted weekly and assigned to PDM Quality auditors. Sentara assesses the accuracy rate of its Provider Directory at least annually to a 95% confidence level. On a monthly basis, Sentara compares the network data to an external database for accuracy.

Usability Requirements: The policy requires consistency in the usability of the Provider Directory whether searching for a M/S or a MH/SUD provider. Usability testing is applied to the Provider Directory in its entirety.

Step 5: Demonstration of comparability and stringency in operation.

See 45 CFR 146.137(c)(5). The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

In operation, Sentara satisfies the goals as written in its maintenance of the Provider Directory. Sentara maintains a directory for all provider types and provides a mechanism for changes and revisions to the Provider Directory for members and for internal departments within Sentara.

The PDM Quality Audit Team audits samples of data in the Provider Directory to meet the 95% confidence level.

Usability requirements are met with System Usability Score (SUS) of 94 out of 100 for font size, reading level, content organization, ease of navigation, and additional languages. This SUS increased .5 from the study completed in June 2022.

Step 6: Findings and conclusions.

See 45 CFR 146.137(c)(6). The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the **FAQ 45** guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Response:

Sentara provided a definition of the Provider Directory NQTL. For Step 1, Sentara provided information as to the content of the Provider Directory, the mechanism to revise information in the Provider Directory, and identified by scope the vendors that provide nightly updates and usability testing. Sentara confirmed there are no separate Provider Directories for M/S and MH/SUD services. In Steps 2 and 3, Sentara provided the factors and sources considered when developing and maintaining a Provider Directory. In Step 4, Sentara described the policies as written and demonstrated compliance with those policies in operation in Step 5. The analysis establishes Sentara is compliant with MHPAEA.

This analysis was completed in September 2026 by members of the following departments at Sentara: Network Management, Compliance, and Legal.

2026 Nonquantitative Treatment Limitation (NQTL) Submission

REIMBURSEMENT: ALL CLASSIFICATIONS

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Sentara submits the following analysis concerning the Reimbursement NQTL. This response is organized to address all applicable categories: Inpatient, Outpatient, and Emergency Services for both in-network and out-of-network providers.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See **45 CFR 146.137(c)(1).** Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also **FAQ 45** (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response:

Description of NQTL:

Reimbursement is the methodology for determining payment of claims to facilities and providers. Payment is not made directly to members.

All inpatient admissions require pre-authorization and must meet medical necessity criteria for coverage. If services are not medically necessary, regardless of whether the provider is in-network or out of network, such services are not covered services and are not subject to reimbursement.

Separate Operating Departments or Divisions

Sentara's Network Management and Contracting Department administers provider reimbursement for both M/S and MH/SUD providers. There is a team devoted to rates for and negotiations with MH/SUD providers within the Network Management and Contracting Department. Another team within the same department handles rates for and negotiations with facilities, both M/S and MH/SUD.

Vendor Involvement

Sentara utilizes vendors as identified below for network services:

1. Sentara utilizes a vendor ("Network Vendor 1") for network services for "Chiropractic Services," as defined in Sentara commercial plan documents. The relationship between Network Vendor 1 and Sentara as it relates to chiropractic services is governed by a delegation agreement and amendments thereto.

2. Sentara utilizes a second vendor ("Network Vendor 2") for network services for transplant services. The relationship between Network Vendor 2 and Sentara is governed by a master agreement and amendments thereto.

3. Sentara utilizes a third vendor ("Network Vendor 3") for "wrap-around" network services outside of Virginia and within certain service areas in Northern Virginia ("NOVA"). The relationship between Sentara and Network Vendor 3 is governed by a services agreement and amendments thereto.

4. Sentara utilizes a fourth vendor ("Network Vendor 4") for the provision of network telehealth services, both M/S and MH/SUD. The relationship between Sentara and Network Vendor 4 is governed by a services agreement (and amendments thereto) and a specialist provider agreement (and amendments thereto).

For In-Network Classifications: As described above and throughout this analysis, Sentara utilizes vendors to provide in-network services using the networks of these vendors.

For Out-of-Network Classifications: With the exception of single case agreements ("SCAs") with out-of-state providers and certain providers in Northern Virginia, Sentara negotiates and administers all SCAs between it and providers internally. Sentara utilizes Network Vendor 3 for network services for out-of-state providers and specified localities in NOVA. To the extent Network Vendor 3 enters into SCAs, Sentara is not a party to those SCAs and has no role in the negotiation of those SCAs. Sentara does not utilize vendors or third parties to determine rates for out-of-network classifications. Sentara negotiates with out-of-network providers internally.

For Emergency Services: Sentara utilizes Network Vendor 3 for network management for out-of-state providers and specified localities in NOVA. Sentara also utilizes Network Vendor 3 to determine rates, complying with Qualifying Payment Amount(s), for non-contracted, out-of-state providers of emergency services. Sentara reimburses those providers at rates set by Network Vendor 3. With the exception of Network Vendor 3, as explained above, Sentara does not utilize vendors or third parties for reimbursement or contracting functions for emergency services.

Provider Types and Payment Structures:

Inpatient, In-Network Hospital Services may be reimbursed on a Diagnosis-Related Group Reimbursement ("DRG") basis. Sentara requires the most current procedure and diagnosis codes based on Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) guidelines for inpatient and outpatient claims. The principal diagnosis is the condition established after study to be chiefly responsible for causing the hospitalization or use of other Hospital services. Each inpatient diagnosis code must indicate in the contiguous field whether symptoms warranting the diagnosis were present on admission. Sentara will group to MS-DRG or APR DRG as appropriate. Other hospital services may be reimbursed on a percentage of charge basis.

Outpatient, In-Network Provider Types and Payment Structures

For reimbursement of in-network, outpatient providers the following payment methodologies are used:

- Per Diem: All services reimbursed at a daily rate
- Case Rate: Services reimbursed at a set rate per episode of care (e.g. home health services at 30-minute increments)
- Fee for Service: By CPT Code
- Percentage of charge: Either billed charge or Medicare/Medicaid
- Capitated: Per member rate (limited to specific services). These capitated rates are the same for M/S and MH/SUD services.

Negotiations of payment methodology for outpatient providers begin at Sentara's standard rates. Providers negotiate for different payment methodologies.

Inpatient, In-Network Provider Types and Payment Structures

Participating in-network hospitals are reimbursed at either DRG, percentage of charge, or case rate methods of payments. Hospital contracting negotiations begin with the DRG rate. The negotiation with hospitals related to payment methodology depends on a number of factors. For example, whether or contracting occurs at a system level. For those hospitals using DRG, certain services may be excepted from DRG and reimbursed on a case rate or percentage of charge methodology. For MH/SUD services provided in a hospital contracted under a DRG payment methodology, those services will be reimbursed under a DRG methodology, unless excepted from that payment methodology. The decision as to whether to carve out any particular service, including MH/SUD services, is provider-initiated and the type of preferred payment method is provider-initiated.

Residential treatment or SUD inpatient facilities are not reimbursed on a DRG and instead are reimbursed on a per diem or percentage of charge basis.

APR ("All Patient Refined")-DRG is a broader, all payer system which recognizes various patient complexities. MS-DRG is utilized by CMS and commercial business and is limited to complexities for an adult population. Largely, hospitals in-network for Sentara that are reimbursed for services under the DRG payment methodology utilize the MS-DRG.

Inpatient, In-Network Skilled Nursing Services, Hospice Services, and Residential Treatment Services often are reimbursed on a per-diem basis.

Outpatient, Out-of-Network and Inpatient, Out-of-Network Provider Types and Payment Structures

The payment methodologies for out-of-network providers or facilities are different than in-network providers. For out-of-network providers, Sentara attempts to negotiate a SCA or to bring that provider in-network as appropriate. If Sentara and the provider are unsuccessful in negotiating a provider agreement or SCA, out-of-network providers are reimbursed using factors such as the usual and customary rate ("UCR") or the actual charge.

Single Case Agreements

Sentara adheres to an internal policy on SCAs. SCAs are negotiated individually, with no set rate or payment methodology. SCAs include various payment methodologies: case rate, per diem, and percentages of charge.

SCAs apply to a specific patient or service and cover an entire episode of care. There could be a scenario where a facility is reimbursed pursuant to a SCA and a particular service is negotiated

separately and subject to a separate SCA. For example, an out-of-network ambulatory surgery center ("ASC") could be subject to a SCA and a service performed by a clinician could be subject to a separate SCA.

Provider Discount Arrangements

Sentara does not utilize provider discount arrangements.

Balance Billing Protections

Regarding nonemergency services for surgical or ancillary services provided by an out-of-network provider at an in-network facility, Sentara utilizes the median rate for that specific specialty in that specific geography area.

Emergency Care

Emergency care benefits (whether professional or facility-based) are reimbursed based upon level of care defined by CPT codes.

Regarding how Sentara classifies certain services, if emergency room facility charges are added to an inpatient or ambulatory surgery bill, the emergency services are categorized in the "Emergency Care" classification. If emergency physician professional services are received while the patient is admitted inpatient, the emergency services and inpatient services are billed and reimbursed based upon level of care and provider type and are classified for MHPAEA purposes based upon the level of care and provider type.

Sentara does not utilize SCAs for emergency services.

Other Payment Models

Sentara does not utilize salary as a payment methodology in any classification. Sentara does not utilize capitation for any out-of-network reimbursement. Sentara does not use capitation for any inpatient reimbursement. As to in-network, outpatient reimbursement, Sentara utilizes capitation for specific services in a specific geography.

List of Services Subject to the NQTL:

For Inpatient, In-Network Hospital Services, facility reimbursement is subject to a negotiated facility agreement. Physician professional services received while admitted inpatient are subject to separate provider agreements. For services rendered in a skilled nursing or residential treatment facility, the facility is reimbursed on a per diem charge which most often includes professional services rendered while the member is inpatient.

Determining Classifications and Sub-Classifications

Classifications are based on specific codes. Classification of facility services is based on bill type/revenue code. Classification of professional services is based on service code.

For example:

- In the situation where a mother gives birth at a participating hospital, both the facility charge and the professional charge would appear under Inpatient, In-Network for MHPAEA purposes.
- For MH/SUD and M/S inpatient, in-network services, reimbursed on a per diem basis, there are typically no separate professional services charges. Both skilled nursing and residential treatment are reimbursed on a per diem basis.
- Evaluation & Management ("E&M") services are billed separately for both M/S and MH/SUD services. If E&M services are provided in an inpatient facility, those services are billed as inpatient services.
- As another example, reimbursement for ASCs are handled separately for facility fee and professional services.

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See **45 CFR 146.137(c)(2).** Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:
  (A) A detailed description of the factor;
  (B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and
  (C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also **FAQ 45** guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining

which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

All Classifications

See Chart of Factors enclosed as Ex. 1.

Step 3: Description of how factors are used in the design and application of the NQTL.

See **45 CFR 146.137(c)(3).** Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to

medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

All Classifications

Base Rates

For inpatient facilities, particularly hospitals, each are individually negotiated and no "go out" base rate exists or is utilized.

Final Rates

The final rates are determined through negotiation with each individual inpatient provider. Similar to the process for negotiation of reimbursement for professional services, predominant in the negotiation are network needs (taking into consideration practice size, multi-specialty, group, hospital, or facility-based providers) and market demands in a geographic region. These in turn determine bargaining power, which ultimately results in a final rate.

Adjusted Rates

Facility agreements typically do not expressly state a time for renegotiation, leaving discussions at the discretion of the provider. Facility agreements further do not contain expiration terms and are subject to evergreen clauses. At the time of renegotiation, the same factors are considered as described above in the negotiation of rates.

See Chart of Factors enclosed as Ex. 1 for a discussion on how each of the factors informs rate setting for base rates, final rates, and adjusted rates.

A description of how each factor is designed and defined is below:

1. Sentara uses standard go out rates, which are benchmark against publicly available fee schedules (Medicare and Medicaid) for transparency. Fee schedules are revised on a regular basis to represent current competitive factors.

2. Market dynamics and bargaining power are factors which affect network adequacy and quality. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. See Sentara's Network Adequacy Analysis. For example, a behavioral healthcare provider that is equipped to service members who use American Sign Language represents bargaining power when compared to other providers in-network who are not equipped to services members using ASL. Bargaining power factors into market dynamics, but adequacy and quality of network is the ultimate driving factor for Sentara to make quality care available to its members.

3. Network adequacy and quality exerts the most influence in rate-setting and reimbursement. Other factors such as market dynamics and bargaining power inform network adequacy and quality.

Sentara contracts with all facilities and providers in the same manner regardless of ownership of the provider or facility. There is no difference between "Sentara" facilities and providers and non-Sentara facilities and providers.

Step 4: Demonstration of comparability and stringency as written.

See 45 CFR 146.137(c)(4). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying

the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.

- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Sentara reviews the factors used in rate setting to ensure that the process for rate setting, both base and final rates, and adjusting those rates is no more stringent for MH/SUD than for M/S services. All reimbursement policies and procedures apply equally to M/S and MH/SUD services. In preparation of this Analysis, Sentara conducted conference calls with each team within Network Management to ensure that all written documents were collected and discussed. The processes to determine reimbursement defined herein apply to both M/S and MH/SUD services, as confirmed by the written policies and the collaboration of the Network Management Department.

Out of Network Benefits

The process for SCAs explained earlier in this Analysis applies equally to M/S and MH/SUD providers. As explained above, Sentara does not utilize provider discount arrangements.

For a discussion of other policies and processes affecting out-of-network coverage, please see Sentara's analysis on the applicable NQTL.

Emergency Benefits

As it relates to emergency benefits, if the member is directly admitted to the same hospital where the emergency services were performed, the emergency room facility charges should be added to

the inpatient or ambulatory surgery bill submitted by the Facility. If the Member is not directly admitted to the same hospital, the Emergency Department charges are paid separately from the inpatient charges. This applies equally to M/S and MH/SUD services. As explained above, Sentara does not use SCAs for emergency services.

Physician versus Non-Physician Reimbursement

M/S and MH/SUD reimbursement is based upon percentage of CMS and DMAS fee schedules. Reimbursement for physicians and non-physicians for MH/SUD is tiered.

Documentation of Each Factor Defined in Steps Two and Three

Please see Chart of Factors included herewith as Ex. 1. Sentara reviews the factors used in rate setting to ensure that the process for rate setting, both base and final rates, and adjusting those rates is no more stringent for MH/SUD than for M/S services.

Comparison of Existing Written Documents

All Network Management policies and procedures apply equally to M/S and MH/SUD providers.

How Factors are Comparably Applied

Please see Chart of Factors included herewith as Ex. 1. Sentara reviews the factors used in rate setting to ensure that the process for rate setting, both base and final rates, and adjusting those rates is no more stringent for MH/SUD than for M/S services.

Reasons for Any Deviations or Variations

No deviation or variation exists in Network Management policies and procedures.

Base Rates

For inpatient facilities, particularly hospitals, each are individually negotiated and no "go out" base rate exists. Typically rate discussions begin with a proposal from the inpatient facility. For professional services, on the other hand, Sentara uses its standard go out rate then negotiations, to the extent there ae any, follow. See Chart of Factors at Ex. 1, pertaining to all classifications.

Final Rates

The final rates are determined through negotiation with each individual provider and facility. Predominant in the negotiation are network needs (taking into consideration practice size, multi-specialty, group, hospital, or facility-based providers) and market demands in a geographic region. These in turn determine bargaining power, which ultimately results in a final rate. See Chart of Factors at Ex. 1, pertaining to all classifications.

Adjusted Rates

Facility agreements typically do not expressly state a time for renegotiation, leaving discussions

at the discretion of the provider. Facility agreements further do not contain expiration terms and are subject to evergreen clauses. At the time of renegotiation, the same factors are considered as described above in the negotiation of rates. See Chart of Factors at Ex. 1, pertaining to all classifications.

Step 5: Demonstration of comparability and stringency in operation.

See **45 CFR 146.137(c)(5).** The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional

safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

In operation, the Base Rates are developed based upon publicly available fees scheduled. Any adjustments to these rates necessarily occur based upon the factors and methodologies defined in the Chart of Factors and result from provider negotiations.

Step 6: Findings and conclusions.

See 45 CFR 146.137(c)(6). The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the FAQ 45 guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara defined the Reimbursement NQTL, which applies to all facilities and other providers. Sentara identified and defined the factors that are considered for provider reimbursement for inpatient and outpatient services, including Sentara's use of base, final, and adjusted rates for both inpatient and outpatient providers. Sentara defined policies for reimbursement of emergency services and reimbursement of services provided by out of network providers, when permitted by the plan documents. Sentara's Network Management department relies on the same factors when negotiating with M/S and MH/SUD providers to ensure Sentara's network is adequate to provide members with quality care.

This analysis was completed in September 2026 by the following Sentara departments: Network Management, Compliance, and Legal.

EXHIBIT 1
FACTORS FOR RATE DETERMINATIONS

Reimbursement Methodology: MS-DRG

	Factors for Base Rates	Factors for Final Rates	Factors for Adjusted Rates[1]
Inpatient, In-network (facility)	For hospitals, there are no defined "base rates," as initial contracting for hospitals is rare and did not occur in 2024. The default for hospital reimbursement for both M/S and MH/SUD is the MS-DRG. DRG is not used for other inpatient facilities.	Hospital contracting begins with the DRG rate. The negotiation with hospitals related to payment methodology depends on a number of factors: Contracts with hospital systems. In accordance with those contracts, certain hospitals will be reimbursed at DRG. For those hospitals using DRG, certain services may be excepted from DRG and reimbursed on a case rate or percentage of charge/Medicare methodology. For MH/SUD services provided in a hospital contracted under a DRG payment methodology, those services will be reimbursed under a DRG methodology, unless excepted from that payment methodology. The decision as to whether to carve out any particular service, including MH/SUD services is provider-initiated. Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take	All hospital contracts are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."

[1] Factors for adjusted rates in single case agreements are determined by the methodology used in the SCA. For example, if an SCA uses MS-DRG, the factors for adjusted rates for that SCA will be the factors listed in the adjusted rates column of the MS-DRG chart herein. As explained in Sentara's analysis, Sentara does not use provider discount arrangements.

		place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	
Inpatient, In-network (professional)	N/A to professional services		
Outpatient, In-network (facility)	N/A to outpatient facilities		
Outpatient, In-network (professional)	N/A to professional services		
Inpatient, out-of-network (facility)	N/A as no Virginia based hospitals are out-of-network		
Inpatient, out-of-network (professional)	N/A to professional services		
Outpatient, out-of-network (facility)	N/A to outpatient facilities		
Outpatient, out-of-network (professional)	N/A to professional services		
Emergency Services (professional)	N/A to emergency services in-network or out-of-network		
Emergency Services (facility)	N/A to emergency services in-network or out-of-network		

Reimbursement Methodology: APR-DRG

	Factors for Base Rates	**Factors for Final Rates**	**Factors for Adjusted Rates**
Inpatient, In-network (facility)	Utilized when a facility's services align better with APR-DRG.	Utilized when a facility's services align better with APR-DRG.	Contract is evergreen contract. Any contract rate adjustment is

			provider initiated and subject to the same factors identified for "final rates."
Inpatient, In-network (professional)	N/A to professional services		
Outpatient, In-network (facility)	N/A to outpatient facilities		
Outpatient, In-network (professional)	N/A to professional services		
Inpatient, out-of-network (facility)	N/A as no Virginia based hospitals are out-of-network		
Inpatient, out-of-network (professional)	N/A to professional services		
Outpatient, out-of-network (facility)	N/A to outpatient facilities		
Outpatient, out-of-network (professional)	N/A to professional services		
Emergency Services (professional)	N/A to emergency services in-network or out-of-network		
Emergency Services (facility)	N/A to emergency services in-network or out-of-network		

Reimbursement Methodology: Per Diem

	Factors for Base Rates	**Factors for Final Rates**	**Factors for Adjusted Rates**
Inpatient, In-network (facility)	Standard Go-Out Rates. Standard per diem rates are based upon similar facilities in same geography.	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies.	Contracts for inpatient facilities are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."

		Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.* Additionally, Per Diem is appropriate for long-term services for which DRG would likely not account for the extended member stay. Additionally, many smaller facilities prefer a Per Diem methodology (or request a Per Diem carveout for services the facility does not render often) due to the lower volume of services.	
Inpatient, In-network (professional)	N/A to professional services		
Outpatient, In-network (facility)	Standard Go-Out Rates	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	Contracts for outpatient facilities are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."

		Additionally, many smaller facilities prefer a Per Diem methodology (or request a Per Diem carveout for services the facility does not render often) due to the lower volume of services.	
Outpatient, In-network (professional)	N/A to professional services		
Inpatient, out-of-network (facility)	N/A unless subject to policy on SCA	If no agreement is reached with an out-of-network inpatient provider, reimbursement is based on factors like the UCR and actual charge	No adjusted rates.
Inpatient, out-of-network (professional)	N/A to professional services		
Outpatient, out-of-network (facility)	N/A unless subject to policy on SCA	If no agreement is reached with an out-of-network inpatient provider, reimbursement is based on factors like the UCR and actual charge	No adjusted rates.
Outpatient, out-of-network (professional)	N/A to professional services		
Emergency Services (professional)	N/A to emergency services, in-network or out-of-network		
Emergency Services (facility)	N/A to emergency services, in-network or out-of-network		

Reimbursement Methodology: Fee-for-Service (FFS)

	Factors for Base Rates	**Factors for Final Rates**	**Factors for Adjusted Rates**
Inpatient, In-network (facility)	N/A to facility-based services		
Inpatient, In-network (professional)	Standard Go-Out Rates	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality	Contracts for professional services are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same

		represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	factors identified for "final rates."
Outpatient, In-network (facility)	N/A to facility-based services		
Outpatient, In-network (professional)	Standard Go-Out Rates	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	Contracts for professional services are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."
Inpatient, out-of-network (facility)	N/A to non-emergency facility-based services		
Inpatient, out-of-network (professional)	If provided at an in-network facility, median rates are used	N/A	No adjusted rates.
Outpatient, out-of-network (facility)	N/A to non-emergency facility-based services		
Outpatient, out-of-network (professional)	N/A unless subject to SCA policy	If no agreement is reached with an out-of-network inpatient provider,	No adjusted rates.

		reimbursement is based on factors like the UCR and actual charge	
Emergency Services, in-network (facility)	The "base rate" is established by CPT. That "base rate" is then multiplied and based upon level of care (1-5) from least acute to the highest acuity.	Facility contracts for emergency services are negotiated as part of larger hospital contracts. Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	Contracts for facility services are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."
Emergency Services, in-network (professional)	The "base rate" is established by CPT. That "base rate" is then multiplied and based upon level of care (1-5) from least acute to the highest acuity. Fee schedules exist for emergency M/S and MH/SUD services which are based on Medicare rates.	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See*	Contracts for professional services are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."

		Sentara's Network Adequacy Analysis.	
Emergency Services, out-of-network (facility)	No SCA for Emergency Services.	Covered as an in-network benefit with reimbursement to the provider based on factors such as the UCR or actual charge	No adjusted rate.
Emergency Services, out-of-network (professional)	If provided at an in-network facility, median rates are used	Covered as an in-network benefit with reimbursement to the provider based on factors such as the UCR or actual charge	No adjusted rate.

Reimbursement Methodology: Percent of Medicare

	Factors for Base Rates	**Factors for Final Rates**	**Factors for Adjusted Rates**
Inpatient, In-network (facility)	Percent of Medicare is not utilized as a Base or Go-Out Rate for hospital M/S or MH/SUD services For other inpatient facilities, the standard go-out rates are used	Hospital contracting begins with the MS-DRG rate. The negotiation with hospitals related to payment methodology depends on a number of factors: -Contracts with hospital systems. In accordance with those contracts, certain hospitals will be reimbursed at DRG. For those hospitals using DRG, certain services may be excepted from DRG and reimbursed on a case rate or percentage of charge/Medicare methodology. For MH/SUD services provided in a hospital contracted under a DRG payment methodology, those services will be reimbursed under a DRG methodology, unless excepted from that payment methodology. The decision as to whether to carve out any particular service, including MH/SUD services is provider-initiated. Type of preferred payment method is provider initiated	Contracts for inpatient facilities are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."

		and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	
Inpatient, In-network (professional)	Base or Go Out Rate	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	Contracts for professional services are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."
Outpatient, In-network (facility)	For other outpatient facilities, the standard go-out rates are used	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality	Contracts for facility services are evergreen contracts. Any contract rate adjustment is

		depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	provider initiated and subject to the same factors identified for "final rates."
Outpatient, In-network (professional)	Base or Go Out Rate	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	Contracts for professional services are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."
Inpatient, out-of-network (facility)	N/A unless subject to policy on SCA	If no agreement is reached with an out-of-network inpatient provider, reimbursement is based on factors like the UCR and actual charge	No adjusted rates.
Inpatient, out-of-network (professional)	If provided at an in-network facility, median rates are used	N/A	No adjusted rates.

Outpatient, out-of-network (facility)	N/A unless subject to policy on SCA	If no agreement is reached with an out-of-network inpatient provider, reimbursement is based on factors like the UCR and actual charge	No adjusted rates.
Outpatient, out-of-network (professional)	N/A unless subject to policy on SCA	If no agreement is reached with an out-of-network inpatient provider, reimbursement is based on factors like the UCR and actual charge	No adjusted rates.
Emergency Services, in-network (facility)	The "base rate" is established by CPT. That "base rate" is then multiplied and based upon level of care (1-5) from least acute to the highest acuity.	Facility contracts for emergency services are negotiated as part of larger hospital contracts. Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	Contracts for emergency services are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."
Emergency Services, in-network (professional)	The "base rate" is established by CPT. That "base rate" is then multiplied and based upon level of care (1-5) from least acute to the highest acuity. Fee schedules exist for emergency M/S and MH/SUD services	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies.	Contracts for professional services are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."

	which are based on Medicare rates.	Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	
Emergency Services, out-of-network (facility)	No SCA for Emergency Services.	Covered as an in-network benefit with reimbursement to the provider based on factors such as the UCR or actual charge	No adjusted rate.
Emergency Services, out-of-network (professional)	If provided at an in-network facility, median rates are used	Covered as an in-network benefit with reimbursement to the provider based on factors such as the UCR or actual charge	No adjusted rate.

Reimbursement Methodology: Percent of Charge

	Factors for Base Rates	**Factors for Final Rates**	**Factors for Adjusted Rates**
Inpatient, In-network (facility)	Percent of Billed Charge is not a Base Go-Out Rate for inpatient, in-network facilities	Hospital contracting begins with the DRG rate. The negotiation with hospitals related to payment methodology depends on a number of factors: Contracts with hospital systems. In accordance with those contracts, certain hospitals will be reimbursed at DRG. For those hospitals using DRG, certain services may be excepted from DRG and reimbursed on a case rate or percentage of charge/Medicare methodology. For MH/SUD services provided in a hospital contracted under a DRG payment methodology, those services will be reimbursed under a DRG methodology, unless excepted from that	Contracts for facility services are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."

		payment methodology. The decision as to whether to carve out any particular service, including MH/SUD services is provider-initiated. -Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics and negotiating power and network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.* Many smaller facilities prefer a Percent of Billed Charge methodology (or request a Percent of Billed Charge carveout for services the facility does not render often) due to the lower volume of services.	
Inpatient, In-network (professional)	Percent of Billed Charge is not a Base Go-Out Rate for inpatient, in-network professional services	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network	Contracts for professional services are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."

		adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	
Outpatient, In-network (facility)	Percent of Billed Charge is not a Base Go-Out Rate for outpatient, in-network facilities	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.* Percentage of charge is a payment methodology negotiated most frequently by facility providers.	Contracts for facility services are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."
Outpatient, In-network (professional)	Percent of Billed Charge is not a Base Go-Out Rate for outpatient, in-network professional services	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network	Contracts for professional services are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."

		adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	
Inpatient, out-of-network (facility)	N/A unless subject to policy on SCA	If no agreement is reached with an out-of-network provider, reimbursement occurs based on factors such as the UCR and actual charge	No adjusted rates.
Inpatient, out-of-network (professional)	If provided at an in-network facility, median rates are used	N/A	No adjusted rates.
Outpatient, out-of-network (facility)	N/A unless subject to policy on SCA	If no agreement is reached with an out-of-network provider, reimbursement occurs based on factors such as the UCR and actual charge	No adjusted rates.
Outpatient, out-of-network (professional)	N/A unless subject to policy on SCA	If no agreement is reached with an out-of-network inpatient provider, reimbursement is based on factors like the UCR and actual charge	No adjusted rates.
Emergency Services (professional)	Percentage of billed charges N/A to emergency services provided in or out of network		
Emergency Services (facility)	Percentage of billed charges N/A to emergency services provided in or out-of-network		

Reimbursement Methodology: Case Rate

	Factors for Base Rates	**Factors for Final Rates**	**Factors for Adjusted Rates**
Inpatient, In-network (facility)	Standard Go-Out Rates. Standard Go-Out-Rates for inpatient facility services do not include case rates	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality	Contracts for inpatient facilities are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same

		represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.* Case rates are used for episodes of care and carved out services.	factors identified for "final rates."
Inpatient, In-network (professional)	Standard Go-Out Rates. Standard Go-Out Rates for certain professional services (e.g., endoscopy, dialysis) are identified thereon.	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	Contracts for professional services are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."
Outpatient, In-network (facility)	Standard Go-Out Rates. Standard Go-Out-Rates for outpatient facility services do not include case rates	Type of preferred payment method is provider initiated and negotiated to the extent negotiations take place. Network adequacy and quality depend upon market dynamics. Negotiating power, network adequacy and quality	Contracts for inpatient facilities are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same

		represent the driving force in whether negotiations take place or lead to different payment methodologies. Providers have different negotiating power based upon size and specialty. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.* Case rates are used for episodes of care and carved out services.	factors identified for "final rates."
Outpatient, In-network (professional)	Standard Go-Out Rates.	Case rates are used for episodes of care and carved out services. Network adequacy is determined by the number of contracted providers with the same specialty in each area, to adequately service Sentara Health Plans' members. *See Sentara's Network Adequacy Analysis.*	Contracts for professional services are evergreen contracts. Any contract rate adjustment is provider initiated and subject to the same factors identified for "final rates."
Inpatient, out-of-network (facility)	N/A unless subject to policy on SCA	If no agreement is reached with an out-of-network inpatient provider, reimbursement is based on factors like the UCR and actual charge	No adjusted rates.
Inpatient, out-of-network (professional)	If provided at an in-network facility, median rates are used	N/A	No adjusted rates.
Outpatient, out-of-network (facility)	N/A unless subject to policy on SCA	If no agreement is reached with an out-of-network inpatient provider, reimbursement is based on factors like the UCR and actual charge	No adjusted rates.
Outpatient, out-of-network (professional)	N/A unless subject to policy on SCA	If no agreement is reached with an out-of-network inpatient provider, reimbursement is based on	No adjusted rates.

		factors like the UCR and actual charge	
Emergency Services (professional)	N/A		
Emergency Services (facility)	N/A		

Reimbursement Methodology: Capitated

	Factors for Base Rates	**Factors for Final Rates**	**Factors for Adjusted Rates**
Inpatient, In-network (facility)	N/A		
Inpatient, In-network (professional)	N/A		
Outpatient, In-network (facility)	N/A		
Outpatient, In-network (professional)	Applies only to certain services		
Inpatient, out-of-network (facility)	N/A		
Outpatient, out-of-network (facility)	N/A		
Outpatient, out-of-network (professional)	N/A		
Emergency Services (professional)	N/A		
Emergency Services (facility)	N/A		

2026 Nonquantitative Treatment Limitation (NQTL) Submission

PROVIDER CREDENTIALING: IN-NETWORK

(BOTH INPATIENT AND OUTPATIENT)

The NQTL submission and analysis in this version dated October 1, 2026 applies to plans issued in the individual and group market by Sentara Health Plans (NAIC 95281) and Sentara Health Insurance Company (NAIC 70715).

Sentara reserves the right to modify and supplement this analysis as applicable, including when updated data becomes available.

Step 1: Description of the Nonquantitative treatment limitation (NQTL).

See **45 CFR 146.137(c)(1).** Step 1 must include the following:

(i) Identification of the NQTL, including the specific terms of the plan or coverage or other relevant terms regarding the NQTL, the policies or guidelines (internal or external) in which the NQTL appears or is described, and the applicable sections of any other relevant documents, such as provider contracts, that describe the NQTL;

(ii) Identification of all mental health (MH) and substance use disorder (SUD) benefits and medical/surgical benefits to which the NQTL applies, including a list of which benefits are considered MH or SUD benefits and which benefits are medical/surgical benefits; and

(iii) A description of which benefits are included in each classification set forth in Section 146.136(c)(2)(ii)(A).

See also **FAQ 45** (Q2, #'s 1 and 2) guidance. This guidance stipulates that a sufficient analysis should include:

- A clear description of the specific NQTL, plan terms, and policies at issue; and
- Identification of the specific MH/SUD and medical/surgical benefits to which the NQTL applies within each benefit classification, and a clear statement as to which benefits identified are treated as MH/SUD and which are treated as medical/surgical.

Issuer Response: *(applies to all in-network benefits)*

Description of the NQTL:

Sentara defines the provider credentialing NQTL as the program that ensures practitioners and organizational providers meet and continue to meet professional standards assuring the competency and quality of the Plan's Network-delivered care to Plan members.

Plan Terms:

Credentialing standards are not included in the Plan documents but are described in the documents identified below. The Plan defines and explains Sentara's Provider Network: "Your Plan contracts with certain doctors and Hospitals to provide Your benefits. These doctors and Hospitals make up the Plan's Provider Network. We also call them Plan Providers or In-Network Providers." Insureds are provided lists of in-network providers, which are available electronically, and are directed in the Plan that they may call Member Services.

Explanation of Policies and Procedures:

All policies and guidelines apply equally to M/S and MH/SUD services.

Credentialing standards are included or described in the following documents: 2026 Credentialing Program Description (https://shc-p-001.sitecorecontenthub.cloud/api/public/content/0e285a3e5e7140ad925afebef48ececc?v=64f48c8b); Credentialing and Recredentialing of Practitioners Policy; Credentialing Program Ongoing Monitoring & Interventions Policy; Credentialing Program Confidentiality Policy; Credentialing Information Integrity Policy; Credentialing Committee Policy; Credentialing Assessment and Reassessment of Organizational Providers Policy; Credentialing Appeal Rights Policy.

The Sentara Health Plans credentialing process uses the Council for Affordable Quality Healthcare (CAQH) application exclusively for provider credentialing. Providers who do not currently have a CAQH application must complete the CAQH ID Request Form.

The Provider Manual summarizes Credentialing Policies (https://shc-p-001.sitecorecontenthub.cloud/api/public/content/af5dece4ed994cf7a2138ae897f8b02b?v=155ecbc5) and includes a Credentialing overview.

The Plan maintains well defined, documented policies and procedures for initial credentialing, recredentialing, ongoing monitoring and delegated credentialing oversight processes for the purpose of evaluating, selecting and retaining qualified practitioners and organizational providers to provide care to Plan members. The Credentialing Department designee, on an annual basis, reviews all credentialing policies and procedures, makes any necessary updates, and submits them for approval by the Quality and Accreditation Department. Approved Policies and Procedures are electronically stored in the Plan's Policy management system. The Policies and Procedures are expressly set forth in the 2026 Credentialing Program Description (https://shc-p-001.sitecorecontenthub.cloud/api/public/content/0e285a3e5e7140ad925afebef48ececc?v=64f48c8b)

Standard In-Network Provider Contract Terms:

Provider Agreements define "Participating Provider" as a provider that "has been approved to provide Covered Services under applicable Health Benefit Plans in accordance with SHP's credentialing requirements." Moreover, a provider agrees "to the extent applicable, to comply with SHP's credential verification program and to assist in the credentialing and recredentialing process" and to participate and comply with "SHP's credentialing verification program." The Dispute Resolution provision in the Provider Agreement requires providers and Sentara first exhaust all credentialing policies and procedures.

Organizational Provider Credentialing:

Organizations that bill under a Type 2 NPI utilize the organizational credentialing policy and procedure, which are described in the Credentialing Assessment and Reassessment of Organizational Providers policy.

Recredentialing:

The Plan recredentials all practitioners at least every 36 months. The recredentialing process also includes performance-monitoring information on each practitioner from the following areas:

- Member Grievances and/or Complaints;
- Adverse Events, quality deficiencies, and/or quality issue trend patterns;
- Site Assessment and/or Medical Record Keeping Practice/Treatment Assessment Issues

The process for recredentialing follows the policies identified above.

Statutory/Regulatory References:

- NCQA Standards for Credentialing or Recredentialing
- Virginia Code §§ 38.2-3707.10, 38.2-3707.10:1, 38.2-3407.10:2, 12 VAC5-408-170

Currently, the Behavioral Health network is closed across all lines of business with the understanding that exceptions are warranted when a demonstrated clinical or member-specific need exists. The established exception process provides a mechanism for evaluating these circumstances and ensuring that network participation decisions remain responsive to the evolving needs of our membership.

Sentara works to ensure that any network approach does not inadvertently create barriers to care or limit its ability to address legitimate identified clinical needs. Since the closure of the BH network, the vast majority of the provider participation requests received pertain to the Medicaid line of business. Conversely, providers expressing interest in participation in the Commercial line of business have been approved for network participation, including those offering specialty services such as substance use disorder services.

Vendors Utilized for Credentialing:

Delegated credentialing for limited M/S services is handled by a third party vendor.

Ownership of Facilities:

Sentara credentials all providers in the same manner regardless of ownership of the provider or facility. There is no difference between "Sentara" facilities and providers and non-Sentara facilities and providers.

Lists of Services Subject to NQTL:

A. Practitioners Within Scope of Credentialing and Recredentialing

1. Medical Health Practitioners:

- Practitioners are licensed, certified or registered by the state to practice independently;
- Practitioners who have an independent relationship with the Plan. An independent relationship exists when the Plan directs its members to see a specific practitioner or group of practitioners, including all practitioners whom members can select as Primary Care Practitioners (PCPs). An independent relationship is not synonymous with an independent contract;
- Practitioners may seek approval from the Plan to participate as a Primary Care Practitioner and a Specialist provided they meet the Plan's participation criteria for all scopes of practice being requested;
- Practitioners who see members outside inpatient hospital/outside freestanding ambulatory facility settings;
- Practitioners who are hospital based but who also see the Plan members as a result of an independent relationship with the Plan;
- Pain Medicine practitioners;
- Oral Surgeons and Dentists who provide care to Plan members under their medical benefits;
- Non-physician practitioners who have an independent relationship with the Plan and who provide care to members under the Plan's medical benefits;
- Telemedicine Practitioners;
- Rental Network practitioners that are part of the Plan's primary network and the Plan has members who reside in the rental area;
- Rental Network practitioners that are part of the Plan's out-of-area care and members may see only those practitioners or are given an incentive to see the rental network practitioners;
- PPO Network practitioners if information about the Network is included in member materials or on a member ID Card that directs members to use the Network or there are incentives for members to see the PPO Network practitioners.

2. Behavioral Health Practitioners:

- Addiction Medicine practitioners
- Psychiatrists and other physicians
- Doctoral or Master's level Psychologists
- Master's level Clinical Social Workers
- Master's level Clinical Nurse Specialists
- Psychiatric Nurse Practitioners
- Psychiatric Physician Assistants
- Behavioral Analysts and Assistant Behavioral Analysts

The following list identifies by discipline the practitioner types that fall under the Plan's scope of credentialing and recredentialing. These lists are not all inclusive.

Doctorate Level Practitioners

- Medical Doctors (MD)
- Osteopathic Doctors (DO)
- Chiropractors (DC)
- Optometrists (OD)
- Podiatrists (DPM)
- Oral Surgeons (DDS/DMD)
- Psychologists (PsyD/PhD)
- Pharmacists (PharmD)

Dental Practitioners

- Dentists (DDS/DMD)

Allied Health Professionals

- Acupuncturists
- Audiologists
- Diabetes Educators
- Dieticians and Nutritionists
- Physical, Occupational, Massage and Speech Therapists
- Psychologists
- Clinical Social Workers
- Mental Health Counselors and Professional Counselors
- Behavior Analysts and Assistant Behavior Analysts
- Nurse Practitioners
- Physician Assistants
- Certified Nurse Midwives

B. *Practitioners who are not within the Plan's scope to be credentialed and recredentialed.*

The Plan defines the types of practitioners who are not credentialed or recredentialed, as those practitioners who do not have an independent relationship with the Plan, and meet any of the following criteria:

- Practitioners who practice exclusively within the inpatient setting, and who provide care for Plan members only as a result of members being directed to the hospital or other inpatient setting;
- Practitioners who practice exclusively within free standing facilities and who provide care to Plan members only as a result of members being directed to the facility;
- Pharmacists who work in conjunction with a pharmacy benefit management organization to which the Plan delegates utilization management functions;
- Covering practitioners (e.g., Locum Tenens);
- Practitioners who do not provide care for Plan members (e.g., Board Certified Consultants who may provide a professional opinion to the treating practitioner);
- Rental network practitioners who provide out-of-area care only, and members are not required or given an incentive to seek care from them.

Hospital Based Practitioners may include, but are not limited to:

- Anesthesiologists & Certified Registered Nurse Anesthetists
- Emergency Medicine
- Hospitalists & Hospital Medicine
- Pathologists
- Radiologists
- Neo-Natal / Peri-Natal
- Critical Care Medicine
- Trauma Medicine
- Any other practitioner specialty practicing exclusively in an inpatient setting

Non-inpatient facilities in which practitioners may practice exclusively and provide care for members only as a result of members being directed to the facility may include, but are not limited to:

- Mammography Centers & Free-Standing Radiology Centers
- Urgent Care Centers

- Surgery Centers
- Ambulatory Behavioral Health Facilities
- Psychiatric and Addiction Disorder Clinics

Organizational Provider Types:

1. Medical

    - Hospitals (Acute Care, Children's, Critical Access, Rehabilitation)
    - Home Health Agencies
    - Skilled Nursing Facilities
    - Free-Standing Ambulatory Surgery Centers
    - Long Term Acute Care Facility (LTACs)
    - Hospices

2. Medical Ancillary

    - Comprehensive Outpatient Rehab Facilities (CORFs)
    - Rural Health Clinics (RHCs)
    - Federally Qualified Health Clinic's (FQHCs)
    - Health Departments
    - Community Service Boards
    - Early Intervention Centers
    - Outpatient Clinics
    - Diagnostic Imaging Centers
    - Mobile Imaging
    - Infusion and/or Chemo Therapy Centers
    - Physical Therapy Clinics
    - Occupational Therapy Clinics
    - Speech Therapy Clinics
    - Durable Medical Equipment Suppliers
    - Dialysis Centers
    - Hearing Aid Suppliers
    - Laboratories
    - Orthotic and Prosthetic Suppliers
    - Pharmacies
    - Pharmacy Clinics
    - Optical Suppliers
    - Urgent Care Centers

3. Long Term Care, Home and Community Based

    - Adult Companion Services
    - Adult Day Care Services
    - Adult Day Health
    - Assisted Living Facilities
    - Attendant Care
    - Case Management Services
    - Community Care Management Agency (CCMA)

- Community Care Foster Family Home (CCFFH)
- Early Intervention Services (Infant/Toddler)
- Environmental Accessibility Adaptation Services
- Family Training Services
- Financial Assessment Risk Reduction Services
- Home Delivered Meals
- Home Maintenance
- Housekeeping and Chore Services
- Service Facilitation Services
- Personal Care and/or Respite Care
- Nutrition Assessment Risk Reduction Services
- Private Duty Nursing
- Social Day Care
- Medically Frail Day Care
- Mentally Challenged Day Care
- Mental Health Skills Building

4. Behavioral Health

- Hospitals (Psychiatric)
- Community Mental Health Centers (CMHCs)
- Community Service Boards
- Residential Treatment Centers for Psychiatric or Addiction Disorders
- Addiction Disorder Treatment Centers
- Mental Health and Addiction Disorder Counseling Centers
- Opioid Treatment Centers

Step 2: Identification and definition of the factors and evidentiary standards used to design or apply the NQTL.

See **45 CFR 146.137(c)(2).** Step 2 must include, with respect to every factor considered or relied upon to design or apply the NQTL to MH or SUD benefits and medical/surgical benefits, the following:

(i) Identification of every factor considered or relied upon, as well as the evidentiary standards considered or relied upon to design or apply each factor and the sources from which each evidentiary standard was derived, in determining which MH or SUD and which medical/surgical benefits are subject to the NQTL; and

(ii) A definition of each factor, including:

(A) A detailed description of the factor;

(B) A description of each evidentiary standard used to design or apply each factor (and the source of each evidentiary standard) identified under paragraph (i) above; and

(C) A description of any steps the plan or issuer has taken to correct, cure, or supplement any information, evidence, sources, or standards that would otherwise have been considered biased or not objective.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient analysis includes:

- (Q2, #3) Identification of any factors, evidentiary standards or sources, or strategies or processes considered in the design or application of the NQTL and in determining which benefits, including both MH/SUD benefits and medical/surgical benefits, are subject to the NQTL. Analyses should explain whether any factors were given more weight than others and the reason(s) for doing so, including an evaluation of any specific data used in the determination.

- (Q2, #4) To the extent the plan or issuer defines any of the factors, evidentiary standards, strategies, or processes in a quantitative manner, it must include the precise definitions used and any supporting sources.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q3, #5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response: *(including professional and facility)*

Initiation of Credentialing Process: The credentialing and recredentialing process does not vary based upon how credentialing is initiated

- Provider Request to Become Part of the Network: The Sentara Health Plans credentialing process uses the Council for Affordable Quality Healthcare (CAQH) application exclusively for provider credentialing. Providers who do not currently have a CAQH application must complete the CAQH ID Request Form on the Provider Data Portal website listed below.

- Provider Request to be Recredentialed: Sentara recredentials all practitioners at least every 36 months and follows the same process described for credentialing. Recredentialing includes performance monitoring including review of adverse data from member grievances, utilization management, quality improvement and site assessment/medical record keeping.

- Network Recruitment: Based upon Network Adequacy. Sentara cross-references its Network Adequacy NQTL analysis.

List of Factors that Determine which MH/SUD and M/S Practitioners Are Subject to Credentialing Requirements:

- Practitioners are licensed, certified or registered by the state to practice independently;

- Practitioners who have an independent relationship with the Plan. An independent relationship exists when the Plan directs its members to see a specific Practitioner or group of Practitioners, including all Practitioners whom members can select as Primary

Care Practitioners (PCPs). An independent relationship is not synonymous with an independent contract. The Plan does not credential some Practitioners with whom it holds independent contracts, however, if a Practitioner is listed in the Plan's Network Directory, the Practitioner must be credentialed;

- Practitioners may seek approval from the Plan to participate as a Primary Care Practitioner and a Specialist provided they meet the Plan's participation criteria for all scopes of practice being requested;
- Practitioners who see members outside the inpatient hospital setting or outside freestanding ambulatory facilities;
- Practitioners who are hospital based but who also see the Plan members as a result of an independent relationship with the Plan;
- Pain Medicine Practitioners;
- Oral Surgeons and Dentists who provide care to Plan members under their medical benefits;
- Non-physician Practitioners who have an independent relationship with the Plan and who provide care to members under the Plan's medical benefits;
- Telemedicine Practitioners.

Credentialing Criteria:

- Practitioner must hold active unrestricted (no limitations), current and valid professional licensure(s) to practice in any state the Practitioner is providing care to Plan membership.
- As applicable, Practitioner must hold a current and valid Federal Drug Administration Certificate with authority to write prescriptions for their scope of practice.
- As applicable, Practitioner must hold a current and valid State Controlled Substance Registration Certificate (CSR/CDS) in any state with this Certificate requirement for Practitioners prescribing controlled substances, if those states are states in which the Practitioner will render care to Plan membership.
- As applicable, Board Certification by an approved certifying Board, in a recognized practice specialty. In lieu of Board Certification, the Practitioner must have completed education and training in his/her practicing specialty and this training must be able to be primary source verified by the Plan.
- As applicable, Practitioner must hold current, unrestricted clinical privileges at a participating Plan hospital: In lieu of clinical privileges, the Practitioner must provide evidence of patient coverage or transfer arrangements with another Plan participating Practitioner to manage their Plan membership hospitalizations; or have documented admission arrangements with a hospitalist group to a participating Plan hospital.
- Practitioner must have acceptable 24-hour coverage which includes arrangements for alternate care of patients when the Practitioner is unavailable through another qualified

Practitioner consistent with the Plan's policies and procedures and standards and/or criteria.

- Practitioner must carry active professional malpractice liability coverage (where required by state law), meeting the regulatory monetary coverage amounts required by the state(s) they are providing care to Plan members in.

- Practitioner must have absence of a history of denial or cancellation of professional malpractice liability insurance, and evidence that any history of malpractice suits, arbitrations or settlements do not suggest an on-going substandard professional competence or conduct as determined by the Credentialing Committee.

- Practitioner must have absence of health problems including drug or alcohol abuse, which may interfere with judgment or competence, substantially impeding their ability to perform the essential functions of his/her scope of practice as determined by the Credentialing Committee.

- Practitioner must have absence of a history of criminal felony convictions and/or, indictments, or evidence this history does not suggest an effect on professional competence or conduct. A conviction within the meaning of this section includes a plea or verdict of guilt or a conviction following a plea of nolo contendere.

Any differences in credentialing criteria are based upon whether a practitioner is a doctoral level for both MH/SUD and M/S providers. The criteria listed above applies to all practitioners and in addition doctoral level practitioners must: (i) hold or continue to hold board certification or have verifiable education and training in specialties practiced; (ii) hold or continue to hold current hospital or ambulatory surgery privileges or have a formal arrangement with another participating physician or hospitalist group for hospitalization coverage of Plan members; and (iii) documented arrangements for coverage for Plan members when absent from the practice or unavailable.

List of Factors that Must Be Met To Secure Credentialing for Inpatient and Outpatient

In addition to the factors listed directly above for practitioners, Organizational Providers must meet the following criteria in order to participate in the Plans Network:

- Submit a complete application at initial assessment and during reassessment;

- Hold a current, valid state license without restriction, as applicable for each state of practice;

- Hold current, valid Professional and General Liability coverage within the policy limits established by their governing state laws, as applicable;

- Be in good standing with state and federal regulatory bodies;

- Have an acceptable Disclosure of Ownership, Controlling Interest and Management Statement required by 42 CFR Part §455;

- Hold a current NPI appropriate for their facility specialty type taxonomy;

- Non-Accredited facilities must provide their most recent state or CMS site survey or allow the Plan to conduct a quality assessment if they do not have a state or CMS site survey to provide.

Credentialing and Recredentialing:

The factors do not vary between credentialing and recredentialing. For Recredentialing, Sentara monitors compliance of all Network Providers (both practitioners and facilities) to ensure maintenance of compliance with all applicable licensure regulations, Medicare/Medicaid sanctions or exclusions, member complaint, quality issues and adverse events. Specifically, Medicare and Medicaid and licensure sanctioning is monitored monthly, as is confirmation of licensing status and NPI numbers. Sentara investigates complaints as received and monitors for adverse events at least monthly.

Step 3: Description of how factors are used in the design and application of the NQTL.

See **45 CFR 146.137(c)(3).** Step 3 must include the following: A description of how each factor identified and defined under Step 2 is used in the design or application of the NQTL to MH and SUD and medical/surgical benefits in a classification, including:

(1) A detailed explanation of how each factor identified and defined in Step 2 is used to determine which MH or SUD benefits and which medical/surgical benefits are subject to the NQTL;

(2) An explanation of the evidentiary standards or other information or sources (if any) considered or relied upon in designing or applying the factors or relied upon in designing and applying the NQTL, including in the determination of whether and how MH or SUD or medical/surgical benefits are subject to the NQTL;

(3) If the application of the factor depends on specific decisions made in the administration of benefits, the nature of the decisions, the timing of the decisions, and the professional designations and qualification of each decision maker;

(4) If more than one factor is identified and defined in Step 2, an explanation of:

(A) How all of the factors relate to each other;

(B) The order in which all of the factors are applied, including when they are applied;

(C) Whether and how any factors are given more weight than others; and

(D) The reasons for the ordering or weighting of the factors.

(5) Any deviations or variations from a factor, its applicability, or its definition (including the evidentiary standards used to define the factor and the information or sources from which evidentiary standards was derived), such as how the factor is used differently to apply the NQTL to MH or SUD benefits as compared to

medical/surgical benefits, and a description of how the plan or issuer establishes such deviations or variations.

See also FAQ 45 guidance. This FAQ guidance stipulates that a sufficient response includes:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q2, #6) If the application of the NQTL turns on specific decisions in administration of benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 3 in the context of committees/experts that design the NQTL, such as a Pharmacy & Therapeutics Committee or Prior Authorization Committee].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 5) Reference to factors and evidentiary standards that were defined or applied in a quantitative manner, without the precise definitions, data, and information necessary to assess their development or application.

Issuer Response:

The factors identified in Step 2 do not vary based upon the service type, whether M/S or MH/SUD. For Practitioners, the credentialing requirements depend largely on provider type, whether doctoral or allied health professionals. For inpatient facilities, the credentialing and recredentialing criteria are the same for all facilities, whether M/S or MH/SUD. The factors are designed around NCQA standards and do not vary from those standards. The factors and compliance program comply with Virginia law.

Ownership of Facilities:

Sentara credentials all providers in the same manner regardless of ownership of the provider or facility. There is no difference between "Sentara" facilities and providers and non-Sentara facilities and providers.

Interaction of Factors:

Sentara follows NCQA standard without deviation. The decision whether to initiate credentialing depends on the provider submitting an application.

Decision Makers and Discretion:

The Credentialing Committee is the designated review body of the Plan used to make Network participation decisions for credentialing, recredentialing, ongoing monitoring and delegated credentialing activities. The Credentialing is a heterogenous, clinical peer-review body of participating Plan practitioners who span a range of health care professions, including primary care, specialty care and behavioral health specialists. The Plan Medical Director has oversight responsibilities and serves as the Chairperson for the Credentialing Committee.

Only clinical members have voting ability. These members: represent a varying span of medical and behavioral health professions which are represented throughout the Plan's participating Network; are external to the Plan (not employed), and must hold an active Plan Network contract for participation; are not excluded from the Plan's credentialing, recredentialing and ongoing monitoring processes, policies and procedures, including all governing regulations; provide advice and expertise while engaging in meaningful peer review discussions before rendering decisions on which Practitioners and facilities meet qualifications and expectations for Plan participation; understand membership on the Credentialing Committee is voluntary and they may resign their Committee duties at any time without retaliation by the Plan.

The Credentialing Committee meets at least monthly. However, additional or more frequent meetings will be scheduled as deemed necessary by the Plan Medical Director. A quorum attendance of 51% of voting membership must be present at each meeting for all items and cases requiring a vote, for the proceedings to be considered valid. Meetings and decisions may take place in real-time, virtual meetings (i.e., through video conference or web conference with audio), but may not be conducted only through email.

The Medical Director approves all "Clean Files." Clean files are those deemed to meet the Plan's established network participation. The Committee is presented with a list of all Practitioners and facilities approved as clean.

The Credentialing Committee has responsibility for reviewing all credentialing, recredentialing and monitoring cases that do not meet the Plan's established Network participation criteria. This review evaluates files identified as "Issue" files or those files with problematic or concerning trends in their history (e.g., malpractice cases, licensure issues, adverse events, quality concerns, etc.). The Credentialing Committee shall:

- Review Issue files thoughtfully, engaging in robust discussion among all Committee Members giving consideration to all elements applicable to each case and the Practitioner or facilities ability to deliver appropriate care, services and quality to Plan members before rendering a Plan Network participation decision;
- The Committee may vote to administer any of the following actions regarding Network participation: approve for a full 3-Year Cycle, approve for a limited cycle (6-month, 1 year, or 2 years); pend the case for further information; or deny participation.

Credentialing and Recredentialing:

The factors do not vary between credentialing and recredentialing. For Recredentialing, Sentara monitors compliance of all Network Providers (both practitioners and facilities) to ensure maintenance of compliance with all applicable licensure regulations, Medicare/Medicaid sanctions or exclusions, member complaint, quality issues and adverse events. Specifically, Medicare and Medicaid and licensure sanctioning is monitored monthly, as is confirmation of licensing status and NPI numbers. Sentara investigates complaints as received and monitors for

adverse events at least monthly. The Credentialing Committee reviews provider sanction, complaints and other adverse events if referred to the Credentialing Committee post Physician Leadership Review Committee.

Step 4: Demonstration of comparability and stringency as written.

See 45 CFR 146.137(c)(4). The comparative analysis must evaluate whether, in any classification, under the terms of the plan (or health insurance coverage) as written, any processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) Documentation of each factor identified and defined in Step 2 that was applied to determine whether the NQTL applies to MH or SUD benefits and medical/surgical benefits in a classification, including, as relevant;

(A) Quantitative data, calculations, or other analyses showing whether, in each classification in which the NQTL applies, MH or SUD benefits and medical/surgical benefits met or did not meet any applicable threshold identified in the relevant evidentiary standard to determine that the NQTL would or would not apply; and

(B) Records maintained by the plan or issuer documenting the consideration and application of all factors and evidentiary standards, as well as the results of their application;

(2) In each classification in which the NQTL applied to MH or SUD benefits, comparison of how the NQTL, as written, is designed and applied to MH or SUD benefits and to medical/surgical benefits, including the specific provisions of any forms, checklists, procedure manuals, or other documentation used in designing and applying the NQTL or that address the application of the NQTL;

(3) Documentation demonstrating how the factors are comparably applied, as written, to MH or SUD benefits and medical/surgical benefits in each classification to determine which benefits are subject to the NQTL; and

(4) An explanation of the reasons for any deviations or variations in the application of a factor used to apply the NQTL, or the application of the NQTL, to MH or SUD benefits as compared to medical/surgical benefits, and how the plan or issuer establishes such deviations or variations, including [Note that this is asking the issuer to

explain/justify any differences between MH/SUD benefits and M/S benefits and to explain why the differences are not more restrictive for MH/SUD benefits]:

(A) In the definition of the factors, the evidentiary standards used to define the factors, and the sources from which the evidentiary standards were derived;

(B) In the design of the factors or evidentiary standards; or

(C) In the application or design of the NQTL.

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s) [Note that this applies to Step 4 in the context of the processes used to apply the NQTL, such as first-level review, second-level review, and peer-to-peer review].
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid::

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.
- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Application of Factors and Evidentiary Standards:

The Credentialing Program Description (https://shc-p-001.sitecorecontenthub.cloud/api/public/content/0e285a3e5e7140ad925afebef48ececc?v=64f48c8b) . As written, the Credentialing Program Description does not distinguish between credentialing

criteria for M/S or MH/SUD. The factors identified in Step 2: namely, initiation of credentialing process, determination of which practitioners are subject to credentialing requirements, and determination of which facilities are subject to credentialing does not vary between M/S and MH/SUD. All providers are required to complete the same application using the CAQH form (https://proview.caqh.org.)/ All providers are subject to the same credentialing criteria which only varies based upon professional level and whether the provider is a practitioner or facility. Within these categories, there is no distinction between M/S and MH/SUD providers.

Discretion by the Credentialing Committee is limited to circumstances where providers do not submit "Clean Files." Clean files are approved by the Medical Director.

Related Network Composition Processes:

Claim submission and billing restrictions do not vary between M/S and MH/SUD services. Categorially, Sentara does not permit non-credentialed providers to provide services under the Plan. Terms of provider contracting do not vary between M/S and MH/SUD providers.

Tracking Dispositions:

Following the decision by the Credentialing Committee to suspend, reduce, or terminate a Practitioner's or Organizational Provider's Plan participation for quality reasons, written notice will be sent to the Practitioner or Organizational Provider by the Credentialing Department indicating the action(s) to be taken within 30 days of the decision. Appeal Rights and timeframes will be stated in the letter and a copy will be retained electronically in the Plan's Credentialing System. All providers maintain the same appeal rights:

> Informal Meeting: Upon receipt of written notice of an Adverse Action, the Practitioner or Organizational Provider may request to meet on an informal basis with an Ad Hoc Committee concerning the Adverse Action recommended by the Credentialing Committee by submitting such request in writing to the Chair of the Credentialing Committee or designee within 10 business days. Members of the Ad Hoc Committee shall be clinical Practitioners of the same professional discipline as the affected Practitioner and considered qualified peers to review the case, not be in direct economic competition with the affected Practitioner or Organizational Provider; and not be a member of the Plan's Credentialing Committee. Following the meeting, the Ad Hoc Committee shall notify the Credentialing Committee Chair or their designee and the Practitioner or Organizational Provider of its recommendation to accept, modify, or reject the Adverse Action.
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> Appeal Hearing: The Hearing Panel members shall be clinical Practitioners of the same professional discipline as the affected Practitioner and considered qualified peers to review the case, not be in direct economic competition with the affected Practitioner or Organizational Provider; and not be a member of the Plan's Credentialing Committee. The Provider has the right to be represented by counsel, have a copy of the Appeal Hearing record, present evidence, including the calling of witnesses to submit a statement of completion of the Appeal Hearing. Decisions of the Hearing Panel are final.
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> Appellate Review: Upon a timely written request for an appellate review, the Plan Medical Director Team shall review the recommendation from the Hearing Panel. The Plan Medical Director Team may choose to delegate this appellate review responsibility to a subcommittee of its members. The Provider shall submit to the Plan Medical Director Team a type-written argument, not to exceed ten pages in length. Upon receipt of such type-written argument, the Plan Medical Director Team shall distribute copies to the Plan

Credentialing Committee. The Plan Credentialing Committee shall have an opportunity to respond by submitting to the Plan Medical Director Team within 10 business days of its receipt of the Practitioner's or Organizational Provider's written argument, its own type-written argument, not to exceed ten pages in length. Within 10 business days the Plan Medical Director Team shall decide whether to uphold or reverse the recommendation of the Hearing Panel. The decision shall be final and binding upon issuance.

Providers can withdraw from the credentialing process at any time prior to the completion of their credentialing file. A provider is not given an opportunity to withdraw an application once the credentialing committee has received, reviewed, and made a denial decision.

Credentialing and Recredentialing:

The factors do not vary between credentialing and recredentialing. For Recredentialing, Sentara monitors compliance of all Network Providers (both practitioners and facilities) to ensure maintenance of compliance with all applicable licensure regulations, Medicare/Medicaid sanctions or exclusions, member complaint, quality issues and adverse events. Specifically, Medicare and Medicaid and licensure sanctioning is monitored monthly, as is confirmation of licensing status and NPI numbers. Sentara investigates complaints as received and monitors for adverse events at least monthly. The Credentialing Committee reviews provider sanction, complaints and other adverse events if referred to the Credentialing Committee post Physician Leadership Review Committee.

Step 5: Demonstration of comparability and stringency in operation.

See **45 CFR 146.137(c)(5).** The comparative analysis must evaluate whether, in any classification, in any classification, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL with respect to medical/surgical benefits. The comparative analysis must include, with respect to the NQTL and the factors used in designing and applying the NQTL:

(1) A comprehensive explanation of how the plan or issuer evaluates whether, in operation, the processes, strategies, evidentiary standards, or other factors used in designing and applying the NQTL to MH or SUD benefits in a classification are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards or other factors used in designing and applying the NQTL with respect to medical/surgical benefits, including:

(A) An explanation of any methodology or underlying data used to demonstrate the application of the NQTL, in operation;

(B) The sample period, inputs used in any calculations, definitions of terms used, and any criteria used to select the MH or SUD benefits and medical/surgical benefits to which the NQTL is applicable;

(C) With respect to an NQTL for which relevant data is temporarily unavailable as described in Section 146.136(c)(4)(iii)(A)(3)(i) a detailed explanation of the lack of relevant data, the basis for the plan's or issuer's conclusion that there is a lack of relevant data, and when and how the data will become available and be collected and analyzed; and

(D) With respect to an NQTL for which no data exist that can reasonably assess any relevant impact of the NQTL on relevant outcomes related to access to MH and SUD benefits and medical/surgical benefits as described in Section 146.136(c)(4)(iii)(A)(3)(ii), a reasoned justification as to the basis for the conclusion that there are no data that can reasonably assess the BQTL's impact, an explanation of why the nature of the NQTL prevents the plan or issuer from reasonably measuring its impact, an explanation of what data was considered and rejected, and documentation of any additional safeguards or protocols used to ensure the NQTL complies with Section 146.136(c)(4)(iii)(A);

(2) Identification of the relevant data collected and evaluated, as required under Section 146.136(c)(4)(iii)(A);

(3) Documentation of the outcomes that resulted from the application of the NQTL to MH or SUD benefits and medical/surgical benefits, including:

(A) The evaluation of relevant data as required by Section 146.136(c)(4)(iii)(A)];

(B) A reasoned justification and analysis that explains why the plan or issuer concluded that any differences in the relevant data do or do not suggest the NQTL contributes to material differences in access to MH or SUD benefits as compared to medical/surgical benefits, in accordance with Section 146.136(c)(4)(iii)(B)(2);

(4) A detailed explanation of any material differences in access demonstrated by the outcomes evaluated under paragraph (c)(5)(iii), including:

(A) A reasoned explanation of any material differences in access that are not attributable to differences in the comparability or relative stringency of the NQTL as applied to MH or SUD benefits and medical/surgical benefits (including any considerations beyond a plan's or issuer's control that contribute to the existence of material differences) and a detailed explanation of the bases for concluding that material differences are not attributable to differences in the comparability or relative stringency of the NQTL; and

(B) To the extent differences in access to MH or SUD benefits are attributable to generally recognized independent professional medical or clinical standards or carefully circumscribed measures reasonably and appropriately designed to detect or prevent and prove fraud and abuse that minimize the negative impact on access to appropriate MH ad SUD benefits, and such standards or measures are used as the basis for a factor or evidentiary standard used to design or apply

an NQTL, documentation explaining how any such differences are attributable to those standards or measures, as required by Section 146.136(c)(4)(iii)(B)(2)(ii); and

(5) A discussion of the actions that have been or are being taken by the plan or issuer to address any material differences in access to MH or SUD benefits as compared to medical/surgical benefits, including the actions the plan or issuer has taken or is taking under Section 146.136(c)(4)(iii)(B)(1) to address material differences to comply, in operation with Section 146.136(c)(4), including as applicable:

(A) A reasoned explanation of any material differences in access to MH or SUD benefits as compared to medical/surgical benefits that persist despite reasonable actions that have been or are being taken; and

(B) For a plan or issuer designing and applying one or more NQTLs related to network composition, a discussion of the actions that have been or are being taken to address material differences in access to in-network MH and SUD benefits as compared to in-network medical/surgical benefits, including those listed in 146.136(c)(4)(iii)(C).

See also FAQ 45 guidance that states that the following is necessary for a sufficient response:

- (Q2, #5) The analyses, as documented, should explain whether there is any variation in the application of a guideline or standard used by the plan or issuer between MH/SUD and medical/surgical benefits and, if so, describe the process and factors used for establishing that variation.
- (Q 2, # 6) If the application of the NQTL turns on specific decisions in administration of the benefits, the plan or issuer should identify the nature of the decisions, the decision maker(s), the timing of the decisions, and the qualifications of the decision maker(s).
- (Q2, #7) If the plan's or issuer's analyses rely upon any experts, the analyses, as documented, should include an assessment of each expert's qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluations in setting recommendations regarding both MH/SUD and medical/surgical benefits.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 1) Production of a large volume of documents without a clear explanation of how and why each document is relevant to the comparative analysis.
- (Q3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.
- (Q 3, # 3) Identification of processes, strategies, sources, and factors without the required or clear and detailed comparative analysis.

- (Q 3, # 4) Identification of factors, evidentiary standards, and strategies without a clear explanation of how they were defined and applied in practice.

Issuer Response:

Sentara provides the following data from January 1, 2025 to December 31, 2025:

Initial Credentialing	Goal/Metric	YTD
Overall Initial Credentialing TAT	Less than or equal to 20 days	14.5
Total Medical Initial Credentialing Cases Completed	Actual	4150
Total BH Initial Credentialing Cases Completed	Actual	3432
Total Initial Credentialing Cases Completed	Actual	7582

Recredentialing	Goal/Metric	YTD
Total Medical Recredentialing Cases Completed	Actual	3942
Total BH Recredentialing Cases Completed	Actual	2769
Total Recredentialing Cases Completed	Actual	6711

Initial Credentialing- Facility	Goal/Metric	YTD
Facility Initial Applications Completed	Actual	159
BH Facility Applications Completed	Actual	48
Credentialing Committee	**Goal/Metric**	**YTD**
Number Deferred by Committee	Actual	1
Number Denied by Committee	Actual	22
Number Appeals Meeting Completed	Actual	0
Total Practitioners Non-Clean Files Presented to Committee (including behavioral health and non-behavioral health/ initial credentialing and recredentialing)	Actual	172
Approval Letters	Actual	14271

In the 2025 time period, 14,271 credentialing approvals were issued. Of this total, 172 Non-Clean Files (1.2%) were presented to the Credentialing Committee. Of this 172, 22 applications (12.8%) were denied. The TAT for initial credentialing totaled 14.5 days, below the policy as written.

Currently, the Behavioral Health network is closed across all lines of business with the understanding that exceptions are warranted when a demonstrated clinical or member-specific need exists. The established exception process provides a mechanism for evaluating these circumstances and ensuring that network participation decisions remain responsive to the evolving needs of our membership.

works to ensure that any network approach does not inadvertently create barriers to care or limit its ability to address legitimate identified clinical needs. Since the closure of the BH network, the vast majority of the provider participation requests received pertain to the Medicaid line of business. Conversely, providers expressing interest in participation in the Commercial line of business have been approved for network participation, including those offering specialty services such as substance use disorder services.

Step 6: Findings and conclusions.

See **45 CFR 146.137(c)(6).** The comparative analysis must address the findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, and other factors used in designing and applying the NQTL to MH or SUD benefits and medical/surgical benefits within each classification, and the relative stringency of their application, both as written and in operation, and include:

(1) Any findings or conclusions indicating that the plan or coverage is or is not (or might or might not be) in compliance with the requirements of Section 146.136(c)(4), including any additional actions the plan or issuer has taken or intends to take to address any potential areas of concern or noncompliance;

(2) A reasoned and detailed discussion of the findings and conclusions described in (1) above;

(3) Citations to any additional specific information not otherwise included in the comparative analysis that supports the findings and conclusions in (1) above not otherwise discussed in the comparative analysis;

(4) The date the analysis is completed and the title and credentials of all relevant persons who participated in the performance and documentation of the comparative analysis; and

(5) If the comparative analysis relies upon an evaluation by a reviewer or consultant considered by the plan or issuer to be an expert, an assessment of each expert's

qualifications and the extent to which the plan or issuer ultimately relied upon each expert's evaluation in performing and documenting the comparative analysis of the design and application of the NQTL applicable to both MH or SUD benefits and medical/surgical benefits.

See also the FAQ 45 guidance, which states that a sufficient response should include:

- (Q 2, # 8) A reasoned discussion of the plan's or issuer's findings and conclusions as to the comparability of the processes, strategies, evidentiary standards, factors, and sources identified above within each affected classification, and their relative stringency, both as applied and as written. This discussion should include citations to any specific evidence considered and any results of analyses indicating that the plan or coverage is or is not in compliance with MHPAEA.

This FAQ guidance stipulates what plans and issuers should avoid:

- (Q 3, # 2) Conclusory or generalized statements, including mere recitations of the legal standard, without specific supporting evidence and detailed explanations.

Issuer Conclusions and Findings:

Sentara provided a definition of the Credentialing NQTL. In Step 1, Sentara provided Plan terms, descriptions of all policies and guidelines concerning credentialing, and identified all providers for which credentialing is necessary. In Step 2, Sentara provided the factors and standards considered when a provider requests to be credentialed or recredentialed and explained the factors for credentialing/recredentialing requirements for certain providers. In Step 3, Sentara described how those factors are used and measured in the credentialing processes, including a thorough explanation of the role of the Credentialing Committee. In Step 4, Sentara described the policies as written and demonstrated compliance with those policies in operation in Step 5. Sentara explained that its Behavioral Network is closed but providers expressing interest in participation in the Commercial line of business have been approved for network participation, including those offering specialty services such as substance use disorder services.

The analysis establishes Sentara is compliant with MHPAEA.

This analysis was completed in September 2026 by members of the following departments at Sentara: Network Management, Credentialing, Compliance, and Legal.