BRIGHT HEALTH PLAN YEAR 2021 NON-QUANTITATIVE TREATMENT LIMITATION COMPARATIVE ANALYSIS FOR COMPLIANCE WITH MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT (MHPAEA)

Assumptions for Analysis:

1. Look-Back Period for Review is 1/1/2022-9/30/2022.
2. For Clinical Data, Date is based on **initial determination date** regardless of when the request was submitted, appealed, etc.
3. Unless otherwise notes (IE pharmacy data), comparative analysis is market agnostic; processes, strategies, evidentiary standards are consistent across all markets when related to clinical NQTLs. Therefore, Bright conducts its internal analysis at the line-of-business level .
4. Analysis for UM authorizations (IE – PA, CR, Retro) is conducted for all covered benefits which excludes out-of-network benefits; data will include in-network authorization data across applicable benefit classifications (ie IP, OP-other) subject to each NQTL

#REF!	Benefits		Classifications						Sub-Classifications			
Non-Quantitative Treatment Limitations	Is NQTL applied to Medical/Surgical benefits?	Is NQTL applied to Mental Health/Substance Use Disorder benefits?	Is NQTL applied to In Network Inpatient classification?	Is NQTL applied to Out of Network Inpatient classification?	Is NQTL applied to In Network Outpatient classification?	Is NQTL applied to Out of Network Outpatient classification?	Is NQTL applied to Emergency classification?	Is NQTL applied to Prescription classification?	Is NQTL applied to In Network Outpatient-Office subclassification?	Is NQTL applied to Out of Network Outpatient-Office subclassification?	Is NQTL applied to In Network Outpatient-All Other subclassification?	Is NQTL applied to Out of Network Outpatient-All Other subclassification?
Prior Authorization	Yes	Yes	Yes	No	Subclassify	No	No	Yes	No	No	Yes	No
Concurrent Review	Yes	Yes	Yes	No	No	No	No	No	No	No	No	No
Retrospective Review	Yes	Yes	Yes	No	Subclassify	No	No	No	No	No	Yes	No
Medical Necessity Criteria	Yes	Yes	Yes	No	Subclassify	No	No	No	No	No	Yes	No
Fail First Protocols	Yes	Yes	No	No	No	No	No	Yes	No	No	No	No
Formulary Design	Yes	Yes	No	No	No	No	No	Yes	No	No	No	No
Experimental/Investigational	Yes	Yes	Yes	No	Subclassify	No	No	No	No	No	Yes	No
Provider Credentialing	Yes	Yes	Yes	No	Yes	No	No	No	Yes	No	Yes	No
Out of Network (OON) Coverage Standards	Yes	Yes	No	Yes	No	Yes	No	No	No	No	No	No
Geographic Restrictions	Yes	Yes	Yes	No	Yes	No	No	No	Yes	No	Yes	No
Plan Standards to Ensure Network Adequacy	Yes	Yes	Yes	No	Yes	No	No	No	No	No	No	No

#REF!	INN- Inpatient	Step 1 Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.		Step 2 Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		Step 3	Step 4	Step 5	Step 6
NQTL	Covered Service	Description of Med/Surg applicability:	Description of MH/SUD applicability:	Factors	Sources	Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
Prior Authorization	Medical/Surgical (M/S) inpatient benefits subject to prior authorization review: Inpatient Hospital Services – Medical/Surgical Inpatient Habilitation/Rehabilitation Services Skilled Nursing Facility Mental Health/Substance Use Disorder (MH/SUD) inpatient benefits subject to Prior Authorization Review: Inpatient Hospital Services – Mental Health Inpatient Hospital Services – Substance Use Disorder Inpatient Detox – Substance Use Disorder Residential Treatment – Mental Health Residential Treatment – Substance Use Disorder	Prior Authorization (COC)– Prior Authorization is the process of reviewing a request for health care services prior to receiving care. Prior Authorization may be required to make sure services are Medically Necessary, performed in the least costly setting, and that the Provider is In-Network. Please refer to Your Schedule of Benefits to see which services require Prior Authorization. Prior Authorization – the process of collecting information prior to selected procedures, diagnostic studies, medical equipment, or medications, and checking to make sure that the requested care meets selected clinical protocols and standard cost-effectiveness analysis. Prior Authorization does require judgment or interpretation for Benefits coverage. That coverage determination is based on plan documents, information from the Provider, information from nationally recognized guidelines, and occasionally input from a nationally recognized expert in the field relevant to the requested care. Utilization Review (COC)– Is a process used to monitor the use of, or evaluate the clinical	Prior Authorization (COC)– Prior Authorization is the process of reviewing a request for health care services prior to receiving care. Prior Authorization may be required to make sure services are Medically Necessary, performed in the least costly setting, and that the Provider is In-Network. 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Utilization Review (COC)– Is a process used to monitor the use of, or evaluate the clinical	Bright Health completes an analysis of all identified factors at least annually when determining when to apply utilization review (prior authorization, concurrent review, and retrospective review) requirements to a benefit. Ensuring Appropriate Care Utilization Patterns and Cost of Care Evaluations Regulatory Requirements and Industry Standards Administrative Efficiencies	• Nationally recognized evidence-based treatment guidelines; • Peer-reviewed literature; • Expert medical review by Plan Clinical Leaders including medical and behavioral health; • Consultation with vendors and partners with expertise; • Internal authorization analysis • Internal claims analysis • UM Program operating cost analysis • State and federal regulatory requirements and guidance • National Accreditation standards • Evidence-based guidelines and protocols for standards of quality care • Current clinical policies and medical necessity criteria • Member Plan Documents • Managed Care Industry Standards	Bright Health completes an analysis of all identified factors at least annually when determining when to apply utilization review (prior authorization, concurrent review, and retrospective review) requirements to a benefit. Ensuring Appropriate Care – evaluation of services for which generally accepted standards of care indicate specified treatments; ex - Services for which a lower intensity or less restrictive level of care may be medically appropriate. Variability in quality, safety, utilization, and cost of services is considered. Efficacy of services provided is reviewed according to generally accepted standards of care. Sources: Evidence-based treatment guidelines; medical necessity criteria; expert opinion of internal panel of Plan Clinical Leaders including medical and behavioral health; consultation with vendors and partners with expertise; peer-reviewed literature; Utilization Patterns and Cost of Care Evaluations – authorization and claims data review and analyses. Cost and use variability are evaluated both through internal reporting and published Internal claims reports and data analysis are reviewed at a unit and total cost level. Sources: Authorization reports; evidence-based treatment guidelines; internal authorization and claims analysis by volume, approval/denial rates, claims analysis of unit cost, total cost; fee schedules and reimbursement rates; nationally recognized evidence based treatment guidelines. Regulatory Requirements and Industry Standards – federal and/or state requirements are evaluated to ensure compliance; review of current guidance from regulatory entities and professional organizations; comparisons of other insurer practices	BrightHealthCare completes a comprehensive analysis of identified factors at least annually when determining when to apply utilization review (prior authorization, concurrent review, and retrospective review) requirements to a benefit. The same process is completed for both medical/surgical and mental health/substance use disorder benefits. The only factor which is weighed more heavily is compliance with regulatory requirements which supersedes the other factors in the decision-making process. Bright HealthCare leaders involved in the process to evaluate factors for the application of utilization review requirements include professionals with experience in medical and behavioral health care. Once approved, Prior Authorization lists are available to members and providers on the Bright Health website. Documentation of UM Processes: Prior Authorization is applied through the utilization review process. The process for utilization review is the same for medical/surgical benefits as is in place for mental health/substance use disorder benefits. The utilization review process is consistent with URAC accreditation standards and is applied comparably for both medical and behavioral health benefits. For both medical/surgical and mental health/substance use disorder benefits, Bright Health policies outline in detail the processes for conducting utilization review and are available upon request: MED-017 UM Determinations MED-069 UM Clinical Peer Review Policy MED-070 UM Certification MED-071 UM Non-Certification MED-074 UM Concurrent Review	All utilization review NQTLs (medical necessity, prior authorization, concurrent review, retrospective review, experimental/investigational) are evaluated through comparative analyses of Quality Oversight outcomes and Utilization Review data. See "2022 Comparative Analysis Data Attachment - Georgia" for detailed analysis of Quality Oversight and Utilization Review comparative analysis data outcomes broken out for each NQTL, in operation. Quality Oversight: Application of approved medical necessity criteria is evaluated through the Inter-rater reliability process which is captured in full in Bright Health policy: Med-039 UM Inter-rater Reliability Monitoring All Bright HealthCare staff responsible for clinical decision-making during the utilization review process (ie. Clinicians, peer reviewers, medical directors) will participate in the annual IRR examinations. All clinical criteria relied upon to evaluate medical necessity for medical and behavioral health utilization review is included in the IRR process (for example, MCG, ASAM, Bright HealthCare Medical Policy) that the individual may apply during utilization review. IRR passing threshold is 90% for both medical and behavioral health staff. In addition to the annual IRR process, clinical quality audits are conducted monthly for both medical/surgical and mental health/substance use disorder utilization review staff to evaluate consistent use of utilization review policies and application of appropriate clinical criteria. Each case record is audited for 14 key elements including: •Verification of benefits, eligibility, network •Compliance with utilization review processes as written	Bright HealthCare defines prior authorization the same for medical/surgical and mental health/substance use disorder benefits. The factors, sources, and evidentiary standards in place to design and apply utilization review NQTLs to mental health/substance use and medical/surgical benefits are the same. The process to determine which benefits to apply utilization review requirements to is the same for medical/surgical and mental health/substance use disorder benefits. The same processes are used when conducting utilization review for mental health/substance use disorder and medical/surgical benefits. IRR results and ongoing quality monitoring audits of utilization review demonstrate consistent and comparable application of medical necessity criteria and the process of utilization review between medical/surgical reviewers and mental health/substance use disorder reviewers. Bright Health also evaluates medical necessity determinations through authorization analysis comparably for MH/SUD utilization review as we do for M/S. Based on the analyses, Bright HealthCare concludes that the processes, strategies, evidentiary standards, and other factors used to apply utilization review to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply utilization review to medical or surgical benefits.
Concurrent Review	Medical/Surgical (M/S) inpatient benefits subject to prior authorization review: Inpatient Hospital Services – Medical/Surgical Inpatient Habilitation/Rehabilitation Services Skilled Nursing Facility Mental Health/Substance Use Disorder (MH/SUD) inpatient benefits subject to Prior Authorization Review: Inpatient Hospital Services – Mental Health Inpatient Hospital Services – Substance Use Disorder Inpatient Detox – Substance Use Disorder Residential Treatment – Mental Health Residential Treatment – Substance Use Disorder	Utilization Review (COC, p. 112)– Is a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Areas of review may include prospective review, concurrent review or retrospective review. Case management and Prior Authorization are also types of Utilization Review. Concurrent review (Provider Manual, p. 49): As part of our UM program, Bright HealthCare conducts concurrent reviews of inpatient admissions and certain outpatient services for duration of stay, level of care reviews, and other medical necessity reviews. Providers are required to cooperate with UM program and concurrent reviews, as stated in their Network Participation Agreements. Concurrent Review: Utilization management conducted during a Member's hospital stay or course of treatment. Timeliness: Concurrent Review: 24 hours	Utilization Review (COC, p. 112)– Is a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Areas of review may include prospective review, concurrent review or retrospective review. Case management and Prior Authorization are also types of Utilization Review. 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Retrospective Review	Services that are subject to prior authorization processes, and that were rendered without prior authorization, require retrospective review for medical necessity and/or benefit coverage. Medical/Surgical (M/S) inpatient benefits subject to prior authorization review: Inpatient Hospital Services – Medical/Surgical Inpatient Habilitation/Rehabilitation Services Skilled Nursing Facility Mental Health/Substance Use Disorder (MH/SUD) inpatient benefits subject to Prior Authorization Review: Inpatient Hospital Services – Mental Health Inpatient Hospital Services – Substance Use Disorder Inpatient Detox – Substance Use Disorder Residential Treatment – Mental Health Residential Treatment – Substance Use Disorder	Utilization Review (COC, p. 112)– Is a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. 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The same processes are used when conducting utilization review for mental health/substance use disorder and medical/surgical benefits. IRR results and ongoing quality monitoring audits of utilization review demonstrate consistent and comparable application of medical necessity criteria and the process of utilization review between medical/surgical reviewers and mental health/substance use disorder reviewers. Bright Health also evaluates medical necessity determinations through authorization analysis comparably for MH/SUD utilization review as we do for M/S. Based on the analyses, Bright HealthCare concludes that the processes, strategies, evidentiary standards, and other factors used to apply utilization review to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply utilization review to medical or surgical benefits.
Medical Necessity Criteria	All covered benefits for both Medical/Surgical and Mental Health/Substance Use Disorder must be medically necessary.	(COC p.107) Medically Necessary/Medical Necessity – health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. We use these terms to help Us determine whether a particular service or supply will be covered. When possible, We develop written criteria (called clinical review criteria) that We use to determine Medical Necessity. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put clinical criteria in policies that We make available to the medical community and Our members. We do this so that You and Your Providers will know in advance, when possible, what We will pay for. If a service or supply is not Medically Necessary according to Our published clinical criteria, We will not pay for it. If a service or supply is not addressed by Our clinical criteria, We will consider it to be Medically Necessary only if We determine that it is: •Appropriate and necessary for the symptoms, diagnosis, or treatment of Your medical	Medically Necessary/Medical Necessity – health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. We use these terms to help Us determine whether a particular service or supply will be covered. When possible, We develop written criteria (called clinical review criteria) that We use to determine Medical Necessity. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put clinical criteria in policies that We make available to the medical community and Our members. We do this so that You and Your Providers will know in advance, when possible, what We will pay for. If a service or supply is not Medically Necessary according to Our published clinical criteria, We will not pay for it. If a service or supply is not addressed by Our clinical criteria, We will consider it to be Medically Necessary only if We determine that it is: •Appropriate and necessary for the symptoms, diagnosis, or treatment of Your medical	All benefits for MH/SUD and M/S are required to be medically necessary as defined in the members certificate of coverage. Bright Health evaluates medical necessity of covered benefits by conducting utilization review through the medical management processes including prior authorization, concurrent review, and retrospective. Clinical review criteria used during utilization review is evidence based and applied consistently. Bright HealthCare defines medical necessity as: Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine. Bright HealthCare may consider health care services or supplies medically necessary if it is determined that the services are: •Appropriate and necessary for the symptoms, diagnosis, or treatment of the member's medical condition. •Provided for the diagnosis or direct care and treatment of the member's medical condition. •In accordance with standards of good medical practice accepted by the organized medical community. •Not primarily for the convenience and/or comfort of the member, the member's family, or the provider. •Not investigational or experimental. •Performed in the least costly setting, method, or manner, or with the least costly supplies required by the member's medical condition.	Bright Health develops written clinical review criteria into medical policies which are used to support medical necessity determinations. Bright Health develops and adopts clinical review criteria that are based on scientific evidence, align with current best practices, and are intended to be guidelines to support utilization management review determinations. Bright Health applies clinical review criteria to support clinical decision-making, including: 1. Internally developed criteria. 2. Commercially available criteria developed by a third-party, including Milliman Care Guidelines (MCG) and American Society of Addiction Medicine (ASAM) 3. Member's Plan Documents 4. State and federal requirements. 5. Other evidence-based external resources. Bright HealthCare relies on information from comparable sources when developing and adopting medical necessity criteria for both mental health/substance use disorder and medical/surgical benefits including: Bright HealthCare relies on the following evidentiary standards when developing and adopting explicit clinical criteria for benefits and services to evaluate medical necessity: •Plan-developed medical policies and clinical criteria •Commercially available criteria developed by a third-party, including MCG Care Guidelines (MCG) and American Society of Addiction Medicine (ASAM)	Bright Health provides coverage for MH/SUD and M/S services that are medically necessary. Bright Health defines medical necessity the same for mental health/substance use disorder and medical/surgical health services. Bright HealthCare develops and adopts clinical review criteria that are based on scientific evidence, align with current best practices, and are intended to be guidelines to support utilization management review determinations. Bright HealthCare's Utilization Management Committee (UMC) oversees the development, review, approval, and evaluation of clinical criteria applied during utilization review to determine medical necessity. Bright HealthCare's UMC members include professionals from diverse specialties that represent the needs of Bright Health's members based on member demographics. The Committee includes medical and behavioral health subject matter experts and may request the input of additional specialists through ad-hoc consultation or expansion of committee membership or as determined by the Committee. The clinical review criteria are: 1.developed with the involvement of actively practicing physicians, pharmacists and other providers (e.g., chiropractor and therapist) with current knowledge relevant to the criteria or scripts under review to develop the needed clinical criteria 2.based on current, evidence-based clinical principles and processes. The clinical criteria, once developed, are approved by the Chief Medical Officer and the Utilization Management Committee. All internal and external (third-party) clinical criteria is evaluated at least annually. Approval and annual evaluation of all clinical criteria is captured in the UMC minutes. Subject matter	Bright Health defines medical necessity the same for both medical/surgical and mental health/substance use disorder benefits. The process for developing and adopting medical necessity criteria is the same for both medical/surgical and mental health/substance use disorder. The application of medical necessity criteria is through utilization review which follows the same process for medical/surgical and mental health/substance use disorder benefits. The panel of experts involved in the development, adoption, and annual evaluation of medical necessity criteria include medical and behavioral health professionals with diverse experience. The process to apply medical necessity criteria through the utilization review process is the same for medical/surgical and mental health/substance use disorder. All staff are evaluated annually on the appropriate and consistent application of the approved medical necessity criteria. The results of the annual IRR evaluation indicate that both medical/surgical and mental health/substance use disorder benefit UM staff consistently apply approved medical necessity criteria appropriately. Bright HealthCare concludes that parity exists for medical necessity criteria as it is applied to medical/surgical and mental health/substance use disorder benefits.
Experimental/Investigational	All	Certificate of Coverage: Section 8 - Limitations/Exclusions (What is Not Covered) Experimental, Investigational, or Unproven Services Health care services excluded under this provision include Experimental, Investigational, and Unproven Services and all related services. The fact that an Experimental, Investigational, or Unproven Service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational, or Unproven in the treatment of that particular condition. This exclusion does not apply to a prescribed drug if: • The drug was approved by the FDA as an "investigational new drug for treatment use" or • It is a drug classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life-threatening disease" as that term is defined in FDA regulations This exclusion does not apply to Covered Health Services provided during a clinical trial as described under the Benefits/Coverage (What is Covered) section of this EOC. Denials for services deemed Experimental,	Certificate of Coverage: Section 8 - Limitations/Exclusions (What is Not Covered) Experimental, Investigational, or Unproven Services Health care services excluded under this provision include Experimental, Investigational, and Unproven Services and all related services. The fact that an Experimental, Investigational, or Unproven Service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational, or Unproven in the treatment of that particular condition. This exclusion does not apply to a prescribed drug if: • The drug was approved by the FDA as an "investigational new drug for treatment use" or • It is a drug classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life-threatening disease" as that term is defined in FDA regulations This exclusion does not apply to Covered Health Services provided during a clinical trial as described under the Benefits/Coverage (What is Covered) section of this EOC. Denials for services deemed Experimental,	Clinical Efficacy of the proposed treatment or services Safety Members Coverage Policy	•Expert Medical Review •Preponderance of peer-reviewed studies of medical literature •State and Federal Regulatory Requirements •Generally accepted standards of medicine •FDA or other regulatory approval •Credible knowledgebases e.g. Hayes, UpToDate, MCG, etc. or textbooks of medicine. •Current and published scientific evidence and technology literature •Technology updates, news and summaries from Hayes, the Cochrane •Collaborative or other nationally recognized organizations, such as medical experts or affected specialty societies •Definition of "clinical trial":	Bright Health does not provide coverage for services that are determined to be Investigational or Experimental unless those health services are: 1.Mandated by State or Federal rules or specified in the member's coverage policy, or 2.Deemed to be routine care costs during the course of an approved Clinical Trial:. Clinical trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs: (A)Federally Funded Trials -The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following: (i)The National Institutes of Health. (ii)The Centers for Disease Control and Prevention. (iii)The Agency for Health Care Research and Quality. (iv)The Centers for Medicare & Medicaid Services. (v)cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs. (vi)A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants. (vii)A study or investigation has been conducted and approved through a system of peer review by one of the following: (I)The Department of Veterans Affairs. (II)The Department of Defense. (III)The Department of Energy.	A request for coverage under a benefit exception process requires the following information to be submitted with the request for the benefit exception in order to render a coverage decision: • A letter of explanation from the referring provider outlining the specific needs of the member •Relevant medical records. •Other materials in support of the request including, but not limited to, peer-reviewed studies, clinical trial protocols, clinical evidence-based research, peer opinion, etc. (See "Prior Authorization" description of Intake through initial clinical review. Below is the additional process and criteria for Experimental/Investigational requests.) Bright HealthCare MD Peer Reviewer will evaluate each request on a case-by-case basis. The MD Peer Reviewer will review peer-reviewed literature and other evidentiary standards listed above when conducting the clinical review. MD Peer Reviewer will determine a request for services is denied on the basis of being experimental/investigational as defined by any of the following: 1)The service does not have unrestricted market approval from the Food and Drug Administration or final approval from any other regulatory body for use in treatment of the member's condition. It also includes medications that are prescribed for "Off-label" uses as described in the FDA approved labelling.	All utilization review NQTLs (medical necessity, prior authorization, concurrent review, retrospective review, experimental/investigational) are evaluated through comparative analyses of Quality Oversight outcomes and Utilization Review data. See "2022 Comparative Analysis Data Attachment - Georgia" for detailed analysis of Quality Oversight and Utilization Review comparative analysis data outcomes broken out for each NQTL, in operation. Quality Oversight: Application of approved medical necessity criteria is evaluated through the Inter-rater reliability process which is captured in full in Bright Health policy: Med-039 UM Inter-rater Reliability Monitoring All Bright HealthCare staff responsible for clinical decision-making during the utilization review process (ie. Clinicians, peer reviewers, medical directors) will participate in the annual IRR examinations. All clinical criteria relied upon to evaluate medical necessity for medical and behavioral health utilization review is included in the IRR process (for example, MCG, ASAM, Bright HealthCare Medical Policy) that the individual may apply during utilization review. IRR passing threshold is 90% for both medical and behavioral health staff. In addition to the annual IRR process, clinical quality audits are conducted monthly for both medical/surgical and mental health/substance use disorder utilization review staff to evaluate consistent use of utilization review policies and application of appropriate clinical criteria. Each case record is audited for 14 key elements including: •Verification of benefits, eligibility, network •Compliance with utilization review processes as written	Bright HealthCare defines Experimental/Investigational Treatment the same for M/S and MH/SUD benefits. The process to determine which benefits meet criteria for Experimental/Investigational is the same for M/S and MH/SUD benefit determinations. The same evidentiary standards are used when conducting utilization review for Experimental/Investigational requests. Operational monitoring of these requests for comparability and stringency is in place and ongoing through clinical quality auditing program and evaluation of utilization metrics such as denial rates. Based on the analyses, Bright HealthCare concludes that the processes, strategies, evidentiary standards, and other factors used evaluate Experimental/Investigational Treatment requests for medical or surgical benefits.

Provider Credentialing	All	The scope of credentialing and re-credentialing applies to the following types of providers: • Providers who are licensed, certified or registered by the state to practice independently without direction or supervision. • Providers who have an independent relationship with Bright Health (Providers to whom Bright Health directs its members for care). • Providers who provide care to members under Bright Health medical benefit Furthermore, the scope of credentialing and re-credentialing applies to providers in the following settings: • Individual and group practices • Telemedicine	The scope of credentialing and re-credentialing applies to the following types of providers: • Providers who are licensed, certified or registered by the state to practice independently without direction or supervision. • Providers who have an independent relationship with Bright Health (Providers to whom Bright Health directs its members for care). • Providers who provide care to members under Bright Health medical benefit Furthermore, the scope of credentialing and re-credentialing applies to providers in the following settings: • Individual and group practices • Telemedicine	1. State License 2. DEA / CDS 3. Education / Training 4.Board Certification 5. Current Malpractice History 6. Work History (N/A for re-credentialing) 7. Medicare and Medicaid Sanctions 8. State Sanctions, Restrictions, and Limitations	The factors are based on URAC Health Plan Standards, P-CR 1-17	The factors are based on URAC Health Plan Standards, P-CR 1-17	Bright Health follows the policy and procedures outlined in CRE-001. There are no separate desktop level procedures for MH/SUD and MED/SURG providers. Both follow the same policy.	1. Bright Health credentialing standards have not, to date, been the source of a provider complaint. 2. Bright Health's credentialing standards do not adversely impact MH/SUD providers ability to be fully-credentialed to participate in the Bright Health provider network. Within the scope of this NQTL analysis, a nominal amount of providers (<5) did not pass credentialing due to identified sanctions against the provider. None of the providers in this cohort were MH/SUD providers.	Bright Health reviewed the CRE-001 policy, which details requirements for credentialing both MH/SUD and MED/SURG providers, to identify any requirements or standards that might have an adverse impact on providers who have applied to the Bright Health network. We concluded that the policy and all applicable desk-level procedures did not require any deviation or difference in processing procedures with respect to processing credentialing applications of MH/SUD providers and MED/SURG providers. Additionally, we reviewed the elements for Licensure Primary Source Verification (PSV) to identify if any of these elements proved challenging for MH/SUD providers to produce evidence of compliance. We reviewed what PSVs were the source of credentialing application rejections. Only one PSV proved result in rejections of credentialing applications within the scope of this NQTL analysis. That PSV was state or federal sanctins/exclusions. Upon further analysis, no MH/SUD providers were the applicants of these rejected applications. In operation, the credentialing team closely follows the policy and procedure CRE-001, referenced in this document. Bright Health also reviewed any open remediation plans where the Credentialing Department was directly responsible for remediating a deficiency, and concluded that the active remediation did not impact MH/SUD providers specifically. Remediation plans in place were specific to how the credentialing committee reviews practitioners to ensure that they were not previously terminated or denied. This did not adversely impact MH/SUD providers in particular, and is instead focused on improving the quality and effectiveness of the Credentialing Committee governance structure.
Geographic Restrictions	All	The plan will provide covered services within the service area as filed with the state Division of Insurance.	The plan will provide covered services within the service area as filed with the state Division of Insurance.	Bright Health reviews the eligible number of members by reviewing: - Population Density - Historical enrollment - Opportunities to partner with health systems	For Population Density: CMS Public Use File For Historical Enrollment: Bright Health record of enrollment data.	not applicable	Service area restrictions are based on counties.	not applicable	not applicable
Plan Standards to Ensure Network Adequacy	All	Bright Health adheres to applicable federal and/or state requirements and accreditation standards to maintain and monitor an adequate network of contracted and credentialed providers that meets the needs of its membership. In the absence of applicable federal and/or state standards for commercial health products, Bright Health establishes access and availability standards that adequately meet the needs of its membership.	Bright Health adheres to applicable federal and/or state requirements and accreditation standards to maintain and monitor an adequate network of contracted and credentialed providers that meets the needs of its membership. In the absence of applicable federal and/or state standards for commercial health products, Bright Health establishes access and availability standards that adequately meet the needs of its membership.	Bright Health adheres to applicable federal and/or state requirements and accreditation standards to maintain and monitor an adequate network of contracted and credentialed providers that meets the needs of its membership.	Bright Health adheres to applicable federal and/or state requirements and accreditation standards to maintain and monitor an adequate network of contracted and credentialed providers that meets the needs of its membership.	Federal and state guidelines	Please see NET-002 Network Adequacy and Access	Bright Health reviewed plan standards to ensure network adequacy and compared MH/SUD standards vs MED/SURG standards. Results: Ratios: Primary Care, OB/GYN, Pediatrics: Large Metro, Metro, and Micro: 1 provider per 1,000 members Mental Health, Behavioral Health, and SUD care providers: 1 provider per 1,000 members Network Adequacy Standards: Psychology and Psychiatry share the same network access standards as physical therapy and rehabilitative medicine.	According to this analysis (outlined in Step 5), Bright Health has concluded that plan standards to ensure network adequacy have been established in parity with MED/SURG services. The provider network is built to ensure members have timely access to participating providers, that there are sufficient providers in the network relative to the number of members in a plan, and those standards are applied equally between MH/SUD and MED/SURG providers.

Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit eligibility.	Examples of factors for medical management and utilization review include: - Excessive utilization - Recent medical cost escalation - Lack of adherence to quality standards - High levels of variation in length of stay - High variability in cost per episode of care - Clinical efficacy of the proposed treatment or service - Provider discretion in determining diagnoses - Claims associated with a high percentage of fraud - Severity or chronicity of the MH/SUD or medical/surgical condition	Examples of sources for medical management and utilization review factors include: - Internal claims analyses - Internal quality standard studies - Expert medical review	Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards. Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations. Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include: - Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data. - Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data. - Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards. - Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay. - Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode. - More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care). - Two published RCTs required to establish a treatment or service is not experimental or investigational. - Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines. - State regulatory standards for health plan network adequacy. - Health plan accreditation standards for quality assurance. *(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)*	Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits. Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations. Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met. Examples of comparative analyses include: - Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL. - Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services. - A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols. - A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable. - Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy. - Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner. - Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational. *(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)*	Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical/surgical benefits. Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency. Illustrative analyses includes: Medical Management - Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable. - Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits. - Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved. - Audit results that demonstrate utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews. - Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits. - Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits. - Audit review of denial and appeal rates (both medical and administrative) by service type or benefit category. - Audit review of utilization review documentation requirements. - Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines. - A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers. Network Adequacy - Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification. - Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided). (These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)
	Examples of factors for provider network adequacy include: - Service type - Geographic market - Current demand for services - Projected demand for services - Practitioner supply and provider-to-enrollee ratios - Wait times - Geographic access standards - Out-of-network utilization rates *(These examples are merely illustrative and not exhaustive.)*	Examples of sources for provider network adequacy factors include: - State and federal regulatory requirements - National accreditation standards - Internal plan market analyses - CAHPS data		
	Examples of factors for provider reimbursement include: - Geographic market (i.e., market rate and payment type for provider type and/or specialty) - Provider type (i.e., hospital, clinic, and practitioner) and/or specialty - Supply of provider type and/or specialty - Network need and/or demand for provider type and/or specialty - Medicare reimbursement rates - Training, experience, and licensure of provider *(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)*	Examples of sources for provider reimbursement factors include: - External healthcare claims database (e.g., Fair Health) - Current Medicare Physician Fee Schedule - Internal market and competitive analysis - Medicare RVUs for CPT codes. *(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)*		

#REF!	OON- Inpatient	Step 1 Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.		Step 2 Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		Step 3	Step 4	Step 5	Step 6
NQTL	Covered Service	Description of Med/Surg applicabilty:	Description of MH/SUD applicability:	Factors	Sources	Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
Out of Network (OON) Coverage Standards	All OON emergent services/ OON non-emergent approved I	This applies when a member pursues care at non-participating provider or facility.	This applies when a member pursues care at non-participating provider or facility.	Network participation is the primary factor in evaluating whether an OON service will be covered. For OON services to be covered, Bright Health also considers the following UM factors to determine coverage: Bright Health may make an exception to the in-network only coverage requirement and authorize out-of-network care if ALL the following are met: a) The service is a covered benefit per the members plan document; b) The service is Medically Necessary and is not Investigational, as determined by Bright Health; c) As defined in policy NET-002, there are no accessible in-network providers identified who both have sufficient training and expertise and agree to treat the member's condition; d) The service to be rendered by out-of-network providers is not primarily for the convenience of the patient or in-network provider; e) The requested out-of-network service must be supported by scientific evidence that meets ALL the following: i) The member or provider provides Bright Health with sufficient scientific evidence that permits Bright Health to conclude the services will, more likely than not, result in clinically significant improved results over the methods available in network; AND ii) The scientific evidence consists of well-designed and well-conducted investigations, published in peer-reviewed journals that	Bright Health uses best practice and industry standards when determining appropriateness of applying an NQTL to MH/SUD benefits. Evidentiary standards include: > Clinical Practice Guidelines (i.e. ICSI) > Commercial Clinical Policies (i.e. MCG) > Hayes Report > Drug references (Micromedex, Clinical Pharmacology) > Utilization Management (UM) Committee consisting of medical experts > State and Federal Requirements > URAC Health plan accreditation organization's requirements	Bright Health uses best practice and industry standards when determining appropriateness of applying an NQTL to MH/SUD benefits. Evidentiary standards include: > Clinical Practice Guidelines (i.e. ICSI) > Commercial Clinical Policies (i.e. MCG) > Hayes Report > Drug references (Micromedex, Clinical Pharmacology) > Utilization Management (UM) Committee consisting of medical experts > State and Federal Requirements > URAC Health plan accreditation organization's requirements	Bright Health equally applies OON Coverage Standards NQTLs to Med/Surg and MH/SUD, as documented. This is evaluated through the following analyses: -Thorough review of national guidelines, standards of care, and prior authorization criteria by the Utilization Management (UM) Committee of Med/Surg and MH/SUD benefits and services. The Utilization Management Committee Membership is made up of internal experts representing a diverse group of clinical leaders within the organization. Based on these analyses, Bright Health concludes the NQTLs are applied no more stringently, as written.	Bright Health equally applies OON Coverage Standards NQTLs to Med/Surg and MH/SUD authorization, in operation. See "2022 Comparative Analysis Data Attachment - Georgia" for detailed analysis of Quality Oversight and Utilization Review comparative analysis data outcomes broken out for each NQTL, in operation.	The process to design OON coverage standards requirements is the same for both MH/SUD benefits and Med/Surg benefits. Considerations include Member safety and quality of care; benefits vs harm; resource use; overall quality of clinical and scientific evidence; and outcomes of treatment and clinical data. This process is done with an understanding that benefit/service has appropriate coverage for members to access with no difference between medical/surgical and MH/SUD benefit/service. For these reasons, Bright Health has concluded compliance with MHPAEA.

Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit elegibility.

Examples of factors for medical management and utilization review include:
- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

Examples of sources for medical management and utilization review factors include:
- Internal claims analyses
- Internal quality standard studies
- Expert medical review

Examples of factors for provider network adequacy include:
- Service type
- Geographic market
- Current demand for services
- Projected demand for services
- Practitioner supply and provider-to-enrollee ratios
- Wait times
- Geographic access standards
- Out-of-network utilization rates

(these examples are merely illustrative and not exhaustive)

Examples of sources for provider network adequacy factors include:
- State and federal regulatory requirements
- National accreditation standards
- Internal plan market analyses
- CAHPS data

Examples of factors for provider reimbursement include:
- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
- Provider type (i.e., hospital, clinic, and practitioner) and/or specialty
- Supply of provider type and/or specialty
- Network need and/or demand for provider type and/or specialty
- Medicare reimbursement rates
- Training, experience, and licensure of provider

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Examples of sources for provider reimbursement factors include:
- External healthcare claims database (e.g., Fair Health)
- Current Medicare Physician Fee Schedule
- Internal market and competitive analysis
- Medicare RVUs for CPT codes.

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include:
- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
- Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).
- Two published RCTs required to establish a treatment or service is not experimental or investigational.
- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:
- Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services.
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits.

Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.

Illustrative analyses includes:

Medical Management
- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs.
MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category.
- Audit/review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

Network Adequacy
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

#REF!	INN- Outpatient	Step 1 Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.		Step 2 Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		Step 3	Step 4	Step 5	Step 6
NQTL	Covered Service	Description of Med/Surg applicabilty:	Description of MH/SUD applicability:	Factors	Sources	Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
Provider Credentialing	All providers listed in the directory must be credentialed according to Bright Health Plan's accreditation certification with URAC. The NQTL discussed in this analysis is specific to credentialing standards/processes	All providers (including MH/SUD, and MED/SURG providers) listed in the directory must be credentialed according to Bright Health Plan's accreditation certification with URAC.	All providers (including MH/SUD, and MED/SURG providers) listed in the directory must be credentialed according to Bright Health Plan's accreditation certification with URAC.	Credentialing criteria outlined in Bright Health's internal credentialing policies, including CRE-001. The scope of credentialing applies to the following provider types: . - Providers who are licensed, certified or registered by the state to practice independently without direction or supervision. - Providers who have an independent relationship with Bright Health (Providers to whom Bright Health directs its members for care). - Providers who provide care to members under Bright Health medical benefit The following credentialing factors are reviewed for both MH/SUD and MED/SURG providers: - Education and Training (highest level of education achieved) - Board Certification - Current Malpractice - Malpractice History - Work HIstory - Medicare and Medicaid Sanctions - State Sanctions, Restrictions, Limitations	These are the acceptable verification sources, applied to both MH/SUD and MED/SURG providers: - Education and Training (highest level of education achieved). Sources include: State Licensing agency if PSV of education is verified to be performed Verification of Board Certification AMA Physician Profile AOA Physician Profile - Board Certification. Sources include: Physicians: AMA Physician Profile; AOA Physician Profile Board Certified Docs (official ABMS display agent) CertiFACTS is acceptable for re-credentialing Specific Board verification web site Other health care professionals: State licensing agency if PSV of board certification is performed - Current Malpractice. Source: Copy from Insurance Company - Malpractice History. Malpractice carrier; National Practitioner Databank-Healthcare Integrity and Protection Databank (NPDB-HIPDB) - Work HIstory. Source: Verification of Work history is not required but must be reviewed from Application or Curriculum Vitae - Medicare and Medicaid Sanctions. OIG/ GSA NPDB, CMS Preclusion List - State Sanctions, Restrictions, Limitations. Source: State licensing board(s) certified web site	Licensure Primary Source Verification (PSV) Bright Health will verify provider licensure or certification only in the state(s) where the provider provides care for Bright Health members. Any actions on the provider's license is examined and documented by the Credentialing Staff. Any providers found to have license restrictions or sanctions will require Credentialing Committee review as a "Risk File". The evidentiary standards for these factors are directly required BY PR-5, Credentialing Application Standards, issued by URAC via the Health Plan Accreditation Guide Version 7.2. All evidentiary standards are determined by URAC to ensure patient safety. • Board Certification Verification of board certification must be done for any provider who reports they are board certified (and is recommended to be), and for all of a provider's specialties listed in the Directory. Verification of board certification does not apply to non- physician health care professionals unless the board certification information is communicated to members. Further, see above Table 3 for exceptions that Bright Health may make on Board Certifications. Lifetime board certification shall be verified and documented at every credentialing cycle. State licensing agency can be utilized to meet the board certification requirement if the state performs PSV of board certification as part of its licensing process; documentation of the PSV will be kept on file and updated each year it is applied. If provider is not board certified, we verify the highest level of education. • Drug Enforcement Agency (DEA) If a qualified provider does not have a valid DEA at the time of credentialing, or if it is pending, this will be noted in the credentialing file and confirmation will be obtained of an arrangement for another provider to fill prescriptions who possess a valid DEA.	Bright Health follows the policy and procedures outlined in CRE-001. There are no separate desktop level procedures for MH/SUD and MED/SURG providers. Both follow the same policy.	1. Bright Health credentialing standards have not, to date, been the source of a provider complaint. 2. Bright Health's credentialing standards do not adversely impact MH/SUD providers ability to be fully-credentialed to participate in the Bright Health provider network. Within the scope of this NQTL analysis, a nominal amount of providers (<5) did not pass credentialing due to identified sanctions against the provider. None of the providers in this cohort were MH/SUD providers.	Bright Health reviewed the CRE-001 policy, which details requirements for credentialing both MH/SUD and MED/SURG providers, to identify any requirements or standards that might have an adverse impact on providers who have applied to the Bright Health network. We concluded that the policy and all applicable desk-level procedures did not require any deviation or difference in processing procedures with respect to processing credentialing applications of MH/SUD providers and MED/SURG providers. Additionally, we reviewed the elements for Licensure Primary Source Verification (PSV) to identify if any of these elements proved challenging for MH/SUD providers to produce evidence of compliance. We reviewed what PSVs were the source of credentialing application rejections. Only one PSV proved result in rejections of credentialing applications within the scope of this NQTL analysis. That PSV was state or federal sanctins/exclusions. Upon further analysis, no MH/SUD providers were the applicants of these rejected applications. In operation, the credentialing team closely follows the policy and procedure CRE-001, referenced in this document. Bright Health also reviewed any open remediation plans where the Credentialing Department was directly responsible for remediating a deficiency, and concluded that the active remediation did not impact MH/SUD providers specifically. Remediation plans in place were specific to how the credentialing committee reviews practitioners to ensure that they were not previously terminated or denied. This did not adversely impact MH/SUD providers in particular, and is instead focused on improving the quality and effectiveness of the Credentialing Committee governance structure.
Geographic Restrictions	All	The plan will provide covered services within	The plan will provide covered services within	Bright Health reviews the eligible number of members by	For Population Density: CMS Public Use File	not applicable	Service area restrictions are based on counties.	not applicable	not applicable
Plan Standards to Ensure Network	All	Bright Health adheres to applicable federal	Bright Health adheres to applicable federal	Bright Health adheres to applicable federal and/or state	Bright Health adheres to applicable federal and/or state	Federal and state guidelines	Please see NET-002 Network Adequacy and Access	Bright Health reviewed plan standards to ensure network adequacy and	According to this analysis (outlined in Step 5), Bright Health has concluded that plan

Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit elegibility.

Examples of factors for medical management and utilization review include:
- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

Examples of sources for medical management and utilization review factors include:
- Internal claims analyses
- Internal quality standard studies
- Expert medical review

Examples of factors for provider network adequacy include:
- Service type
- Geographic market
- Current demand for services
- Projected demand for services
- Practitioner supply and provider-to-enrollee ratios
- Wait times
- Geographic access standards
- Out-of-network utilization rates

(these examples are merely illustrative and not exhaustive)

Examples of sources for provider network adequacy factors include:
- State and federal regulatory requirements
- National accreditation standards
- Internal plan market analyses
- CAHPS data

Examples of factors for provider reimbursement include:
- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
- Provider type (i.e., hospital, clinic, and practitioner) and/or specialty
- Supply of provider type and/or specialty
- Network need and/or demand for provider type and/or specialty
- Medicare reimbursement rates
- Training, experience, and licensure of provider

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Examples of sources for provider reimbursement factors include:
- External healthcare claims database (e.g., Fair Health)
- Current Medicare Physician Fee Schedule
- Internal market and competitive analysis
- Medicare RVUs for CPT codes.

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include:
- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
- Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).
- Two published RCTs required to establish a treatment or service is not experimental or investigational.
- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:
- Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services.
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits.

Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.

Illustrative analyses includes:

Medical Management
- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs.
MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category.
- Audit/review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

Network Adequacy
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

#REF!	OON- Outpatient	Step 1 Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.		Step 2 Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		Step 3	Step 4	Step 5	Step 6
NQTL	Covered Service	Description of Med/Surg applicabilty:	Description of MH/SUD applicability:	Factors	Sources	Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
Out of Network (OON) Coverage Standards	All OON emergent services/ OON non-emergent approved l	This applies when a member pursues care at non-participating provider or facility.	This applies when a member pursues care at non-participating provider or facility.	Network participation is the primary factor in evaluating whether an OON service will be covered. For OON services to be covered, Bright Health also considers the following UM factors to determine coverage: Bright Health may make an exception to the in-network only coverage requirement and authorize out-of-network care if ALL the following are met: a) The service is a covered benefit per the members plan document; b) The service is Medically Necessary and is not Investigational, as determined by Bright Health; c) As defined in policy NET-002, there are no accessible in-network providers identified who both have sufficient training and expertise and agree to treat the member's condition; d) The service to be rendered by out-of-network providers is not primarily for the convenience of the patient or in-network provider; e) The requested out-of-network service must be supported by scientific evidence that meets ALL the following: i) The member or provider provides Bright Health with sufficient scientific evidence that permits Bright Health to conclude the services will, more likely than not, result in clinically significant improved results over the methods available in network; AND ii) The scientific evidence consists of well-designed and well-conducted investigations, published in peer-reviewed journals that	Bright Health uses best practice and industry standards when determining appropriateness of applying an NQTL to MH/SUD benefits. Evidentiary standards include: > Clinical Practice Guidelines (i.e. ICSI) > Commercial Clinical Policies (i.e. MCG) > Hayes Report > Drug references (Micromedex, Clinical Pharmacology) > Utilization Management (UM) Committee consisting of medical experts > State and Federal Requirements > URAC Health plan accreditation organization's requirements	Bright Health uses best practice and industry standards when determining appropriateness of applying an NQTL to MH/SUD benefits. Evidentiary standards include: > Clinical Practice Guidelines (i.e. ICSI) > Commercial Clinical Policies (i.e. MCG) > Hayes Report > Drug references (Micromedex, Clinical Pharmacology) > Utilization Management (UM) Committee consisting of medical experts > Stateand Federal Requirements > URAC Health plan accreditation organization's requirements	Bright Health equally applies OON Coverage Standards NQTLs to Med/Surg and MH/SUD, as documented. This is evaluated through the following analyses: -Thorough review of national guidelines, standards of care, and prior authorization criteria by the Utilization Management (UM) Committee of Med/Surg and MH/SUD benefits and services. The Utilization Management Committee Membership is made up of internal experts representing a diverse group of clinical leaders within the organization. Based on these analyses, Bright Health concludes the NQTLs are applied no more stringently, as written.	Bright Health equally applies OON Coverage Standards NQTLs to Med/Surg and MH/SUD authorization, in operation. See "2022 Comparative Analysis Data Attachment - Georgia" for detailed analysis of Quality Oversight and Utilization Review comparative analysis data outcomes broken out for each NQTL, in operation.	The process to design OON coverage standards requirements is the same for both MH/SUD benefits and Med/Surg benefits. Considerations include Member safety and quality of care; benefits vs harm; resource use; overall quality of clinical and scientific evidence; and outcomes of treatment and clinical data. This process is done with an understanding that benefit/service has appropriate coverage for members to access with no difference between medical/surgical and MH/SUD benefit/service. For these reasons, Bright Health has concluded compliance with MHPAEA.

Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit elegibility.

Examples of factors for medical management and utilization review include:
- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

Examples of sources for medical management and utilization review factors include:
- Internal claims analyses
- Internal quality standard studies
- Expert medical review

Examples of factors for provider network adequacy include:
- Service type
- Geographic market
- Current demand for services
- Projected demand for services
- Practitioner supply and provider-to-enrollee ratios
- Wait times
- Geographic access standards
- Out-of-network utilization rates

(these examples are merely illustrative and not exhaustive)

Examples of sources for provider network adequacy factors include:
- State and federal regulatory requirements
- National accreditation standards
- Internal plan market analyses
- CAHPS data

Examples of factors for provider reimbursement include:
- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
- Provider type (i.e., hospital, clinic, and practitioner) and/or specialty
- Supply of provider type and/or specialty
- Network need and/or demand for provider type and/or specialty
- Medicare reimbursement rates
- Training, experience, and licensure of provider

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Examples of sources for provider reimbursement factors include:
- External healthcare claims database (e.g., Fair Health)
- Current Medicare Physician Fee Schedule
- Internal market and competitive analysis
- Medicare RVUs for CPT codes.

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include:
- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
- Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).
- Two published RCTs required to establish a treatment or service is not experimental or investigational.
- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:
- Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services.
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits.

Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.

Illustrative analyses includes:

Medical Management
- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs.
MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category.
- Audit/review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

Network Adequacy
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

#REF! NQTL	Emergency Covered Service	Step 1 Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed. Description of Med/Surg applicability:	Step 1 Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed. Description of MH/SUD applicability:	Step 2 Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits. Factors	Step 2 Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits. Sources	Step 3 Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Step 4 Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Step 5 Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Step 6 Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
		Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit eligibility.		Examples of factors for medical management and utilization review include: - Excessive utilization - Recent medical cost escalation - Lack of adherence to quality standards - High levels of variation in length of stay - High variability in cost per episode of care - Clinical efficacy of the proposed treatment or service - Provider discretion in determining diagnoses - Claims associated with a high percentage of fraud - Severity or chronicity of the MH/SUD or medical/surgical condition	Examples of sources for medical management and utilization review factors include: - Internal claims analyses - Internal quality standard studies - Expert medical review	Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards. Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations. Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include: - Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data. - Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data. - Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards. - Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay. - Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode. - More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care). - Two published RCTs required to establish a treatment or service is not experimental or investigational. - Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines. - State regulatory standards for health plan network adequacy. - Health plan accreditation standards for quality assurance. *(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)*	Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits. Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations. Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met. Examples of comparative analyses include: - Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL. - Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services. - A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols. - A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable. - Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy. - Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner. - Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational. *(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)*	Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical/surgical benefits. Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency. Illustrative analyses include: Medical Management - Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable. - Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits. - Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved. - Audit results that demonstrate utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews. - Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits. - Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits. - Audit review of denial and appeal rates (both medical and administrative) by service type or benefit category. - Audit review of utilization review documentation requirements. - Audit results that indicate that coverage approvals and denials corresponded to the plan's criteria and guidelines. - A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers. Network Adequacy - Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification. - Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided). (These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)
				Examples of factors for provider network adequacy include: - Service type - Geographic market - Current demand for services - Projected demand for services - Practitioner supply and provider-to-enrollee ratios - Wait times - Geographic access standards - Out-of-network utilization rates *(these examples are merely illustrative and not exhaustive)*	Examples of sources for provider network adequacy factors include: - State and federal regulatory requirements - National accreditation standards - Internal plan market analyses - CAHPS data			
				Examples of factors for provider reimbursement include: - Geographic market (i.e., market rate and payment type for provider type and/or specialty) - Provider type (i.e., hospital, clinic, and practitioner) and/or specialty - Supply of provider type and/or specialty - Network need and/or demand for provider type and/or specialty - Medicare reimbursement rates - Training, experience, and licensure of provider *(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)*	Examples of sources for provider reimbursement factors include: - External healthcare claims database (e.g., Fair Health) - Current Medicare Physician Fee Schedule - Internal market and competitive analysis - Medicare RVUs for CPT codes. *(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)*				

#REF!	**INN-Outpatient-Office**	**Step 1** **Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.**		**Step 2** **Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.**		**Step 3**	**Step 4**	**Step 5**	**Step 6**
NQTL	Covered Service	**Description of Med/Surg applicabilty:**	**Description of MH/SUD applicability:**	**Factors**	**Sources**	**Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.**	**Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written**	**Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation**	**Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.**
Provider Credentialing	All providers listed in the directory must be credentialed according to Bright Health Plan's accreditation certification with URAC. The NQTL discussed in this analysis is specific to credentialing standards/processes	All providers (including MH/SUD, and MED/SURG providers) listed in the directory must be credentialed according to Bright Health Plan's accreditation certification with URAC.	All providers (including MH/SUD, and MED/SURG providers) listed in the directory must be credentialed according to Bright Health Plan's accreditation certification with URAC.	Credentialing criteria outlined in Bright Health's internal credentialing policies, including CRE-001. The scope of credentialing applies to the following provider types: . - Providers who are licensed, certified or registered by the state to practice independently without direction or supervision. - Providers who have an independent relationship with Bright Health (Providers to whom Bright Health directs its members for care). - Providers who provide care to members under Bright Health medical benefit The following credentialing factors are reviewed for both MH/SUD and MED/SURG providers: - Education and Training (highest level of education achieved) - Board Certification - Current Malpractice - Malpractice History - Work HIstory - Medicare and Medicaid Sanctions - State Sanctions, Restrictions, Limitations	These are the acceptable verification sources, applied to both MH/SUD and MED/SURG providers: - Education and Training (highest level of education achieved). Sources include: State Licensing agency if PSV of education is verified to be performed Verification of Board Certification AMA Physician Profile AOA Physician Profile - Board Certification. Sources include: Physicians: AMA Physician Profile; AOA Physician Profile Board Certified Docs (official ABMS display agent) CertiFACTS is acceptable for re-credentialing Specific Board verification web site Other health care professionals: State licensing agency if PSV of board certification is performed - Current Malpractice. Source: Copy from Insurance Company - Malpractice History. Malpractice carrier; National Practitioner Databank-Healthcare Integrity and Protection Databank (NPDB-HIPDB) - Work HIstory. Source: Verification of Work history is not required but must be reviewed from Application or Curriculum Vitae - Medicare and Medicaid Sanctions. OIG/ GSA NPDB, CMS Preclusion List - State Sanctions, Restrictions, Limitations. Source: State licensing board(s) certified web site	Licensure Primary Source Verification (PSV) Bright Health will verify provider licensure or certification only in the state(s) where the provider provides care for Bright Health members. Any actions on the provider's license is examined and documented by the Credentialing Staff. Any providers found to have license restrictions or sanctions will require Credentialing Committee review as a "Risk File". The evidentiary standards for these factors are directly required BY PR-5, Credentialing Application Standards, issued by URAC via the Health Plan Accreditation Guide Version 7.2. All evidentiary standards are determined by URAC to ensure patient safety. • Board Certification Verification of board certification must be done for any provider who reports they are board certified (and is recommended to be), and for all of a provider's specialties listed in the Directory. Verification of board certification does not apply to non- physician health care professionals unless the board certification information is communicated to members. Further, see above Table 3 for exceptions that Bright Health may make on Board Certifications. Lifetime board certification shall be verified and documented at every credentialing cycle. State licensing agency can be utilized to meet the board certification requirement if the state performs PSV of board certification as part of its licensing process; documentation of the PSV will be kept on file and updated each year it is applied. If provider is not board certified, we verify the highest level of education. • Drug Enforcement Agency (DEA) If a qualified provider does not have a valid DEA at the time of credentialing, or if it is pending, this will be noted in the credentialing file and confirmation will be obtained of an arrangement for another provider to fill prescriptions who possess a valid DEA.	Bright Health follows the policy and procedures outlined in CRE-001. There are no separate desktop level procedures for MH/SUD and MED/SURG providers. Both follow the same policy.	1. Bright Health credentialing standards have not, to date, been the source of a provider complaint. 2. Bright Health's credentialing standards do not adversely impact MH/SUD providers ability to be fully-credentialed to participate in the Bright Health provider network. Within the scope of this NQTL analysis, a nominal amount of providers (<5) did not pass credentialing due to identified sanctions against the provider. None of the providers in this cohort were MH/SUD providers.	Bright Health reviewed the CRE-001 policy, which details requirements for credentialing both MH/SUD and MED/SURG providers, to identify any requirements or standards that might have an adverse impact on providers who have applied to the Bright Health network. We concluded that the policy and all applicable desk-level procedures did not require any deviation or difference in processing procedures with respect to processing credentialing applications of MH/SUD providers and MED/SURG providers. Additionally, we reviewed the elements for Licensure Primary Source Verification (PSV) to identify if any of these elements proved challenging for MH/SUD providers to produce evidence of compliance. We reviewed what PSVs were the source of credentialing application rejections. Only one PSV proved result in rejections of credentialing applications within the scope of this NQTL analysis. That PSV was state or federal sanctins/exclusions. Upon further analysis, no MH/SUD providers were the applicants of these rejected applications. In operation, the credentialing team closely follows the policy and procedure CRE-001, referenced in this document. Bright Health also reviewed any open remediation plans where the Credentialing Department was directly responsible for remediating a deficiency, and concluded that the active remediation did not impact MH/SUD providers specifically. Remediation plans in place were specific to how the credentialing committee reviews practitioners to ensure that they were not previously terminated or denied. This did not adversely impact MH/SUD providers in particular, and is instead focused on improving the quality and effectiveness of the Credentialing Committee governance structure.
Geographic Restrictions	All	The plan will provide covered services within the service area as filed with the state Division of Insurance.	The plan will provide covered services within the service area as filed with the state Division of Insurance.	Bright Health reviews the eligible number of members by reviewing: - Population Density - Historical enrollment - Opportunities to partner with health systems	For Population Density: CMS Public Use File For Historical Enrollment: Bright Health record of enrollment data.	not applicable	Service area restrictions are based on counties.	not applicable	not applicable

Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit elegibility.

Examples of factors for medical management and utilization review include:
- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

Examples of factors for provider network adequacy include:
- Service type
- Geographic market
- Current demand for services
- Projected demand for services
- Practitioner supply and provider-to-enrollee ratios
- Wait times
- Geographic access standards
- Out-of-network utilization rates

(these examples are merely illustrative and not exhaustive)

Examples of factors for provider reimbursement include:
- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
- Provider type (i.e., hospital, clinic, and practitioner) and/or specialty
- Supply of provider type and/or specialty
- Network need and/or demand for provider type and/or specialty
- Medicare reimbursement rates
- Training, experience, and licensure of provider

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Examples of sources for medical management and utilization review factors include:
- Internal claims analyses
- Internal quality standard studies
- Expert medical review

Examples of sources for provider network adequacy factors include:
- State and federal regulatory requirements
- National accreditation standards
- Internal plan market analyses
- CAHPS data

Examples of sources for provider reimbursement factors include:
- External healthcare claims database (e.g., Fair Health)
- Current Medicare Physician Fee Schedule
- Internal market and competitive analysis
- Medicare RVUs for CPT codes.

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include:
- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
- Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).
- Two published RCTs required to establish a treatment or service is not experimental or investigational.
- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:
- Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services.
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits.

Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.

Illustrative analyses includes:

Medical Management
- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category.
- Audit/review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

Network Adequacy
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

#REF!	Rx	Step 1 Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.		Step 2 Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		Step 3	Step 4	Step 5	Step 6
NQTL	Covered Service	Description of Med/Surg applicability:	Description of MH/SUD applicability:	Factors	Sources	Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
Prior Authorization		See "2022 RX Data Attachment - Georgia"	See "2022 RX Data Attachment - Georgia"	Appropriate care is given to ensure that members have access to medications that effectively treat their disease states. Several factors are considered when looking to implement prior authorization on a drug. These factors are applied equally across Med/Surg and MH/SUD drugs. Factors include: -Product FDA labeling -Current clinical literature (including standard clinical guidelines provided by health organizations) -Member Safety -Potential access barriers -Clinical class representation -P and T and Bright Formulary Design panel considerations	Sources used to determine appropriateness of a prior authorization NQTL for both M/S and MH/SUD drugs include: -Package inserts -Current clinical guidelines -Drug references (Micromedex, Clinical Pharmacology) -P&T Committee consisting of medical experts representing the demographics of Bright Health member population -State and Federal Requirements -Internal claim analysis	Bright Health uses best practice and industry standards when determining appropriateness of applying an NQTL to MH/SUD benefits. Evidentiary standards include: -Manufacturer Package inserts -Clinical guidelines developed by relevant professional organizations -ICER reports -Drug references (Micromedex, Clinical Pharmacology) -P&T Committee consisting of medical experts representing the demographics of Bright Health member population -State and Federal Requirements -Health plan accreditation organization's requirements	Bright Health equally applies prior authorization NQTLs to Med/Surg and MH/SUD drugs, as written. This is evaluated through the following analyses: -Thorough review of national guidelines, standards of care, and prior authorization criteria by the Pharmacy and Therapeutics Committee of Med/Surg and MH/SUD drugs. The Pharmacy and Therapeutic Committee Membership is made up of external and internal experts representing a diverse group of specialties that encompass member demographics Based on these analyses, Bright Health concludes the NQTLs are applied no more stringently, as written.	Bright Health equally applies prior authorization NQTLs to Med/Surg and MH/SUD drugs, in operation. This is evaluated through the analyses in "2022 RX Data Attachment - Georgia": -Bright Health evaluates the percentage of prior authorizations assigned to Med/Surg GPIs compared to percentage assigned to MH/SUD GPIs.	The process to design the prior authorization criteria is the same for both MH/SUD benefits and Med/Surg benefits. Criteria considerations include clinical safety and efficacy, bioequivalence and/or therapeutic equivalence, pharmacokinetic and pharmacodynamic properties, place in therapy, outcomes of treatment and pharmacoeconomic data. The formulary is based on careful consideration of industry standards, clinical safety and efficacy, clinical practice guidelines, brand versus generic, and drug cost. Our Pharmacy and Therapeutics Committee reviews all prior authorization for appropriateness on a yearly basis This process is done with an understanding that the specific therapeutic class has appropriate coverage to treat members with no difference between M/S and MH/SUD drugs. For these reasons, Bright Health has concluded compliance with MHPAEA.
Fail First Protocols		See "2022 RX Data Attachment - Georgia"	See "2022 RX Data Attachment - Georgia"	Appropriate care is given to ensure that members have access to medications that effectively treat their disease states. Several factors are considered when looking to implement a step therapy/fail first policy on a drug. These factors are applied equally across Med/Surg and MH/SUD drugs. Factors include: -Product FDA labeling -Current clinical literature (including standard clinical guidelines provided by health organizations) -Member Safety -Potential access barriers -Clinical class representation -P and T and Bright Formulary Design panel considerations	Sources used to determine appropriateness of a step therapy/fail first policy NQTL for both M/S and MH/SUD drugs include: -Package inserts -Current clinical guidelines -Drug references (Micromedex, Clinical Pharmacology) -P&T Committee consisting of medical experts representing the demographics of Bright Health member population -State and Federal Requirements -Internal claim analysis	Bright Health uses best practice and industry standards when determining appropriateness of applying an NQTL to MH/SUD benefits. Evidentiary standards include: -Manufacturer Package inserts -Clinical guidelines developed by relevant professional organizations -ICER reports -Drug references (Micromedex, Clinical Pharmacology) -P&T Committee consisting of medical experts representing the demographics of Bright Health member population -State and Federal Requirements -Health plan accreditation organization's requirements	There is no difference in how Bright Health applies step therapy/fail first policy NQTLs to Med/Surg and MH/SUD drugs. This is evaluated through the following analyses: --Thorough review of national guidelines, standards of care, and step therapy/first fail policies by the Pharmacy and Therapeutics Committee of Med/Surg and MH/SUD drugs. The Pharmacy and Therapeutic Committee Membership is made up of external and internal experts representing a diverse group of specialties that encompass member demographics. Based on these analyses, Bright Health concludes the NQTLs are applied no more stringently, as written.	Bright Health equally applies step therapy/fail first policy NQTLs to Med/Surg and MH/SUD drugs, in operation. This is evaluated through the analyses in "2022 RX Data Attachment - Georgia -Bright Health evaluates the percentage of step therapies/first fail policies on Med/Surg GPIs compared to percentage on MH/SUD GPIs.	The process to design the step therapy/fail first policies is the same for both MH/SUD benefits and Med/Surg benefits. Policy considerations include clinical safety and efficacy, bioequivalence and/or therapeutic equivalence, pharmacokinetic and pharmacodynamic properties, place in therapy, outcomes of treatment and pharmacoeconomic data. The formulary is based on careful consideration of industry standards, clinical safety and efficacy, clinical practice guidelines, brand versus generic, and drug cost. Our Pharmacy and Therapeutics Committee reviews all step therapy/fail first policies for appropriateness This process is done with an understanding that the specific therapeutic class has appropriate coverage to treat members with no difference between M/S and MH/SUD drugs. For these reasons, Bright Health has concluded compliance with MHPAEA.
Formulary Design		Bright Health's Pharmacy and Therapeutics committee has created a list of Prescription Drug Products for this Plan, called a Formulary. The Formulary is referenced to determine what You pay at the pharmacy for covered Prescription Drug Products under the Plan. Products on the Formulary are covered differently than products not listed on the Formulary. Your cost for prescriptions will vary depending on the Formulary status of each specific medication. In general, medications on the Formulary are intended to cost You less than medications not on the Formulary. The Formulary contains both Brand-Name and Generic medications. Your Prescription Drug Benefit includes coverage for the following drug tiers: See "2022 RX Data Attachment - Georgia"	Bright Health's Pharmacy and Therapeutics committee has created a list of Prescription Drug Products for this Plan, called a Formulary. The Formulary is referenced to determine what You pay at the pharmacy for covered Prescription Drug Products under the Plan. Products on the Formulary are covered differently than products not listed on the Formulary. Your cost for prescriptions will vary depending on the Formulary status of each specific medication. In general, medications on the Formulary are intended to cost You less than medications not on the Formulary. The Formulary contains both Brand-Name and Generic medications. Your Prescription Drug Benefit includes coverage for the following drug tiers: See "2022 RX Data Attachment - Georgia"	Appropriate care is given to ensure that members have access to medications that effectively treat their disease states. Several factors are considered when designing the formulary. These are applied equally across M/S and MH/SUD. These factors include: -Place in therapy -Utilization -Safety/toxicity -Potential access barriers -Clinical class representation -P and T and Bright Formulary Design panel considerations -Considerations of Fraud, Waste, and Abuse -Adherence Barriers -Excessive Cost	Sources used to determine appropriateness of a tiering NQTL for both M/S and MH/SUD drugs include: -Package inserts -Product FDA Labeling -Current clinical literature (including standard clinical guidelines provided by health organizations) -Drug references (Micromedex, Clinical Pharmacology) -P&T Committee with members representing the demographics of Bright Health member population -State and Federal Requirements -Internal claim analysis	Bright Health uses best practice and industry standards when determining appropriateness of applying an NQTL to MH/SUD benefits. Evidentiary standards include: -Manufacturer Package inserts -Clinical guidelines developed by relevant professional organizations -ICER reports -Drug references (Micromedex, Clinical Pharmacology) -P&T Committee consisting of medical experts representing the demographics of Bright Health member population -State and Federal Requirements -Health plan accreditation organization's requirements	There is no difference in how Bright Health applies formulary design NQTLs to Med/Surg and MH/SUD drugs. This is evaluated through the following analyses: -Thorough review of national guidelines, standards of care, utilization management and formulary placement by the Pharmacy and Therapeutics Committee of Med/Surg and MH/SUD drugs. The Pharmacy and Therapeutic Committee Membership is made up of external and internal experts representing a diverse group of specialties that encompass member demographics	Bright Health equally applies formulary design NQTLs to Med/Surg and MH/SUD drugs. Bright Health encourages the use of lower cost, equally effective generics by having more available for MH/SUD in a generic tier. This is evaluated through the analyses in "2022 RX Data Attachment - Georgia Bright Health evaluates percentage of drugs across each tier for Med/Surg compared to MH/SUD.	The process to design the formulary and medical necessity criteria is the same for both MH/SUD benefits and medical/surgical benefits. Criteria considerations include clinical safety and efficacy, bioequivalence and/or therapeutic equivalence, pharmacokinetic and pharmacodynamic properties, place in therapy, outcomes of treatment and pharmacoeconomic data. The formulary is based on careful consideration of industry standards, clinical safety and efficacy, clinical practice guidelines, brand versus generic, and drug cost. Our Pharmacy and Therapeutics Committee reviews all formulary tier classifications and utilization management for appropriateness. Our tiering methodology, for MH/SUD drugs, is comparable and applied no more stringently than the tiering methodology for M/S drugs. This process is done with an understanding that the specific therapeutic class has appropriate coverage to treat members with no difference between M/S and MH/SUD drugs. For these reasons, Bright Health has concluded compliance with MHPAEA.

		Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include such step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit eligibility.		Examples of factors for medical management and utilization review include: - Excessive utilization - Recent medical cost escalation - Lack of adherence to quality standards - High levels of variation in length of stay - High variability in cost per episode of care - Clinical efficacy of the proposed treatment or service - Provider discretion in determining diagnoses - Claims associated with a high percentage of fraud - Severity or chronicity of the MH/SUD or medical/surgical condition	Examples of sources for medical management and utilization review factors include: - Internal claims analyses - Internal quality standard studies - Expert medical review	Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards. Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations. Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include: - Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data. - Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data. - Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards. - Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay. - Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode. - More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care). - Two published RCTs required to establish a treatment or service is not experimental or investigational. - Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines. - State regulatory standards for health plan network adequacy. - Health plan accreditation standards for quality assurance. *(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)*	Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits. Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations. Include the results and conclusions from these analyses that clearly substantiate the NQTL-regulatory tests of comparability and equitable application have been met. Examples of comparative analyses include: - Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL. - Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services. - A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols. - A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable. - Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy. - Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner. - Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational. *(These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)*	Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical/surgical benefits. Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency. Illustrative analyses includes: Medical Management - Audit results that demonstrate that the frequency of all types of utilization review for medical surgical vs. MH/SUD, where applicable, are comparable; - Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical surgical vs. MH/SUD within the same classifications of benefits. - Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved. - Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews. - Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits. - Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits. - Audit review of denial and appeal rates (both medical and administrative) by service type or benefit category. - Audit review of utilization review documentation requirements. - Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines. - A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers. Network Adequacy - Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification. - Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided). (These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)	Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical/surgical benefits. Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency. Illustrative analyses includes: Medical Management - Audit results that demonstrate that the frequency of all types of utilization review for medical surgical vs. MH/SUD, where applicable, are comparable; - Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical surgical vs. MH/SUD within the same classifications of benefits. - Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved. - Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviewers and medical/surgical reviews. - Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits. - Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits. - Audit review of denial and appeal rates (both medical and administrative) by service type or benefit category. - Audit review of utilization review documentation requirements. - Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines. - A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers. Network Adequacy - Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification. - Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided). (These are illustrations of comparative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)
				Examples of factors for provider network adequacy include: - Service type - Geographic market - Current demand for services - Projected demand for services - Practitioner supply and provider-to-enrollee ratios - Wait times - Geographic access standards - Out-of-network utilization rates *(these examples are merely illustrative and not exhaustive)*	Examples of sources for provider network adequacy factors include: - State and federal regulatory requirements - National accreditation standards - Internal plan market analyses - CAHPS data				
				Examples of factors for provider reimbursement include: - Geographic market (i.e., market rate and payment type for provider type and/or specialty) - Provider type (i.e., hospital, clinic, and practitioner) and/or specialty - Supply of provider type and/or specialty - Network need and/or demand for provider type and/or specialty - Medicare reimbursement rates - Training, experience, and licensure of provider *(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)*	Examples of sources for provider reimbursement factors include: - External healthcare claims database (e.g., Fair Health) - Current Medicare Physician Fee Schedule - Internal market and competitive analysis - Medicare RVUs for CPT codes. *(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)*				

#REF!	**OON-Outpatient-Office**	**Step 1** Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.		**Step 2** Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		**Step 3**	**Step 4**	**Step 5**	**Step 6**
NQTL	Covered Service	**Description of Med/Surg applicabilty:**	**Description of MH/SUD applicability:**	**Factors**	**Sources**	**Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.**	**Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written**	**Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation**	**Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.**

Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit elegibility.

Examples of factors for medical management and utilization review include:
- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

Examples of sources for medical management and utilization review factors include:
- Internal claims analyses
- Internal quality standard studies
- Expert medical review

Examples of factors for provider network adequacy include:
- Service type
- Geographic market
- Current demand for services
- Projected demand for services
- Practitioner supply and provider-to-enrollee ratios
- Wait times
- Geographic access standards
- Out-of-network utilization rates

(these examples are merely illustrative and not exhaustive)

Examples of sources for provider network adequacy factors include:
- State and federal regulatory requirements
- National accreditation standards
- Internal plan market analyses
- CAHPS data

Examples of factors for provider reimbursement include:
- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
- Provider type (i.e., hospital, clinic, and practitioner) and/or specialty
- Supply of provider type and/or specialty
- Network need and/or demand for provider type and/or specialty
- Medicare reimbursement rates
- Training, experience, and licensure of provider

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Examples of sources for provider reimbursement factors include:
- External healthcare claims database (e.g., Fair Health)
- Current Medicare Physician Fee Schedule
- Internal market and competitive analysis
- Medicare RVUs for CPT codes.

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include:
- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
- Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).
- Two published RCTs required to establish a treatment or service is not experimental or investigational.
- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:
- Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services.
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits.

Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.

Illustrative analyses includes:

Medical Management
- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category.
- Audit/review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

Network Adequacy
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

#REF!	INN-Outpatient-All Other	Step 1 Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.		Step 2 Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		Step 3	Step 4	Step 5	Step 6
NQTL	Covered Service	Description of Med/Surg applicability:	Description of MH/SUD applicability:	Factors	Sources	Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written	Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation	Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.
Prior Authorization	For medical/surgical and mental health/substance use disorder benefits, a full list of all codes that require prior authorization is listed 2022_IFP_SG_PA_List.pdf (brighthealthplan.com) In-Network, Outpatient- Other, Benefits which require prior authorization include: Medical/Surgical: Chemotherapy Radiation Treatment Dialysis Services Durable Medical Equipment Genetic Counseling and Testing Hearing Aids Infertility Services High-Tech Imaging Outpatient Surgery Habilitative and Rehabilitative outpatient Therapy Services Cardiac Rehabilitation Pulmonary Rehabilitation Inhalation/Respiratory Therapy Prosthetics Sleep Studies Mental health/Substance use disorder: Partial Hospitalization Intensive Outpatient	Prior Authorization (COC)– Prior Authorization is the process of reviewing a request for health care services prior to receiving care. Prior Authorization may be required to make sure services are Medically Necessary, performed in the least costly setting, and that the Provider is In-Network. Please refer to Your Schedule of Benefits to see which services require Prior Authorization. Prior Authorization – the process of collecting information prior to selected procedures, diagnostic studies, medical equipment, or medications, and checking to make sure that the requested care meets selected clinical protocols and standard cost-effectiveness analysis. Prior Authorization does require judgment or interpretation for Benefits coverage. That coverage determination is based on plan documents, information from the Provider, information from nationally recognized guidelines, and occasionally input from a nationally recognized expert in the field relevant to the requested care. Utilization Review (COC, p. 112)– Is a process used to monitor the use of, or evaluate the	Prior Authorization (COC)– Prior Authorization is the process of reviewing a request for health care services prior to receiving care. Prior Authorization may be required to make sure services are Medically Necessary, performed in the least costly setting, and that the Provider is In-Network. Please refer to Your Schedule of Benefits to see which services require Prior Authorization. Prior Authorization – the process of collecting information prior to selected procedures, diagnostic studies, medical equipment, or medications, and checking to make sure that the requested care meets selected clinical protocols and standard cost-effectiveness analysis. Prior Authorization does require judgment or interpretation for Benefits coverage. That coverage determination is based on plan documents, information from the Provider, information from nationally recognized guidelines, and occasionally input from a nationally recognized expert in the field relevant to the requested care. Utilization Review (COC, p. 112)– Is a process used to monitor the use of, or evaluate the	Bright Health completes an analysis of all identified factors at least annually when determining when to apply utilization review (prior authorization, concurrent review, and retrospective review) requirements to a benefit. Ensuring Appropriate Care Utilization Patterns and Cost of Care Evaluations Regulatory Requirements and Industry Standards Administrative Efficiencies	• Nationally recognized evidence-based treatment guidelines; • Peer-reviewed literature; • Expert medical review by Plan Clinical Leaders including medical and behavioral health; • Consultation with vendors and partners with expertise; • Internal authorization analysis • Internal claims analysis • UM Program operating cost analysis • State and federal regulatory requirements and guidance • National Accreditation standards • Evidence-based guidelines and protocols for standards of quality care • Current clinical policies and medical necessity criteria • Member Plan Documents • Managed Care Industry Standards	Bright Health completes an analysis of all identified factors at least annually when determining when to apply utilization review (prior authorization, concurrent review, and retrospective review) requirements to a benefit. Ensuring Appropriate Care – evaluation of services for which generally accepted standards of care indicate specified treatments; ex - Services for which a lower intensity or less restrictive level of care may be medically appropriate. Variability in quality, safety, utilization, and cost of services is considered. Efficacy of services provided is reviewed according to generally accepted standards of care. Sources: Evidence-based treatment guidelines; medical necessity criteria; expert opinion of internal panel of Plan Clinical Leaders including medical and behavioral health; consultation with vendors and partners with expertise; peer-reviewed literature; Utilization Patterns and Cost of Care Evaluations – authorization and claims data review and analyses. Cost and use variability are evaluated both through internal reporting and published Internal claims reports and data analysis are reviewed at a unit and total cost level. Sources: Authorization reports; evidence-based treatment guidelines; internal authorization and claims analysis by volume, approval/denial rates, claims analysis of unit cost, total cost; fee schedules and reimbursement rates; nationally recognized evidence based treatment guidelines. Regulatory Requirements and Industry Standards – federal and/or state requirements are evaluated to ensure compliance; review of current guidance from regulatory entities and professional organizations; comparisons of other insurer practices	Bright HealthCare completes a comprehensive analysis of identified factors at least annually when determining when to apply utilization review (prior authorization, concurrent review, and retrospective review) requirements to a benefit. The same process is completed for both medical/surgical and mental health/substance use disorder benefits. The only factor which is weighed more heavily is compliance with regulatory requirements which supersedes the other factors in the decision-making process. Bright HealthCare leaders involved in the process to evaluate factors for the application of utilization review requirements include professionals with experience in medical and behavioral health care. Once approved, Prior Authorization lists are available to members and providers on the Bright Health website. Documentation of UM Processes: Prior Authorization is applied through the utilization review process. The process for utilization review is the same for medical/surgical benefits as is in place for mental health/substance use disorder benefits. The utilization review process is consistent with URAC accreditation standards and is applied comparably for both medical and behavioral health benefits. For both medical/surgical and mental health/substance use disorder benefits, Bright Health policies outline in detail the processes for conducting utilization review and are available upon request: MED-017 UM Determinations MED-069 UM Clinical Peer Review Policy MED-070 UM Certification MED-071 UM Non-Certification MED-074 UM Concurrent Review	All utilization review NQTLs (medical necessity, prior authorization, concurrent review, retrospective review, experimental/investigational) are evaluated through comparative analyses of Quality Oversight outcomes and Utilization Review data. See "2022 Comparative Analysis Data Attachment - Georgia" for detailed analysis of Quality Oversight and Utilization Review comparative analysis data outcomes broken out for each NQTL, in operation. Quality Oversight: Application of approved medical necessity criteria is evaluated through the Inter-rater reliability process which is captured in full in Bright Health policy: Med-039 UM Inter-rater Reliability Monitoring All Bright HealthCare staff responsible for clinical decision-making during the utilization review process (ie. Clinicians, peer reviewers, medical directors) will participate in the annual IRR examinations. All clinical criteria relied upon to evaluate medical necessity for medical and behavioral health utilization review is included in the IRR process (for example, MCG, ASAM, Bright HealthCare Medical Policy) that the individual may apply during utilization review. IRR passing threshold is 90% for both medical and behavioral health staff. In addition to the annual IRR process, clinical quality audits are conducted monthly for both medical/surgical and mental health/substance use disorder utilization review staff to evaluate consistent use of utilization review policies and application of appropriate clinical criteria. Each case record is audited for 14 key elements including: •Verification of benefits, eligibility, network •Compliance with utilization review processes as written	Bright HealthCare defines prior authorization the same for medical/surgical and mental health/substance use disorder benefits. The factors, sources, and evidentiary standards in place to design and apply utilization review NQTLs to mental health/substance use and medical/surgical benefits are the same. The process to determine which benefits to apply utilization review requirements to is the same for medical/surgical and mental health/substance use disorder benefits. The same processes are used when conducting utilization review for mental health/substance use disorder and medical/surgical benefits. IRR results and ongoing quality monitoring audits of utilization review demonstrate consistent and comparable application of medical necessity criteria and the process of utilization review between medical/surgical reviewers and mental health/substance use disorder reviewers. Bright Health also evaluates medical necessity determinations through authorization analysis comparably for MH/SUD utilization review as we do for M/S. Based on the analyses, Bright HealthCare concludes that the processes, strategies, evidentiary standards, and other factors used to apply utilization review to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply utilization review to medical or surgical benefits.
Retrospective Review	Services that are subject to prior authorization processes, and that were rendered without prior authorization, require retrospective review for medical necessity and/or benefit coverage. For medical/surgical and mental health/substance use disorder benefits,a full list of all codes that require prior authorization is listed 2022_IFP_SG_PA_List.pdf (brighthealthplan.com) In-Network, Outpatient- Other, Benefits which require prior authorization include: Medical/Surgical: Chemotherapy Radiation Treatment Dialysis Services Durable Medical Equipment Genetic Counseling and Testing Hearing Aids Infertility Services High-Tech Imaging Outpatient Surgery Habilitative and Rehabilitative outpatient Therapy Services Cardiac Rehabilitation Pulmonary Rehabilitation Inhalation/Respiratory Therapy Prosthetics Sleep Studies	Utilization Review (COC)– Is a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Areas of review may include prospective review, concurrent review or retrospective review. Case management and Prior Authorization are also types of Utilization Review. Retrospective Review: Review conducted after services (including outpatient procedures and services) have been provided to the member. Requests for retrospective authorization of services more than 180 days after the date of service will be Denied. Timeliness: Retrospective Review: 30 days Forms/Information Required: For both medical/surgical and mental health/substance use disorder authorization requests, providers can submit requests for authorization via fax or through the provider portal. Bright HealthCare uses the same authorization request form for both	Utilization Review (COC)– Is a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures or settings. Areas of review may include prospective review, concurrent review or retrospective review. Case management and Prior Authorization are also types of Utilization Review. Retrospective Review: Review conducted after services (including outpatient procedures and services) have been provided to the member. Requests for retrospective authorization of services more than 180 days after the date of service will be Denied. Timeliness: Retrospective Review: 30 days Forms/Information Required: For both medical/surgical and mental health/substance use disorder authorization requests, providers can submit requests for authorization via fax or through the provider portal. Bright HealthCare uses the same authorization request form for both	Bright Health completes an analysis of all identified factors at least annually when determining when to apply utilization review (prior authorization, concurrent review, and retrospective review) requirements to a benefit. Ensuring Appropriate Care Utilization Patterns and Cost of Care Evaluations Regulatory Requirements and Industry Standards Administrative Efficiencies	• Nationally recognized evidence-based treatment guidelines; • Peer-reviewed literature; • Expert medical review by Plan Clinical Leaders including medical and behavioral health; • Consultation with vendors and partners with expertise; • Internal authorization analysis • Internal claims analysis • UM Program operating cost analysis • State and federal regulatory requirements and guidance • National Accreditation standards • Evidence-based guidelines and protocols for standards of quality care • Current clinical policies and medical necessity criteria • Member Plan Documents • Managed Care Industry Standards	Bright Health completes an analysis of all identified factors at least annually when determining when to apply utilization review (prior authorization, concurrent review, and retrospective review) requirements to a benefit. Ensuring Appropriate Care – evaluation of services for which generally accepted standards of care indicate specified treatments; ex - Services for which a lower intensity or less restrictive level of care may be medically appropriate. Variability in quality, safety, utilization, and cost of services is considered. Efficacy of services provided is reviewed according to generally accepted standards of care. Sources: Evidence-based treatment guidelines; medical necessity criteria; expert opinion of internal panel of Plan Clinical Leaders including medical and behavioral health; consultation with vendors and partners with expertise; peer-reviewed literature; Utilization Patterns and Cost of Care Evaluations – authorization and claims data review and analyses. Cost and use variability are evaluated both through internal reporting and published Internal claims reports and data analysis are reviewed at a unit and total cost level. Sources: Authorization reports; evidence-based treatment guidelines; internal authorization and claims analysis by volume, approval/denial rates, claims analysis of unit cost, total cost; fee schedules and reimbursement rates; nationally recognized evidence based treatment guidelines. Regulatory Requirements and Industry Standards – federal and/or state requirements are evaluated to ensure compliance; review of current guidance from regulatory entities and professional organizations; comparisons of other insurer practices	Bright HealthCare completes a comprehensive analysis of identified factors at least annually when determining when to apply utilization review (prior authorization, concurrent review, and retrospective review) requirements to a benefit. The same process is completed for both medical/surgical and mental health/substance use disorder benefits. The only factor which is weighed more heavily is compliance with regulatory requirements which supersedes the other factors in the decision-making process. Bright HealthCare leaders involved in the process to evaluate factors for the application of utilization review requirements include professionals with experience in medical and behavioral health care. Once approved, Prior Authorization lists are available to members and providers on the Bright Health website. Documentation of UM Processes: Prior Authorization is applied through the utilization review process. The process for utilization review is the same for medical/surgical benefits as is in place for mental health/substance use disorder benefits. The utilization review process is consistent with URAC accreditation standards and is applied comparably for both medical and behavioral health benefits. For both medical/surgical and mental health/substance use disorder benefits, Bright Health policies outline in detail the processes for conducting utilization review and are available upon request: MED-017 UM Determinations MED-069 UM Clinical Peer Review Policy MED-070 UM Certification MED-071 UM Non-Certification MED-074 UM Concurrent Review	All utilization review NQTLs (medical necessity, prior authorization, concurrent review, retrospective review, experimental/investigational) are evaluated through comparative analyses of Quality Oversight outcomes and Utilization Review data. See "2022 Comparative Analysis Data Attachment - Georgia" for detailed analysis of Quality Oversight and Utilization Review comparative analysis data outcomes broken out for each NQTL, in operation. Quality Oversight: Application of approved medical necessity criteria is evaluated through the Inter-rater reliability process which is captured in full in Bright Health policy: Med-039 UM Inter-rater Reliability Monitoring All Bright HealthCare staff responsible for clinical decision-making during the utilization review process (ie. Clinicians, peer reviewers, medical directors) will participate in the annual IRR examinations. All clinical criteria relied upon to evaluate medical necessity for medical and behavioral health utilization review is included in the IRR process (for example, MCG, ASAM, Bright HealthCare Medical Policy) that the individual may apply during utilization review. IRR passing threshold is 90% for both medical and behavioral health staff. In addition to the annual IRR process, clinical quality audits are conducted monthly for both medical/surgical and mental health/substance use disorder utilization review staff to evaluate consistent use of utilization review policies and application of appropriate clinical criteria. Each case record is audited for 14 key elements including: •Verification of benefits, eligibility, network •Compliance with utilization review processes as written	Bright HealthCare defines retrospective review the same for medical/surgical and mental health/substance use disorder benefits. The factors, sources, and evidentiary standards in place to design and apply utilization review NQTLs to mental health/substance use and medical/surgical benefits are the same. The process to determine which benefits to apply utilization review requirements to is the same for medical/surgical and mental health/substance use disorder benefits. The same processes are used when conducting utilization review for mental health/substance use disorder and medical/surgical benefits. IRR results and ongoing quality monitoring audits of utilization review demonstrate consistent and comparable application of medical necessity criteria and the process of utilization review between medical/surgical reviewers and mental health/substance use disorder reviewers. Bright Health also evaluates medical necessity determinations through authorization analysis comparably for MH/SUD utilization review as we do for M/S. Based on the analyses, Bright HealthCare concludes that the processes, strategies, evidentiary standards, and other factors used to apply utilization review to mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to apply utilization review to medical or surgical benefits.
Medical Necessity Criteria	All covered benefits for both Medical/Surgical and Mental Health/Substance Use Disorder must be medically necessary.	(COC) Medically Necessary/Medical Necessity – health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. We use these terms to help Us determine whether a particular service or supply will be covered. When possible, We develop written criteria (called clinical review criteria) that We use to determine Medical Necessity. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put clinical criteria in policies that We make available to the medical community and Our members. We do this so that You and Your Providers will know in advance, when possible, what We will pay for. If a service or supply is not Medically Necessary according to Our published clinical criteria, We will not pay for it. If a service or supply is not addressed by Our clinical criteria, We will consider it to be Medically Necessary only if We determine that it is: •Appropriate and necessary for the symptoms, diagnosis, or treatment of Your medical	(COC) Medically Necessary/Medical Necessity – health care services or supplies needed to diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine. We use these terms to help Us determine whether a particular service or supply will be covered. When possible, We develop written criteria (called clinical review criteria) that We use to determine Medical Necessity. We base these criteria on peer-reviewed literature, recognized standards of medical practice, and technology assessments. We put clinical criteria in policies that We make available to the medical community and Our members. We do this so that You and Your Providers will know in advance, when possible, what We will pay for. If a service or supply is not Medically Necessary according to Our published clinical criteria, We will not pay for it. If a service or supply is not addressed by Our clinical criteria, We will consider it to be Medically Necessary only if We determine that it is: •Appropriate and necessary for the symptoms, diagnosis, or treatment of Your medical	All benefits for MH/SUD and M/S are required to be medically necessary as defined in the members certificate of coverage. Bright Health evaluates medical necessity of covered benefits by conducting utilization review through the medical management processes including prior authorization, concurrent review, and retrospective. Clinical review criteria used during utilization review is evidence based and applied consistently. Bright HealthCare defines medical necessity as: Health care services or supplies needed to diagnose or treat an illness, injury, condition, disease, or its symptoms and that meet accepted standards of medicine. Bright HealthCare may consider health care services or supplies medically necessary if it is determined that the services are: •Appropriate and necessary for the symptoms, diagnosis, or treatment of the member's medical condition. •Provided for the diagnosis or direct care and treatment of the member's medical condition. •In accordance with standards of good medical practice accepted by the organized medical community. •Not primarily for the convenience and/or comfort of the member, the member's family, or the provider. •Not investigational or experimental. •Performed in the least costly setting, method, or manner, or with the least costly supplies required by the member's medical condition.	Bright Health develops written clinical review criteria into medical policies which are used to support medical necessity determinations. Bright Health develops and adopts clinical review criteria that are based on scientific evidence, align with current best practices, and are intended to be guidelines to support utilization management review determinations. Bright Health applies clinical review criteria to support clinical decision-making, including: 1. Internally developed criteria. 2. Commercially available criteria developed by a third-party, including Milliman Care Guidelines (MCG) and American Society of Addiction Medicine (ASAM) 3. Member's Plan Documents 4. State and federal requirements. 5. Other evidence-based external resources. Bright HealthCare relies on information from comparable sources when developing and adopting medical necessity criteria for both mental health/substance use disorder and medical/surgical benefits including: Bright HealthCare relies on the following evidentiary standards when developing and adopting explicit clinical criteria for benefits and services to evaluate medical necessity: •Plan-developed medical policies and clinical criteria •Commercially available criteria developed by a third-party, including MCG Care Guidelines (MCG) and American Society of Addiction Medicine (ASAM)	Bright Health provides coverage for MH/SUD and M/S services that are medically necessary. Bright Health defines medical necessity the same for mental health/substance use disorder and medical/surgical benefits and services. Bright HealthCare develops and adopts clinical review criteria that are based on scientific evidence, align with current best practices, and are intended to be guidelines to support utilization management review determinations. Bright HealthCare's Utilization Management Committee (UMC) oversees the development, review, approval, and evaluation of clinical criteria applied during utilization review to determine medical necessity. Bright HealthCare's UMC members include professionals from diverse specialties that represent the needs of Bright Health's members based on member demographics. The Committee includes medical and behavioral health subject matter experts and may request the input of additional specialists through ad-hoc consultation or expansion of committee membership or as determined by the Committee. The clinical review criteria are: 1.developed with the involvement of actively practicing physicians, pharmacists and other providers (e.g., chiropractor and therapist) with current knowledge relevant to the criteria or scripts under review to develop the needed clinical criteria 2.based on current, evidence-based clinical principles and processes. The clinical criteria, once developed, are approved by the Chief Medical Officer and the Utilization Management Committee. All internal and external (third-party) clinical criteria is evaluated at least annually. Approval and annual evaluation of all clinical criteria is captured in the UMC minutes. Subject matter	Bright Health applies the same definition of medical necessity for both MH/SUD benefits as is applied to M/S benefits. Bright Health relies on the same evidentiary standards and follows the same process to develop, adopt, and review medical necessity clinical criteria for MH/SUD benefits as is relied for M/S benefits. Comparable experts with experience in medical and behavioral health are involved in the process. Medical necessity criteria is applied through the utilization review process which is the same for mental health/substance use disorder and medical/surgical (as described in the Prior Authorization, Concurrent Review, and Retrospective Review analysis). Bright Health concludes compliance with MHPAEA as written.	All utilization review NQTLs (medical necessity, prior authorization, concurrent review, retrospective review, experimental/investigational) are evaluated through comparative analyses of Quality Oversight outcomes and Utilization Review data. See "2022 Comparative Analysis Data Attachment - Georgia" for detailed analysis of Quality Oversight and Utilization Review comparative analysis data outcomes broken out for each NQTL, in operation. Quality Oversight: Application of approved medical necessity criteria is evaluated through the Inter-rater reliability process which is captured in full in Bright Health policy: Med-039 UM Inter-rater Reliability Monitoring All Bright HealthCare staff responsible for clinical decision-making during the utilization review process (ie. Clinicians, peer reviewers, medical directors) will participate in the annual IRR examinations. All clinical criteria relied upon to evaluate medical necessity for medical and behavioral health utilization review is included in the IRR process (for example, MCG, ASAM, Bright HealthCare Medical Policy) that the individual may apply during utilization review. IRR passing threshold is 90% for both medical and behavioral health staff. In addition to the annual IRR process, clinical quality audits are conducted monthly for both medical/surgical and mental health/substance use disorder utilization review staff to evaluate consistent use of utilization review policies and application of appropriate clinical criteria. Each case record is audited for 14 key elements including: •Verification of benefits, eligibility, network •Compliance with utilization review processes as written	Bright HealthCare defines medical necessity the same for both medical/surgical and mental health/substance use disorder benefits. The process for developing and adopting medical necessity criteria is the same for both medical/surgical and mental health/substance use disorder. The application of medical necessity criteria is through utilization review which follows the same process for medical/surgical and mental health/substance use disorder benefits. The panel of experts involved in the development, adoption, and annual evaluation of medical necessity criteria include medical and behavioral health professionals with diverse experience. The process to apply medical necessity criteria through the utilization review process is the same for medical/surgical and mental health/substance use disorder. All staff are evaluated annually on the appropriate and consistent application of the approved medical necessity criteria. The results of the annual IRR evaluation indicate that both medical/surgical and mental health/substance use disorder benefit UM staff consistently apply approved medical necessity criteria appropriately. Bright HealthCare concludes that parity exists for medical necessity criteria as it is applied to medical/surgical and mental health/substance use disorder benefits.
Experimental/Investigational	All	Certificate of Coverage: Section 8 - Limitations/Exclusions (What is Not Covered) Experimental, Investigational, or Unproven Services Health care services excluded under this provision include Experimental, Investigational, and Unproven Services and all related services. The fact that an Experimental, Investigational, or Unproven Service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational, or Unproven in the treatment of that particular condition. This exclusion does not apply to a prescribed drug if: • The drug was approved by the FDA as an "investigational new drug for treatment use" or • It is a drug classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life-threatening disease" as that term is defined in FDA regulations This exclusion does not apply to Covered Health Services provided during a clinical trial as described under the Benefits/Coverage (What is Covered) section of this EOC. Denials for services deemed Experimental,	Certificate of Coverage: Section 8 - Limitations/Exclusions (What is Not Covered) Experimental, Investigational, or Unproven Services Health care services excluded under this provision include Experimental, Investigational, and Unproven Services and all related services. The fact that an Experimental, Investigational, or Unproven Service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition will not result in Benefits if the procedure is considered to be Experimental, Investigational, or Unproven in the treatment of that particular condition. This exclusion does not apply to a prescribed drug if: • The drug was approved by the FDA as an "investigational new drug for treatment use" or • It is a drug classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life-threatening disease" as that term is defined in FDA regulations This exclusion does not apply to Covered Health Services provided during a clinical trial as described under the Benefits/Coverage (What is Covered) section of this EOC. Denials for services deemed Experimental,	Clinical Efficacy of the proposed treatment or services Safety Members Coverage Policy	•Expert Medical Review •Preponderance of peer-reviewed studies of medical literature •State and Federal Regulatory Requirements •Generally accepted standards of medicine •FDA or other regulatory approval •Credible knowledgebases e.g. Hayes, UpToDate, MCG, etc. or textbooks of medicine. •Current and published scientific evidence and technology literature •Technology updates, news and summaries from Hayes, the Cochrane •Collaborative or other nationally recognized organizations, such as medical experts or affected specialty societies •Definition of "clinical trial":	Bright Health does not provide coverage for services determined to be Investigational or Experimental unless those health services are: 1.Mandated by State or Federal rules or specified in the member's coverage policy; or 2.Deemed to be routine care costs during the course of an approved Clinical Trial:. Clinical trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is described in any of the following subparagraphs: (A)Federally Funded Trials- The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following: (i)The National Institutes of Health. (ii)The Centers for Disease Control and Prevention. (iii)The Agency for Health Care Research and Quality. (iv)The Centers for Medicare & Medicaid Services. (v)cooperative group or center of any of the entities described in clauses (i) through (iv) or the Department of Defense or the Department of Veterans Affairs. (vi)A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants. (vii)A study or investigation has been conducted and approved through a system of peer review by one of the following: (I)The Department of Veterans Affairs. (II)The Department of Defense. (III)The Department of Energy.	A request for coverage under a benefit exception process requires the following information to be submitted with the request for the benefit exception in order to render a coverage decision: • A letter of explanation from the referring provider outlining the specific needs of the member •Relevant medical records. •Other materials in support of the request including, but not limited to, peer-reviewed studies, clinical trial protocols, clinical evidence-based research, peer opinion, etc. (See "Prior Authorization" description of Intake through initial clinical review. Below is the additional process and criteria for Experimental/Investigational requests.) Bright HealthCare MD Peer Reviewer will evaluate each request on a case-by-case basis. The MD Peer Reviewer will review peer-reviewed literature and other evidentiary standards listed above when conducting the clinical review. MD Peer Reviewer will determine a request for services is denied on the basis of being experimental/investigational as defined by any of the following: 1)The service does not have unrestricted market approval from the Food and Drug Administration or final approval from any other regulatory body for use in treatment of the member's condition. It also includes medications that are prescribed for "Off-label" uses as described in the FDA approved labelling.	Review NQTLs (medical necessity, prior authorization, concurrent review, retrospective review, experimental/investigational) are evaluated through comparative analyses of Quality Oversight outcomes and Utilization Review data. See "2022 Comparative Analysis Data Attachment - Georgia" for detailed analysis of Quality Oversight and Utilization Review comparative analysis data outcomes broken out for each NQTL, in operation. Quality Oversight: Application of approved medical necessity criteria is evaluated through the Inter-rater reliability process which is captured in full in Bright Health policy: Med-039 UM Inter-rater Reliability Monitoring All Bright HealthCare staff responsible for clinical decision-making during the utilization review process (ie. Clinicians, peer reviewers, medical directors) will participate in the annual IRR examinations. All clinical criteria relied upon to evaluate medical necessity for medical and behavioral health utilization review is included in the IRR process (for example, MCG, ASAM, Bright HealthCare Medical Policy) that the individual may apply during utilization review. IRR passing threshold is 90% for both medical and behavioral health staff. In addition to the annual IRR process, clinical quality audits are conducted monthly for both medical/surgical and mental health/substance use disorder utilization review staff to evaluate consistent use of utilization review policies and application of appropriate clinical criteria. Each case record is audited for 14 key elements including: •Verification of benefits, eligibility, network •Compliance with utilization review processes as written	Bright HealthCare defines Experimental/Investigational Treatment the same for M/S and MH/SUD benefits. The process to determine which benefits meet criteria for Experimental/Investigational is the same for M/S and MH/SUD benefit determinations. The same evidentiary standards are used when conducting utilization review for Experimental/Investigational requests. Operational monitoring of these requests for comparability and stringency is in place and ongoing through clinical quality auditing program and evaluation of utilization metrics such as denial rates. Based on the analyses, Bright HealthCare concludes that the processes, strategies, evidentiary standards, and other factors used evaluate Experimental/Investigational Treatment requests for mental health or substance use disorder benefits, as written and in operation, are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, and other factors used to evaluate Experimental/Investigational Treatment requests for medical or surgical benefits.
Provider Credentialing	All providers listed in the directory must be credentialed according to Bright Health Plan's accreditation certification with URAC. The NQTL discussed in this analysis is specific to credentialing standards/processes	All providers (including MH/SUD, and MED/SURG providers) listed in the directory must be credentialed according to Bright Health Plan's accreditation certification with URAC.	All providers (including MH/SUD, and MED/SURG providers) listed in the directory must be credentialed according to Bright Health Plan's accreditation certification with URAC.	Credentialing criteria outlined in Bright Health's internal credentialing policies, including CRE-001. The scope of credentialing applies to the following provider types: - Providers who are licensed, certified or registered by the state to practice independently without direction or supervision. - Providers who have an independent relationship with Bright Health (Providers to whom Bright Health directs its members for care). - Providers who provide care to members under Bright Health medical benefit The following credentialing factors are reviewed for both MH/SUD and MED/SURG providers: - Education and Training (highest level of education achieved) Board Certification - Current Malpractice - Malpractice History - Work History - Medicare and Medicaid Sanctions - State Sanctions, Restrictions, Limitations	These are the acceptable verification sources, applied to both MH/SUD and MED/SURG providers: - Education and Training (highest level of education achieved). Sources include: State Licensing agency if PSV of education is verified to be performed Verification of Board Certification AMA Physician Profile AOA Physician Profile - Board Certification. Sources include: Physicians: AMA Physician Profile; AOA Physician Profile Board Certified Docs (official ABMS display agent) CertiFACTS is acceptable for re-credentialing Specific Board verification web site Other health care professionals: State licensing agency if PSV of board certification is performed - Current Malpractice. Source: Copy from Insurance Company - Malpractice History. Malpractice carrier; National Practitioner Databank-Healthcare Integrity and Protection Databank (NPDB-HPDB) - Work History. Source: Verification of Work history is not required but must be reviewed from Application or Curriculum Vitae - Medicare and Medicaid Sanctions. OIG/ GSA NPDB, CMS Preclusion List - State Sanctions, Restrictions, Limitations. Source: State licensing board(s) certified web site	Licensure Primary Source Verification (PSV): Bright Health will verify provider licensure or certification only in the state(s) where the provider provides care for Bright Health members. Any actions on the provider's license is examined and documented by the Credentialing Staff. Any providers found to have license restrictions or sanctions will require Credentialing Committee review as a "Risk File". The evidentiary standards for these factors are directly required BY PR-5, Credentialing Application Standards, issued by URAC via the Health Plan Accreditation Guide Version 7.2. All evidentiary standards are determined by URAC to ensure patient safety. • Board Certification Verification of board certification must be done for any provider who reports they are board certified (and is recommended to be), and for all of a provider's specialties listed in the Directory. Verification of board certification does not apply to non- physician health care professionals unless the board certification information is communicated to members. Further, see above Table 3 for exceptions that Bright Health may make on Board Certifications. Lifetime board certification shall be verified and documented at every credentialing cycle. State licensing agency can be utilized to meet the board certification requirement if the state performs PSV of board certification as part of its licensing process; documentation of the PSV will be kept on file and updated each year it is applied. If provider is not board certified, we verify the highest level of education. • Drug Enforcement Agency (DEA) If a qualified provider does not have a valid DEA at the time of credentialing, or if it is pending, this will be noted in the credentialing file and confirmation will be obtained of an arrangement for another provider to fill prescriptions who possess a valid DEA.	Bright Health follows the policy and procedures outlined in CRE-001. There are no separate desktop level procedures for MH/SUD and MED/SURG providers. Both follow the same policy.	Bright Health reviewed the CRE-001 policy, which details requirements for credentialing both MH/SUD and MED/SURG providers, to identify any requirements or standards that might have an adverse impact on providers who have applied to the Bright Health network. We concluded that the policy and all applicable desk-level procedures did not require any deviation or differences in processing procedures with respect to processing credentialing applications of MH/SUD providers and MED/SURG providers. Additionally, we reviewed the elements for Licensure Primary Source Verification (PSV) to identify if any of these elements proved challenging for MH/SUD providers to produce evidence of compliance. We reviewed what PSVs were the source of credentialing application rejections. Only one PSV proved result in rejections of credentialing applications within the scope of this NQTL analysis. That PSV was state or federal sanctns/exclusions. Upon further analysis, no MH/SUD providers were the applicants of these rejected applications. In operation, the credentialing team closely follows the policy and procedure CRE-001, referenced in this document. Bright Health also reviewed any open remediation plans where the Credentialing Department was directly responsible for remediating a deficiency, and concluded that the active remediation did not impact MH/SUD providers specifically. Remediation plans in place were specific to how the credentialing committee reviews practitioners to ensure that they were not previously terminated or denied. This did not adversely impact MH/SUD providers in particular, and is instead focused on improving the quality and effectiveness of the Credentialing Committee governance structure.	1. Bright Health credentialing standards have not, to date, been the source of a provider complaint. 2. Bright Health's credentialing standards do not adversely impact MH/SUD providers ability to be fully-credentialed to participate in the Bright Health provider network. Within the scope of this NQTL analysis, a nominal amount of providers (<5) did not pass credentialing due to identified sanctions against the provider. None of the providers in this cohort were MH/SUD providers.

Geographic Restrictions	All	The plan will provide covered services within the service area as filed with the state Division of Insurance.	The plan will provide covered services within the service area as filed with the state Division of Insurance.	Bright Health reviews the eligible number of members by reviewing: - Population Density - Historical enrollment - Opportunities to partner with health systems	For Population Density: CMS Public Use File For Historical Enrollment: Bright Health record of enrollment data.	not applicable	Service area restrictions are based on counties.	not applicable	not applicable

Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit elegibility.

Examples of factors for medical management and utilization review include:
- Excessive utilization
- Recent medical cost escalation
- Lack of adherence to quality standards
- High levels of variation in length of stay
- High variability in cost per episode of care
- Clinical efficacy of the proposed treatment or service
- Provider discretion in determining diagnoses
- Claims associated with a high percentage of fraud
- Severity or chronicity of the MH/SUD or medical/surgical condition

Examples of sources for medical management and utilization review factors include:
- Internal claims analyses
- Internal quality standard studies
- Expert medical review

Examples of factors for provider network adequacy include:
- Service type
- Geographic market
- Current demand for services
- Projected demand for services
- Practitioner supply and provider-to-enrollee ratios
- Wait times
- Geographic access standards
- Out-of-network utilization rates

(these examples are merely illustrative and not exhaustive)

Examples of sources for provider network adequacy factors include:
- State and federal regulatory requirements
- National accreditation standards
- Internal plan market analyses
- CAHPS data

Examples of factors for provider reimbursement include:
- Geographic market (i.e., market rate and payment type for provider type and/or specialty)
- Provider type (i.e., hospital, clinic, and practitioner) and/or specialty
- Supply of provider type and/or specialty
- Network need and/or demand for provider type and/or specialty
- Medicare reimbursement rates
- Training, experience, and licensure of provider

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Examples of sources for provider reimbursement factors include:
- External healthcare claims database (e.g., Fair Health)
- Current Medicare Physician Fee Schedule
- Internal market and competitive analysis
- Medicare RVUs for CPT codes.

(These are illustrations of factors and sources are not exhaustive lists of factors and sources. While not illustrated, additional factors and sources would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the evidentiary standard(s) used to define factors identified and any other evidence relied upon to establish the NQTL for MH/SUD benefits are comparable to and applied no more stringently than the evidentiary standard(s) used to define factors and any other evidence relied upon to establish the NQTL for medical/surgical benefits. Describe evidentiary standards that were considered, but rejected and the rationale for rejecting those evidentiary standards.

Please note the term "evidentiary standards" is not limited to a means for defining "factors". Evidentiary standards also include all evidence a plan considers in designing and applying its medical management techniques, such as recognized medical literature, professional standards and protocols (including comparative effectiveness studies and clinical trials), published research studies, treatment guidelines created by professional medical associations or other third-party entities, publicly available or proprietary clinical definitions, and outcome metrics from consulting or other organizations.

Examples of evidentiary standards to define the factors identified, their sources, and other evidence considered include:
- Two standard deviations above average utilization per episode of care may define excessive utilization based on internal claims data.
- Medical costs for certain services increased 10% or more per year for 2 years may define recent medical cost escalation per internal claims data.
- Not in conformance with generally accepted quality standards for a specific disease category more than 30% of time based on clinical chart reviews may define lack of adherence to quality standards.
- Claims data showed 25% of patients stayed longer than the median length of stay for acute hospital episodes of care may define high level of variation in length of stay.
- Episodes of outpatient care are 2 standard deviations higher in total costs than the average cost per episode 20% of the time in a 12-month period may define high variability in cost per episode.
- More than 50% of outpatient episodes of care for specific disease entities are not based on evidence-based interventions (as defined by treatment guidelines published by professional organizations or based on health services research) in a medical record review of a 12-month sample (may define lack of clinical efficacy or inconsistency with recognized standards of care).
- Two published RCTs required to establish a treatment or service is not experimental or investigational.
- Professionally recognized treatment guidelines used to define clinically appropriate standards of care such as ASAM criteria or APA treatment guidelines.
- State regulatory standards for health plan network adequacy.
- Health plan accreditation standards for quality assurance.

(These are illustrations of evidentiary standards are not exhaustive list of evidentiary standards. While not illustrated, additional evidentiary standards would apply to different types of NQTLs.)

Provide the comparative analyses demonstrating that the processes and strategies used to design the NQTL, as written, for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used to design the NQTL, as written, for medical/surgical benefits.

Processes and strategies used to design NQTLs as written include, but are not limited to, the composition and deliberations of decision-making staff, i.e. the number of staff members allocated, time allocated, qualifications of staff involved, breadth of sources and evidence considered, deviation from generally accepted standards of care, consultations with panels of experts, and reliance on national treatment guidelines or guidelines provided by third-party organizations.

Include the results and conclusions from these analyses that clearly substantiate the NQTL regulatory tests of comparability and equitable application have been met.

Examples of comparative analyses include:
- Results from analyses of the health plan's paid claims that established that the identified factors and evidentiary standards (e.g., recent medical cost escalation which exceeds 10%/year) were present in a comparable manner for both MH/SUD and medical/surgical benefits subject to the NQTL.
- Internal review of published information (e.g., an information bulletin by a major actuary firm) which identified increasing costs for services for both MH/SUD and medical/surgical conditions and a determination (e.g., an internal claims analyses) by the plan that this key factor(s) was present with similar frequency and magnitude for specific categories of the health plan's MH/SUD and medical/surgical services.
- A defined process (e.g., internal claims analysis) for analyzing which medical/surgical and MH/SUD services within a specified benefits classification had "high cost variability" (defined by identical factors and evidentiary standards for all services) and, therefore, are subject to a prior authorization, concurrent review and/or retrospective review protocols.
- A market analysis of various factors to establish provider rates for both MH/SUD and medical/surgical services and to establish that the fee schedule and/or usual and customary rates were comparable.
- Internal review of published treatment guidelines by appropriate clinical teams to identify covered treatments or services which lack clinical efficacy.
- Internal review to determine that the issuer or health plan's panel of experts that determine whether a treatment is medically appropriate were comprised of comparable experts for MH/SUD conditions and medical/surgical conditions, and that such experts evaluated and applied nationally-recognized treatment guidelines or other criteria in a comparable manner.
- Internal review to determine that whether the process of determining which benefits are deemed experimental or investigative for MH/SUD benefits is comparable to the process for determining which medical/surgical benefits are deemed experimental or investigational.

(These are illustrations of comprative analyses and are not exhaustive list of comparative analyses. While not illustrated, additional comparative analyses would apply to different types of NQTLs.)

Provide the comparative analysis demonstrating that the processes and strategies used in operationalizing the NQTL for MH/SUD benefits are comparable to and no more stringently applied than the processes and strategies used in operationalizing the NQTL for medical surgical benefits.

Please identify each process employed for a particular NQTL (e.g., consultations with expert reviewers, clinical rationale used in approving or denying benefits, the selection of information deemed reasonably necessary to make a medical necessity determination, etc.) and the analyses which supports comparability and appropriate application stringency.

Illustrative analyses includes:

Medical Management
- Audit results that demonstrate that the frequency of all types of utilization review for medical/surgical vs. MH/SUD, where applicable, are comparable.
- Audit results that demonstrate physician-to-physician utilization reviews for prior or continuing coverage authorization were similar in frequency and content (e.g., review intervals, length of time, documentation required, etc.) of review for medical/surgical vs. MH/SUD within the same classifications of benefits.
- Audit results that demonstrate the process of consulting with expert reviewers for MH/SUD medical necessity determinations is comparable to and no more stringent than the process of consulting with expert reviewers for medical/surgical medical necessity determinations, including the frequency of consultation with expert reviewers and qualifications of staff involved.
- Audit results that demonstrates utilization review staff follow comparable processes for determining which information is reasonably necessary for making medical necessity determinations for both MH/SUD reviews and medical/surgical reviews.
- Audit results that demonstrate that frequency of and reason for reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were comparable to the frequency of reviews for the extension of initial determinations for medical/surgical benefits.
- Audit results that demonstrate that reviews for the extension of initial determinations (e.g., outpatient visits or inpatient days) for MH/SUD benefits were of equivalent stringency to the reviews for the extension of initial determinations for medical/surgical benefits.
- Audit/review of denial and appeal rates (both medical and administrative) by service type or benefit category.
- Audit/review of utilization review documentation requirements.
- Audit results that indicate that coverage approvals and denials correspond to the plan's criteria and guidelines.
- A comparison of inter-rater reliability results between MH/SUD reviewers and medical/surgical reviewers.

Network Adequacy
- Analyses to determine whether out-of-network and emergency room utilization by beneficiaries for MH/SUD services are comparable to those for out-of-network utilization for similar types of medical services within each benefits classification.
- Analyses of provider in-network participation rates (e.g., wait times for appointments, volume of claims filed, types of services provided).

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#REF! **OON-Outpatient-All Other**

NQTL	Covered Service	**Step 1** Any NQTL that applies to only Med/Surg benefits would be compliant for MHPAEA and is not listed.		**Step 2** Identify the factors and the source for each factor used to determine that it is appropriate to apply this NQTL to MH/SUD benefits.		**Step 3**	**Step 4**	**Step 5**	**Step 6**
		Description of Med/Surg applicabilty:	**Description of MH/SUD applicability:**	**Factors**	**Sources**	**Identify and provide the basis of the evidentiary standard(s) for each of the factors identified Step 2 and any other evidence relied upon to design and apply the NQTL.**	**Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, as written**	**Provide the comparative analyses used to conclude that the NQTL is comparable to and no more stringently applied, in operation**	**Provide a detailed summary explanation of how the analyses of all of the specific underlying processes, strategies, evidentiary standards, and other factors used to apply the NQTL to MH/SUD benefits and to medical/surgical benefits have led the plan to conclude compliance with MHPAEA.**

Provide the specific language associated with the limitation, as provided in the plan documents for each covered service listed in column B. This shall include each step, associated triggers, timelines, forms and requirements for both Med/Surg and MH/SUD benefit elegibility.

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